UnityPoint Health
Des Moines

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:_____

Please specify the race you most closely identify with: _____

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

Languages Spoken: _____Intrerpreter Preferred ☐ YES ☐ NO

Insurance Company/Cardholder's name

Primary _____ Secondary: _____

Spouse Name: _____ SSN: _____-__-_____ Birthdate: _____/_____/_____
(Only if the insurance card holder)

Employer: _____ Employer Phone: (_____)_____

Employment Status: ☐ FT ☐ PT ☐ PRN ☐ N/A Cell Phone:(_____)_____

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

Guarantor Name: _____ Relationship to Patient: _____

SSN: _____-__-_____ Birthdate: _____/_____/_____ Cell 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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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): _____

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UnityPoint Health - Des Moines Midwife Services

Dear Patient,
Welcome to Midwife Services. All of our staff is committed to family-centered care for you and your family. Below are some guidelines to help you establish a successful working relationship with your provider.

Late Arrival Policy
Midwife Services makes every effort to keep clinic visits on time. By accepting patients who have arrived late, other patients arriving on time could be delayed. Patients arriving ten minutes past their scheduled appointment time may be asked to reschedule their appointment. Note: If staffing is available, we may be able to ask you to wait and you can be fit in without causing additional delays in the clinic schedule. If we are unable to accommodate you, we will reschedule the appointment for later the same day or find a different day that works for you and the clinic. A late arrival that needs to be rescheduled will be considered a “no show” appointment on your record.

No Show Policy
We request that appointments be cancelled with a 24-hour notice to allow us to schedule other patients waiting for an appointment.
You must cancel at least two hours before the appointment time to avoid a “no show” occurrence. If you arrive for your appointment more than 10 minutes after your scheduled time, you may be asked to reschedule and the appointment will be considered a “no show”.
After three documented “no shows” in a consecutive 12-month period, you may be discharged from our clinic. We will continue to see you for 30 days after discharge until you can find another provider.

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.

Patient’s Name | Signature of Patient or Legal Guardian | Date

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Weather Closing Policy

When bad weather causes the UnityPoint Midwife office to close, an attempt to notify patients will be made as soon as possible.

To get this information in the most timely and efficient manner, you may:

- Visit our website at unitypoint.org.
- Visit our Facebook page (@UnityPointDesMoines or @blankchildrens).

If you experience an urgent situation during a weather-related closing, please call 515-309-6011 and you will be connected to the answering service.

Patient Satisfaction Surveys

Our goal is to make sure you are satisfied with the care you receive.

Following your appointments, you may receive a Press Ganey survey in the mail or email. Your feedback is very valuable to us. Please take a moment and fill out the survey and return it in the postage paid envelope. When filling out the Press Ganey survey, we hope you can tell us that we provided you with very good care.

- We use these surveys to help us identify areas of improvement for our clinic.
- We use the information we obtain to educate our staff and continually improve our quality of care and better serve our patients.

If at any time you feel you did not receive very good care, please let us know. If you would like to talk to one of the management team, for any reason, please give us a call at 515-309-6011.

Yours in service,
Misty Reznik
Clinic Administrator, UnityPoint Health - Des Moines Midwife Services

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Des Moines

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

Effective Date: January 1, 2015, Revised Dale: August 16, 2016