PATIENT INFORMED CONSENT

Please make sure YOU are informed of your insurance benefits

*****Please initial each line upon reading.*****

Today's Date: ______________________

1. _______ **NOTICE TO OUR PATIENTS REGARDING PAYMENT**:

- *If you are **SELF PAY***—FULL payment of services rendered is required at the time of service.
- **CURRENT INSURANCE CARDS MUST BE PRESENTED AT THE TIME OF SERVICE**
- *If we **ARE** contracted with your insurance*—FULL payment of co-pay's, co-insurance, or deductibles are required at the time of service. We will bill your insurance—*as a courtesy to you*. Please understand if we are not contacted by your insurance *within 60 days* the balance will be your responsibility.
- *If we **ARE NOT** contracted with your insurance*—FULL payment of services is required at the time of your visit. We will bill your insurance—*as a courtesy to you*, but full payment is required at the time of service, if a refund is due to you we will issue it when insurance pays us. Please understand if we are not contacted by your insurance within 60 days, the balance will be your responsibility. Or we would be happy to give you the necessary paperwork so you can bill your insurance yourself.
- ***OB patients***: We will bill your insurance, whether we are contracted or not, for your global package— *as a courtesy to you*. The above information *does apply* to services not covered in your OB contract. Please be familiar with what this includes. Non-global problem visits are billed separately.

2. _______ **OB patients with Blue Cross Blue Shield:** For the most part this insurance ONLY pays for ONE ultrasound /pregnancy. If you chose to have a pregnancy confirmation ultrasound as well as the routine 20-week ultrasound, be aware that you may be responsible for full payment of the 20-week ultrasound.

3. _______ **Pre-authorization Requirements:** Southwest Midwives will obtain *ALL referrals from other physicians,* or *pre-authorizations from insurance* to be in compliance with your insurance or medical coverage. However, it is very helpful to us if you are also aware of your insurance requirements and double-check with us that we are meeting those requirements. *If SWMW fails to obtain a required pre-authorization, we will do our best to correct the mistake, but ultimately, you will be responsible for payment.*

4. _______ **Annual Exams:** Some insurance companies do not cover preventive care visits. Due to insurance fraud issues, we *cannot* change the reason for your visit *AFTER* you have left the office. We contract with many insurance carriers to offer you discounted services and specialty care, but we do not know what your specific plan covers. Please let us know whether you are being seen for a problem or a routine physical exam, so that we may provide you with appropriate care and avoid insurance disappointments.

5. _______ **Record Release:** We do charge a fee to release records, unless one of our doctors has referred you elsewhere. We **only** release records for visits and tests done here at this office.

6. _______ **All Medicaid patients** are responsible for ensuring they are eligible for Medicaid benefits at the time of service. *Proof of this eligibility is required in the form of a Medicaid card, an eligibility letter from Medicaid, or an eligibility letter from your case worker.* If Medicaid denies a claim due to *ineligibility* 100% payment is the patient's responsibility.

7. _______ **Account Balances:** All past due balances, or collection accounts must be *paid in full at the time you come in* for your appointment. You may call to set up payment arrangements, but these must be reasonable and paid in a timely manner. All arrangements MUST be made in advance!

8. _______ **Cancellations**: In order to provide the best possible service and availability to ALL our patients, should you need to cancel your appointment, we ask that you please do so at least 24-hours in advance. *If your appointment is **not** cancelled in advance a fee of $30 will be assessed to your account.*

9. _______ **Emergency Contact:** I give my consent to both SW Midwives and Aspen Billing to discuss finances and medical information with my listed Emergency Contact.

Signature (Patient/Guardian):__________________________________Patient D.O.B: ______/_____/_____