916 South 3rd Street
Mt. Vernon, WA 98273-4324
Voice: (360) 336-5658
Fax: (360) 336-5655
www.skagitfamilyhealth.com

MIDWIFERY INFORMED CONSENT

While the course of childbearing is a normal human function, I understand that although the likelihood is small in "low risk" women, in any particular case medical complications can arise unpredictably and suddenly. In such cases, mother and/or baby may be at greater risk being outside a hospital setting. I understand that there are also risks associated with labor and birth in a hospital setting. I have made an informed choice regarding the place of birth of my child. I understand that Skagit Family Health Clinic (SFHC) midwives carry certain emergency equipment but cannot duplicate all services available in the hospital setting. I understand that the midwives do not employ electronic fetal monitoring, perform Cesarean sections or administer blood transfusions at home or free-standing birth center.

I understand that the practice of medicine, nursing, and midwifery are not exact sciences, and I acknowledge that no guarantees can be made to me concerning results of treatments, exams, and procedures to be performed. I have the assurance that information regarding my care while a client of SFHC will be shared with me. In addition, decisions regarding my care will be made in consultation with me. I am aware that SFHC midwives carry malpractice insurance.

In view of above, I understand that in the selection and treatment of women, SFHC midwives will rely on my medical history and information about me which I provide. I affirm that such information is and will be complete, correct, and accurate to the best of my knowledge. In addition, I understand that development of any of the following conditions during my pregnancy could be potentially dangerous for me and/or my baby. In certain situations, it may be necessary to ensure the safety of me and my baby for the midwives to do drug screening. By signing the consent below I give permission for SFHC midwives to do random urine drug screen as they deem necessary.

I agree to inform SFHC midwives if I detect any of the following during pregnancy: vaginal bleeding, severe nausea and vomiting, continued severe headaches, unusual or sudden swelling or puffiness, blurred vision or spots before the eyes, pain or burning on urination, chills and/or fever, sharp or continuous abdominal pain, sudden gush of water or leaking of fluid from the vagina or sudden or unusual decrease in the movement of the baby. I have had an opportunity to inform myself or be informed about complications that could arise. My midwives informed me of potential medical complications that require referral. I agree to assume the risks associated with childbirth out-of-hospital. I am responsible for making informed choices, and asking questions to clarify issues about my own and baby's health. I am expected to follow recommendations, treatments, and office visits.

Per Washington state law we perform newborn screening (to prevent a variety of serious problems with undetected metabolic disorders), congenital heart disease screening (to screen for congenital heart defects), and newborn hearing screening unless parents refuse these services for religious reasons and sign the appropriate waiver(s).

SFHC is a preceptor site for midwifery students. All midwifery students at SFHC have been selected by the midwives and have undergone state required background checks, are certified in neonatal resuscitation, and adult CPR certification, and are under the supervision of the midwives. I consent to having a student midwife participate in my care. I understand that I am under no obligation to participate in student learning and may decline students' involvement in my care. If at anytime I feel that I would prefer a practitioner of SFHC perform a procedure rather than the student, I may request this as well. Please feel free to direct your questions or concerns about student learning to the midwives. If you have specific requests concerning student midwife care, please note them on the back of this form.

I authorize SFHC midwives to treat me and my baby and when necessary in an emergency to transfer me or my baby, to a medical physician or hospital for care.

Signature of client	Print Name	Date
Signature of parent or legal guardian of minor	Print Name	Date

○ Check if you would like a copy of this consent for your records.

MIDWIFERY CLIENT REGISTRATION

Name: First Middle Last Maiden?				Date	Preferred Phone: Alternate Phone:	
Race/Ethnicity	Yrs Educ	Marital Status	Occupation and Type of Industry		Date of Birth	State of Birth
Mailing Address: City: Zip:				Inside City Limits? _____Yes _____No	How long at this address?	
Father of Baby Name: First Middle Last			Race/Ethnicity	Yrs Educ	Date of Birth	State of Birth
Address (if different from above)				Preferred Phone: Alternate Phone:	Occupation and Type of Industry	
Partner/Husband (if different from the Father of Baby)			Emergency Contact Name: Phone: Relationship:			
Religion	Insurance: Policy/ID #	Name of Policy Holder Group #				
Preferred Pharmacy and City (choose one)	Secondary Insurance: Policy/ID #	Name of Policy Holder Group #				
Social Security Number (SSN)	Father's SSN	SSN Requested for baby ___Yes ___No	How did you hear about us?			

FAMILY HISTORY—Indicate if anyone in your immediate family has ever had any of these, who; when.

- ❑ High blood pressure_____
- ❑ Cancer_____
- ❑ Diabetes_____
- ❑ Twins_____
- ❑ Severe emotional problems___
- ❑ Alcohol/drug abuse_____

FATHER OF BABY—Indicate if the baby's father has ever had any of these; when.

- ❑ Sexually transmitted diseases_
- ❑ Herpes: (circle one) Genital Oral
- ❑ Severe emotional problems___
- ❑ Alcohol/drug abuse_____
- ❑ Tobacco use_____
- ❑ Other_____

YOUR MOTHER'S HISTORY—Answer the following regarding your mother.

- ❑ # of pregnancies_____
- ❑ # of births_____
- ❑ Miscarriages_____
- ❑ Any complications_____
- ❑ Your weight at birth_____

PREVIOUS PREGNANCY OUTCOMES- *Please complete this table regarding your own pregnancies (from earliest to most recent)*

Date	# Weeks	Birth/Miscarriage/Termination	Comment/Problems

Your pre-pregnancy Weight: _____ lbs

Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?

Yes No Do you or the FOB have any family members with birth defects or genetic or inherited conditions?

Yes No Are you and the FOB related by blood? (i.e. cousins)

Yes No Are you or the FOB from any of these ethnic/racial groups? (circle)
JEWISH BLACK/AFRICAN ASIAN MEDITERRANEAN

Yes No Have you or the FOB ever had hepatitis or jaundice?

Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?

Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?

Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

Yes No Do you think you are at increased risk for AIDS/HIV?

Yes No Have you ever experienced dramatic fluctuations in your weight?

Yes No Have you ever had anorexia, bulimia, or other eating problems?

Yes No Is there anything about the development of your sexuality that you'd like to discuss?

Yes No Is there a partner from a previous relationship who is making you feel unsafe now?

Yes No Do you feel safe in your current relationship?

Yes No Have you been hit, kicked, punched, or hurt by someone within the past year? If so, by whom?

Yes No Have you ever had severe emotional problems?

Yes No Have you ever been on any medication for psychological problems?

Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

MEDICAL HISTORY: Please indicate if you have ever had any of these and when:

- ❑ Severe headaches__
- ❑ Eye/vision problems_
- ❑ Ear/hearing problems
- ❑ Dental problems____
- ❑ Thyroid problems___
- ❑ Rheumatic fever____
- ❑ Blood clotting prob.__
- ❑ Anemia_____
- ❑ Hemorrhage_____
- ❑ High blood pressure_
- ❑ Varicose veins_____
- ❑ Hemorrhoids_____
- ❑ Tuberculosis_____
- ❑ Asthma_____
- ❑ Skin disorders_____
- ❑ Stomach problems__
- ❑ Ulcers_____
- ❑ Chicken pox_____
- ❑ Bowel problems____
- ❑ Blood in stool_____
- ❑ Gall bladder prob.___
- ❑ Liver problems_____
- ❑ Hepatitis_____
- ❑ Diabetes_____
- ❑ Hypoglycemia_____
- ❑ Bladder infection____
- ❑ Kidney infection____
- ❑ Urinary surgery_____
- ❑ Urethral dilation____
- ❑ Aching joints_____
- ❑ Pelvic/back injuries__
- ❑ Seizures_____
- ❑ Cancer_____
- ❑ Hospitalizations____
- ❑ Surgeries_____
- ❑ Other_____

ALLERGIES:

Do you have any allergies? ___Yes ___No

Please list:_____

_____

_____

GYNECOLOGIC HISTORY

Age at first period_____ Cycle length (days)_____

Regular? ___Yes ___No; Duration (days) _____

When was your last Pap? _____

Ever abnormal Pap? ___Yes ___No; Dates: _____

Please indicate if you have ever had any of the following gynecological conditions and when:

- ❑ Yeast_____
- ❑ Trichomonas_____
- ❑ Group B Strept_____
- ❑ Bacterial Vaginosis__
- ❑ Chlamydia_____
- ❑ Gonorrhea_____
- ❑ Syphilis_____
- ❑ PID/Pelvic infection__
- ❑ Genital sores_____
- ❑ Herpes:_____
  ___Genital ___Oral
- ❑ Genital warts_____
- ❑ Cervicitis_____
- ❑ Cervical surgery____
- ❑ Cervical polyp_____
- ❑ Ovarian cyst_____
- ❑ Fibroids_____
- ❑ Endometriosis_____
- ❑ Abnormal bleeding__
- ❑ Uterine surgery_____
- ❑ Breast lump(s)_____
- ❑ Breast surgery_____
- ❑ Infertility_____
- ❑ Other_____

PRESENT PREGNANCY

Last menstrual period (1st day) _____

Was it a normal period? ___Yes ___No

Suspected date of conception: _____

Positive pregnancy test date: _____

Planned pregnancy? ___Yes ___No

Feelings about pregnancy _____

Father's/Partner's feelings _____

Most recent birth control used _____

Contraception used in past: what, when, any problems?

_____

Please indicate if you've had any of the following problems during this pregnancy:

- ❑ Nausea
- ❑ Vomiting
- ❑ Fever
- ❑ Infections
- ❑ Headache
- ❑ Dizziness
- ❑ Indigestion
- ❑ Leg cramps
- ❑ Rash
- ❑ Backache
- ❑ Swelling
- ❑ Constipation
- ❑ Diarrhea
- ❑ Urinary complaints
- ❑ Gut or pelvic pain
- ❑ Vaginal bleeding
- ❑ Vaginal discharge
- ❑ Bleeding gums
- ❑ Varicose veins
- ❑ Hemorrhoids
- ❑ Depression
- ❑ Loneliness
- ❑ Family/relationship problems
- ❑ Work problems
- ❑ Other

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

- ❑ Tobacco
- ❑ Alcohol
- ❑ Caffeine
- ❑ Marijuana
- ❑ Cocaine
- ❑ Street drugs
- ❑ Other meds
- ❑ Non-pres. Drugs
- ❑ Vitamins
- ❑ Herbs
- ❑ Fumes/sprays
- ❑ X-rays
- ❑ Ultrasound
- ❑ Measles/viruses
- ❑ Travel
- ❑ Vaccinations
- ❑ Cats
- ❑ Other

Planned place of birth:

____Home ____Birth Center ____Hospital

If home, please indicate if you have:

____Water ____Electricity ____Telephone

Are there any particular ethnic, cultural, or religious preferences for your care during pregnancy and birth that you would like to discuss? _____

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FINANCIAL ARRANGEMENTS

Prenatal Care, Delivery, and Postpartum Care

The global midwifery fee includes routine prenatal care, on-call services, delivery, and routine postpartum care for the mother, beginning with your first prenatal visit and ending six weeks following the end of your pregnancy. Newborn exam and follow-up visits are an additional charge. Certain clinical situations may require additional visits or procedures above and beyond routine care which may incur additional fees. There are two methods of payment: insurance, or self-pay. If you have insurance with which we are contracted we will bill your insurance company for services rendered. For self-pay clients, and clients with whom we are not contracted with their insurance, there is a 20% discount for payment if paid in full by 32 weeks of gestation (2 months before your due date). If the fee is not paid in full by this time then the 20% discount no longer applies and the full fee must be paid by 36 weeks gestation (1 month before your due date). Failure to pay in full by 36 weeks may impede your ability to be seen by our providers. If your insurance changes, or care is discontinued, a global fee does not apply and the fee is broken down by services given. The fee break downs are available on request.

Skagit Family Health Clinic (SFHC) accepts third party payments. If you intend to rely on a third-party payer, you must provide SFHC with proof of this insurance coverage at your 1st prenatal visit. If insurance verification is not received by SFHC you will be considered self-pay, with full payment due by 32 weeks gestation to receive 20% discount or 36 weeks gestation for no discount. If verification of your insurance coverage is subsequently obtained, an insurance contract can be instated.

Refund policy

There will be no refund or reduction of your fee if it should be necessary for you to transfer to a hospital setting while labor is in progress or if SFHC spends any time in attendance at your labor or delivery.

Lab and ultrasound fees

Prenatal labs, ultrasound, and other testing is additional and billed through insurance or paid directly to the lab or ultrasound department (if outside ultrasound) where the testing is performed, or our clinic if an in-house ultrasound is performed.

Discontinuation of Care

In the event that the client is referred to the care of another practitioner or the client chooses to discontinue care with SFHC, the fee will be recomputed to reflect the cost of care actually provided. The balance owing will become due in full at the time that the care is discontinued. If the midwife attends your birth in any fashion, you will incur the full fee.

Insurance Payment Authorization

I hereby authorize SFHC, or its representative, to be paid directly by my insurance company. I understand that I am responsible for knowing and understanding my insurance policy and benefits and that I am responsible for any co-pays, deductibles, or services not covered by my insurance. I also authorize SFHC or its representative, to release any medical records that may be necessary for processing of claims.

Past Due Balances

All monthly statement balances are due within 30 days of the statement date. Any balances over 30 days will be assessed 1% interest per month.

_____

Signature of Client Date

_____

Print name

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Contact & Privacy at Skagit Family Health Clinic

Patient name: _____

Contact me

Home Phone: _____
Ok to leave detailed message: □ Yes □ No

Cell Phone: _____
Ok to leave detailed message: □ Yes □ No

Work Phone: _____
Ok to leave detailed message: □ Yes □ No

Email Address: _____
Ok to leave detailed message: □ Yes □ No

Sharing SFHC can share my health info with (i.e. family members):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

*****This form is not a consent to release records to other provider offices*****

Time Limits share records from:

□ Anytime (past/now/future)

□ Dates from _____to _____

For How Long

□ Indefinite

□This date/event: _____

Topic Limits share records:

□ General records & include
- □ Mental Health
- □ Communicable diseases including HIV/AIDs
- □ Alcohol/Drug abuse treatment

Canceling

I can cancel this permission, in writing, at any time. But I can't retroactively cancel permission.

After Sharing

SFHC protects privacy. But SFHC can't control how my designees share information after SFHC has shared it.

Patient/Guardian's Signature_____ Date_____

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FINANCIAL POLICY

Thank you for choosing one of the healthcare providers at Skagit Family Health Clinic (SFHC). We will do our best to provide you with the highest quality medical services. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following Financial Policy prior to your visit, and please ask if you have questions.

CONTRACTED INSURANCE PLANS

SFHC's healthcare providers are contracted with most healthcare insurance plans. SFHC will bill them directly, if services at SFHC are not covered by your healthcare insurance, you are responsible for any balance left after payment and/or denial.

SECONDARY INSURANCE PLANS

If you have secondary insurance, we will courtesy bill the secondary insurance one time only. It will be your responsibility to pay if the secondary insurance denies payment for any reason. We will not bill secondary insurance if the healthcare provider is not contracted with your primary insurance provider (e.g. Medicare). We do not bill tertiary insurance. ***Failure to disclose any or all current insurance coverage will result in you being billed for any charges incurred. SFHC will not sort out any coordination of insurance benefits issues.***

CO-PAYMENTS AND DEDUCTIONS

If your policy has an office visit co-payment, you must agree to pay the co-payment at the time of your visit. Failure to do so will result in an additional $15.00 fee. **Patients are responsible to know the terms of their insurance and whether services are covered.**

PATIENTS WITHOUT INSURANCE

We will require a minimum payment of $50 prior to seeing the provider. The balance is due upon checkout. Just like banks who extend you credit, we require your social security number. If you refuse to provide this form of identification, we will require full payment at the time of service. ***We do offer a discount if full payment is made at the time of service.***

ALTERNATIVE BENEFITS

Naturopathy can be considered an alternative therapy that may or may not be covered by your insurance. It is your responsibility to verify before your scheduled appointment that naturopathic doctors are a covered provider type under your specific insurance policy. Even though our providers may be contracted with your insurance, there are provider specialties and services that can be excluded on insurance plans.

ADDITIONAL CHARGES AND FEES

For any check that is returned for non-sufficient funds, SFHC will charge an additional $30.00 to your account and we will not accept your personal checks in the future. You will be asked to remit the amount of the check plus the service charge in cash or with a credit card payment within 10 days. If your account has not cleared by then, we will refer it for collection action.

All monthly statement balances are due within 30 days of the statement date. Any balances over 30 days will be assessed 1% interest per month.

Patients that "no show" or do not cancel 24 hours prior to their appointment time may be assessed an appointment charge of $25. This charge is your responsibility.

When a child of divorced parents is seen, we will expect payment from whichever parent accompanies that child. We will not bill ex-spouses or the other parent.

I have read and fully understand SFHC's Financial Policy. I hereby authorize SFHC to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

Signature of Patient/Guardian	Printed Name of Patient	Date