Consent to Treat and Financial Responsibility

Treatment Consent: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office, home or any other satellite office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your caregiver about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist, CNM), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Financial Responsibility: Thank you for allowing Labor of Love Midwifery, LLC to help you with your health care needs. In the interest of good health care practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your care as stress-free as possible.

As a courtesy to you, we will bill your insurance. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting insurance on a disputed claim. Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges, or portions of charges that your insurance does not pay. Unpaid portions, Co-Pay, and Deductibles are due within 30 days of statement mailing.

Self-Payment is due at time of treatment. We offer a self-pay discount.

Please contact the clinic if you are not able to keep your scheduled appointment. Appointments should be cancelled at least 24 hours in advance.

I, the undersigned have insurance coverage, and authorize direct payment from my insurance carrier to Labor of Love Midwifery, LLC. You are responsible for knowing your coverage benefits.

I, the undersigned do not have insurance coverage and understand that I am responsible for payment of all charges.

OR

I have read this credit policy and understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account. IF IT BECOMES NECESSARY FOR THIRD **PARTY** COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

PRINT PATIENT NAME:_____

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN must sign if patient is under 18 years of age
SIGNATURE: _____DATE:_____

Witness_____Signature_____DATE:_____