

Chico Nurse Midwifery Service, Inc.
Patient Information for Medical Records (please print legibly)

Date: _____
Patient First Name: _____ Middle Initial: _____ Last Name: _____
Any Former Names Used: _____
Date of Birth: _____
Social Security Number: _____ Driver's License # _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # Home: _____ Phone # Work: _____
Cell: _____ Email: _____
Occupation: _____ Employer: _____
Emergency Contact Name: _____
Emergency Contact Phone #: _____ Relationship to Patient: _____
Emergency Contact Address: _____
Marital Status (circle one): Married Single Separated Divorced Widowed Other
Spouse: _____ DOB: _____
Spouse Social Security Number: _____
Address (if different than patient): _____
Spouse's Employer: _____ Work Phone: _____
Cell #: _____

Medical Insurance Information

Primary Insurance: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____

If someone other than patient is responsible for payment please complete:

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____
Zip: _____ Phone #: _____

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Please remember that insurance is considered a method of reimbursement to you for fees paid to the midwives and is not a substitute for payment. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance/insurances. In order to control your cost of billings, we request that your co-pay be paid at the time of service.

If this account is assigned to an attorney or collection agency, I agree to bear the cost of collection, and/or court cost and reasonable legal fees should this be required. I authorize Chico Nurse Midwifery Service, Inc to disclose to the above insurance company(s) or a designated attorney or agent all information necessary to determine benefits and liability. I hereby assign Chico Nurse Midwifery Service, Inc all money to which I am entitled for medical and/or surgical expenses relative to the service rendered by them, but not to exceed my indebtedness to said Certified Nurse Midwives/Nurse Practitioners. A copy is as valid as the original.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Initial

_____ With my consent, Chico Nurse Midwifery (the practice) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the practice's Notice of Privacy Practices for a more complete description of such uses and disclosures. (Available upon request)

_____ I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Chico Nurse Midwifery Service, Inc the Privacy Officer at 1617 Esplanade, Chico, CA 95926.

_____ With my consent, the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

_____ With my consent, the practice may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

_____ With my consent, the practice may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

_____ By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Chico Nurse Midwifery Service, Inc may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date