INANNA
BIRTH & WOMEN'S CARE

_____

Name_____

Address _____

City State Zip

Telephone (H)_____(W)_____(C)_____

Date of Birth _____ SSN _____ DL# _____

Highest Grade completed _____ Race _____ Are you S M W D Sep ?

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

Partner's Name _____ Occupation _____

How did you hear about us? _____ Pharmacy used_____

Email address _____ Pharmacy Phone # _____

Insurance Information

Company _____ Policy/ID# _____(mcd)

Policy Holder's name _____ DOB _____

Employer _____ Relationship Self Spouse Child Other

Financial Agreement

It is office policy that all visits must be paid for at the time of service. The only exception is PPO/HMO patients for which we are a contracted provider. The co-pay and any charges insurance does not cover will be collected at each visit. Returned checks and balances older than 30 days may be subject to additional collection fees. We file claims to primary insurance. Filing secondary insurance is the responsibility of the patient.

Payment plans are available for our obstetrical patients, with all fees due by 34 weeks.

You will receive 2 bills: one for services provided by the nurse midwife (Birthing from the Heart) and a second for birth center fees (Inanna Birth and Women's Care). Either of these may be filed in or out of network – please check with your insurance to determine in-network eligibility for both entities. There is also a non-refundable $250 birth assistant / transfer fee that is not covered by insurance.

I understand and agree that regardless of my insurance status, I am ultimately responsible for account balances for all services. Insurance claims not been paid after 60 days, may become the responsibility of the patient.

Please note that a 24-hour appointment cancellation notice is required. If no cancellation is received you will receive a bill for $25

I understand that in the event of transfer to the consulting physicians group, financial responsibility for any associated fees will be the patients'.

_____ _____

Patient/Parent Signature Date

I authorize Inanna Birth & Women's Care &/or Birthing from the Heart to release any medical information to my insurance company necessary to process claims related to services provided.

_____ _____

Patient/Parent Signature Date

I have read and been provided with (upon request) a Notice of Privacy that provides a complete description of information uses and disclosures.

_____ _____

Patient/Parent Signature Date