

## Midwife Services Registration

Date: \_\_\_\_\_ Legal Name: \_\_\_\_\_  
First MI Last

Preferred Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_ Employer Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Religion: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employment Status:  Full Time  Part Time  PRN  N/A  Student

My Primary Care Provider/Family Doctor: \_\_\_\_\_

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Please specify the race you most closely identify with: \_\_\_\_\_

Do you consider yourself to be ethnically Hispanic or Latino?:  Yes  No

Language Spoken: \_\_\_\_\_

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### Insurance Company/Cardholder's name

Primary \_\_\_\_\_ Secondary: \_\_\_\_\_

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Spouse Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Only if the insurance card holder)

Employer: \_\_\_\_\_ Employer Phone: (\_\_\_\_\_) \_\_\_\_\_

Employment Status:  FT  PT  PRN  N/A Alternate Phone:(\_\_\_\_\_) \_\_\_\_\_

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***Please complete if insurance held by someone other than you OR your spouse:***

Guarantor Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone:(\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Employment Status:  FT  PT  PRN  N/A

# Midwife Services Patient Communication Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

The purpose of this form is to obtain guidance about how we should communicate about you and to you.

## SECTION 1: Communications to Family Members and Others Involved In My Healthcare

I give my permission to Midwife Services to communicate information concerning my medical condition and medical treatment to the person(s) listed below.

*(Note: If the patient is a minor, pursuant to Iowa law, information generally will be given to both parents unless Midwife Services otherwise deem the communication inappropriate.)*

Name 1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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Name 1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that it is my responsibility to update the above information if I want it changed. This communication information will be used for all medical conditions and treatment obtained at Midwife Services or at the request of one of the healthcare providers employed at Midwife Services. I understand that mental health, substance abuse treatment and/or HIV information may not be disclosed pursuant to this form and that a HIPAA- compliant Patient Authorization to Release Information form must be completed to disclose any mental health, substance abuse treatment and/or HIV information. Additionally, I understand that if there are exceptions to the communications permitted pursuant to this form, it is my responsibility to notify Midwife Services.

This form does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner or representative, or if you wish to set up a living will, please discuss this with your primary healthcare physician or your attorney.

## SECTION 2: Standard Methods to Communicate to Me (the patient)

Detailed information regarding my medical condition and medical treatment may be left on:

My Home Answering Machine  Yes  No Home number is: \_\_\_\_\_

My Work Answering Machine  Yes  No Work number is: \_\_\_\_\_

My Cell Phone  Yes  No Cell number is: \_\_\_\_\_

Exceptions (types of information that cannot be left as messages): \_\_\_\_\_

This form will be in effect until revoked, but I may be asked to confirm the information with a new dated signature on an annual basis.

Signature of Patient or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship (if not patient): \_\_\_\_\_

## Midwife Services Policies & Procedures

### Policy for Arriving Late:

Appointments are scheduled at your convenience and allow our day to flow efficiently for each patient and family. If you arrive 5 minutes late for your scheduled appointment it may be necessary to reschedule your appointment.

### Policy for No-Show Appointments:

To offer you the best patient care, a positive relationship and regular visits are essential. All "failed" appointments by the patient will be documented by the staff in the patient's records and will be reviewed by the providers. A patient is considered to have failed an appointment when the patient has not called or checked in within 15 minutes of appointment time. After three "no-shows or failed" appointments in a 12 month period, the providers will be given the option to terminate your care.

### FMLA and Short Term Disability Paperwork:

There are no fees for filling out patient FMLA or Short Term Disability forms. Paperwork needs to be dropped off at the front desk to be processed. Please allow three to five business days for paperwork to be completed.

### Insurance/Payment: .

I understand that as a patient of Midwife Services of UnityPoint Health – Des Moines, it is my responsibility to know my insurance plan and what benefits are covered, to know if and when a referral is necessary, and have verified that the providers here are in network with my plan. Any balance remaining after insurance has paid is my responsibility. Any questions or concerns that I may have can be addressed to the financial counselor by calling the office during business hours.

My signature below represents **I have read and understand** the statements above.

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Patient's Name

Signature of Patient or Legal Guardian

Date



**CONSENT TO TREAT**

I request and give my consent to medical care and treatment from UnityPoint Health – Des Moines providers and healthcare workers. I understand this includes and is not limited to diagnostic procedures, screening procedures, pathology services, and radiology services. I agree that photographs may be taken of me and used for my treatment or identification purposes.

**FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS**

I understand that I am financially responsible to pay UnityPoint Health – Des Moines its usual charges for all services received through UnityPoint Health – Des Moines , including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to UnityPoint Health – Des Moines, and direct that payment of proceeds be made directly to UnityPoint Health – Des Moines .

**RECORDS RELEASE FOR CLAIMS PAYMENT**

I authorize the release of medical record information or excerpts thereof to any insurance company or third party payer for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

**My signature below represents I have read and understand the terms and statements above.**

This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Patient Name (please print): \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**ACKNOWLEDGMENT OF PRIVACY PRACTICES RECEIPT**

I **have been given** a brochure on Notice of Privacy Practices:

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

I **do not want** a brochure on Notice of Privacy Practices:

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date