Homebirth Collaborative Care Registration Form

** Indicates required field*

Section 1: Personal Information

First: Last:

Date of Birth:
Email:
Phone Number:

Emergency Contact:
Emergency Contact Relationship:
Emergency Contact Telephone Number:
Address:

Line 1

Line 2

City

State Zip Code

Section 2: Type of Collaboration Requested

- ☐ Physician Back-up for Homebirth-Hospital Transfer
- ☐ Antepartum testing: BPP or NST
- ☐ Infant Screening or Circumcision

☐ Obstetrics Consultation

If requesting back-up services, which of our hospitals would you prefer in the event of a transfer? *

☐ HonorHealth Shea
☐ HonorHealth Sonoran
☐ Not Applicable

Due Date or Delivery Date:
Please List any Complications in your current pregnancy or recent delivery *

Midwife or Current Medical Provider:
Midwife's Email:
Midwife's Mailing Address:

Line 1

Line 2

City State

Zip Code

Section 3: Obstetrics and Medical History

Number of Previous Term Vaginal Deliveries:
Number of Previous Cesarean Deliveries:
Number of Previous Preterm Deliveries (<37wks):
Number of Previous Miscarriages or Terminations of Pregnancy:

Please List Any Complications in your Previous Deliveries or write "none":

Please List Any Current or Past Medical Problems or write "none":

Please List Any Past Surgeries or Hospitalizations or write "none":

Please list any medications you are taking or write "none":

Please List Any Allergies to Medication or write "none":

Section 4: Insurance Information

Do you have Medical Insurance? *

- ☐ Yes
- ☐ No

Insurance Provider:
Insurance ID Number:
Insurance Guarantor:
Guarantor Relationship to Patient:

- ☐ Self
- ☐ Spouse
- ☐ Parent

Guarantor Date of Birth:

Section 5: Consents and Acknowledgments

HIPAA and Privacy Information

HIPAA NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO SHOWS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN FOR YOUR RECORDS. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable

health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information. As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations. • Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination. • Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. • Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information by removing all references to individually identifiable information. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: • The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We, are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. • The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. • The right to inspect and copy your protected health information. • The right to amend your protected health information. • The right to receive an accounting of disclosures of protected health information. • The right to obtain a paper copy of this notice from us upon request. We are required by

law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint For more information about HIPAA or to file a complaint, contact: The U.S. Department of Health and Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 Tel. (202) 619-02570

HIPAA ACKNOWLEDGEMENT

With my consent, Wombkeepers may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO), as further detailed in the Notice of Privacy Practices. I have the right to review the Notice of Privacy Practices prior to signing this consent. Wombkeepers reserves the right to revise its Notice of Privacy Practices at anytime and patients may request to receive any revisions in person or in writing. With my consent, Wombkeepers 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 in my care or as necessary for payment. Wombkeepers may also 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, Wombkeepers 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 Wombkeepers 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 by this agreement. By signing this form, I am consenting to Wombkeepers 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. ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF

PRIVACY PRACTICES By signing this document I acknowledge that I have read and/or received a copy of the Wombkeepers Obstetrics and Gynecology HIPAA Notice of Privacy Practices. I have also read the contents of this form.

I consent to the use and disclosure of my protected health information by Wombkeepers in order to carry out treatment, healthcare procedures and payment. I have had the opportunity to ask questions and all my questions have been answered.
Signature:
Date:

Patient Rights and Responsibilities

In order to ensure effective patient care, Wombkeepers OB/GYN and the Renewal Center for Birth has adopted a Patient Rights and Responsibilities Policy.
Rights:

- You are entitled to be treated with courtesy, consideration, respect, and recognition of your dignity, individuality, and right to privacy, including but not limited to auditory and visual privacy. Your privacy shall also be respected when facility personnel are discussing your care.
- You are entitled to personal, respectful and safe care without Abuse, Neglect, Exploitation, Coercion, Manipulation, Sexual abuse, Sexual assault, Except as allowed in R9-10-1012(B), restraint or seclusion, Retaliation for submitting a complaint to the Department or another entity, Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student
- A patient or the patient's representative may: Except in an emergency, either consents to or refuses treatment, May refuse or withdraw consent for treatment before treatment is initiated, Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure

- You will be informed of the following: The outpatient treatment center’s policy on health care directives, and the patient complaint process
- Not to be photographed unless consent to photographs of the patient is obtained before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes and Except as otherwise permitted by law, provides written consent to the release of information in the patient’s: Medical record or Financial records.
- The right not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- You are entitled to exercise your civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices or any attendance at any religious service shall be imposed upon any patient.
- You are entitled to know the names and functions of the people involved in your care
- It is the facility’s responsibility to explain your care in language which you can understand
- No diagnostic or therapeutic procedure will be performed on you without your expressed verbal or written consent
- You have the right to refuse medication and treatment after possible consequences of your decision have been explained to you, understanding that your refusal may hinder your ability to be cared for at Wombkeepers or the Renewal Center for Birth
- You have the right to be fully informed about your treatment, procedures, and expected outcomes before it is performed
- You have the right to receive care in a safe setting
- No research or experimental procedures will ever be used on you without your full consent
- You are entitled to know if other healthcare or educational institutions will be involved in your care and you have the right to refuse such involvement

- You are entitled to be informed of our policies regarding life-saving methods and arranging for that care
- If further care is required you may be transferred to HonorHealth Shea
- Your medical records are only for the purpose of your care. No information in them will be released or shared without your permission, except as directly needed for your care or as required by law. You have the right to review, upon written request, the your own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01
- We will, upon request, review and provide an explanation of your bill, even though it may be covered by insurance
- You are entitled to present any grievances or complaints to our office at 480-454-4490

Responsibilities: You are expected to:

- Provide accurate information about your medical history
- Cooperate with the personnel at Wombkeepers and the Renewal Center for Birth
- Ask questions if you do not understand the treatment or procedure
- Be considerate of other patients
- Provide information necessary for processing your insurance coverage
- Be ultimately responsible for any agreed upon payments as per the Financial Agreement
- Help the doctors, midwives, nurses and medical personnel in their effort to give you quality care by following their instructions and medical orders.

I have read the patient Rights and Responsibilities

Signature:

Date:

Advanced Directives Notice

The AzHDR is designed to help honor patients' end-of-life healthcare wishes by providing seamless access to advance directives, documents that outline a person's healthcare preferences, across the continuum of care. The new secure online AzHDR provides a safe place to store and make accessible Arizonans' advance directive documents so end-of-life care will be guided by their wishes. Any patient who will be potentially entering a hospital for care is encouraged to complete an advanced directive.

Registering advance directives with the AzHDR is free to Arizona residents, provides peace of mind to registrants and offers easy access to participating healthcare providers – ensuring wishes registered are wishes honored.

For information about registered your advanced directives, please visit the website: https://azhdr.org/

The staff at Wombkeepers and the Renewal Center for Birth can sign any forms prior to your submission and keep a copy as part of your medical record with the Renewal Center for Birth.

I have read the Advance Directives Notice
Signature:
Date:

Consent to Treat

I give my consent for:

Physical Examination: I engage and authorize any member of the midwifery, physician, or nursing staff to perform according to the expertise of each discipline, physical examinations on my person to confirm general health, pregnancy, and labor status, obtain the usual specimens and perform the usual diagnostic procedures including but not limited to: drawing of blood for Rh factor, serology, and other tests, pregnancy tests, urinalysis, blood pressure, internal examination, vaginal with or without instruments, obtaining rectal, vaginal, or cervical specimens, including pap smear.

Authority to Treat: I engage and authorize any member of the healthcare staff to treat, administer, and provide as necessary to me and my baby the following: healthcare including prenatal education and instruction, physical examination, obtaining of blood or other specimens or laboratory tests, oral medications, intramuscular, subcutaneous, and IV injections and local anesthesia, intravenous infusions, delivery of my baby, episiotomy and repair, postpartum care, in-house newborn care, follow-up visits by a staff nurse or midwife, such other procedures related to childbearing as may be deemed necessary. I grant to the members of the medical team staff full authority to administer and perform all and singular drugs, treatments , diagnostic procedures, examinations, and ministrations to or upon me and my baby.

Informed Consent for Pregnancy: While the course of pregnancy childbearing is a normal human function, it has been explained to me and I understand that in any particular case, medical problems may arise unpredictably and suddenly which may be a hazard of childbearing or of being born or may be aggravated by the stress of childbearing or being born. **I understand no diagnostic blood test or ultrasound guarantees a healthy infant and the infant may be affected by any number of genetic or infectious conditions or intrauterine loss, even with normal testing.** I also understand that, while some genetic testing may be performed at Wombkeepers and the Renewal Center for Birth, we do not provide genetic counselling and **if I have a concern about a specific genetic condition, I may request a complete genetic consultation to address any my concerns**. I also understand that in childbirth, there is a possibility of excessive blood loss, infection, convulsions, coma, allergic reaction, and respiratory distress. Other possible maternal problems include placental abruption, rupture of an undiagnosed aneurysm, amniotic embolism, uterine rupture, cardiac arrest, anaphylactic shock, and death. Other potential fetal problems include umbilical cord prolapse and related problems, congenital anomalies, fetal distress, malpresentation, immaturity and post maturity, birth injuries, stillbirth, shoulder dystocia, and amnionitis or infection. I also understand that, if I chose an out-of-hospital birth, were one of these rare but serious complications of childbirth to occur, my homebirth midwife would not have all the tools and personnel to immediately respond to such an emergency and transfer to hospital would be necessary and may result in a delay of appropriate care, possibly resulting in a poorer outcome than if the event had occurred in the hospital, even when all proper protocols are followed. I have been informed with regard to all of the

foregoing and am advised that I may have more detailed and complete explanations of each condition described and/or other even more remote risks, consequences and conditions. I am aware that obstetrics, advanced practice nursing and midwifery are not exact sciences and I acknowledge that no guarantees or assurances have been made to me concerning the results of the treatments, examinations, and procedures to be performed.

Signature:

Date:

Financial Policy- Please Review Carefully

Thank you for choosing us to collaborate in your care. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide. We are **in-network** with several major insurers, including **Blue Cross Blue Shield, Aetna, Cigna, and United Health Care**, and directly bill your insurance for all medical services covered by your insurance. You are responsible for all deductibles, co-insurances, and co-pays. We also provide out-of-network billing for other insurers, however we may require a deposit or payment in full prior to delivery.

Special considerations for patients seeking collaborative care include:

- For **back-up physician services**, we charge a **$250 administrative fee** when we accept your registration for care. For patients insured with one of our in-network insurance providers, we will bill your insurance directly for any care provided by our physician during your labor and delivery. Any co-pays, deductibles or co-insurance will be billed to you and is due within 30 days of delivery.
- **If you do not have insurance or we are not in-network with your insurance**, we will **require advance payment for any in-office care** provided to you or your child and will provide a superbill that you may submit to your insurer, health savings account, or health share for reimbursement. For obstetrics patients wishing to register **for back-up physician services, we will require an upfront deposit of $500** that will be **refunded if you do not require transfer services** for labor and delivery. If you require transfer, the balance of our fees will due after your delivery, within 30 days. Please review our cash-pay fee schedule for homebirth patients.

Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies. Fees and Payments Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit or within 30 days of a received bill and can be made with cash, personal check, Visa, MasterCard, or Discover. Insurance co-payments are due at the time of service. We will not bill your secondary insurance for co-payments. If you are unable to pay your co-payment at your visit, your appointment may need to be rescheduled. If it is necessary that you be seen, a $25.00 Copay Service charge will be added to your account. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract. In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate any changes in your personal information. Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover, therefore we can't guarantee payment of all claims by your insurance company. Some common examples of non-covered services are contraception and infertility. Additionally, some plans do not cover preventative or obstetrical services. Reduction or rejection of your claim does not relieve you of your financial responsibility. PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by Insurance Companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Required at Check-In

- Verify Personal Contact Information
- Present Current Copy of Insurance Card and Present Current Picture ID
- Payment of any Outstanding Balance and Payment of Today's Visit

We will verify your coverage at each visit. If we are unable to do so, you will be considered self pay and will be responsible for your visit. Self-Pay In order to address the needs of our patients without insurance and patients with

coverage limitations, we offer a 30% prompt payment discount. For gynecologic services, this 30% discount is available to patients paying upfront, prior to their visit. For obstetrics patients, this discount is available to patients paying their entire global fee prior to 36 weeks. This discount acknowledges the lower cost involved in billing and collections when a claim does not need to be submitted to a third party payer.

Annual Exams and Mammography Please verify that your insurance will cover these preventative services before making your appointment. Depending on your age and the plan, these services may not be covered. Also, some insurance companies are very strict in enforcing time limits between visits and may not cover your visit if you are even one day early.

Family Medical Leave Act and Disability Paperwork If your employer requires Family Medical Leave Act (FMLA) or Disability paperwork to be completed by your provider, we offer two options: • A form created by our practice that meets the needs of both employer and patient. Patients may request this form to be filled out at any time to clarify their current condition. The turnaround time for this form is 5 business days and there is no charge for this. • Forms directly from your employer requiring additional information take considerable time for the staff to complete. We are happy to complete these forms for you; however there is a 10 business day turnaround.

Miscellaneous Charges Returned Check Charge : Late accounts will be charged a fee: 25$ at 30 days, 50$ at 60 days, 100$ at 90 days, and 18% interest on the account after 120 days, accruing monthly. Non Sufficient Funds (NSF) checks are subject to a $25.00 fee (in addition to fees from your bank). Collections Charge: Accounts that are not paid within 120 days from due date may be sent to an External Collection agency and reported to the Credit Bureau. In addition to your outstanding balance, a 33% surcharge may be added to cover our costs. In addition, you may be removed from the practice.

Lab Charges: Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the Lab facility. Please understand that we do not have knowledge of what labs your insurance will and will not cover or at what cost.

It is your responsibility to discover this information and we are not responsible for any lab costs associated with tests we order. We order the tests we deem appropriate to provide care and you may choose whether or not to have them performed.

Refunds: Patient Refunds are processed on the last Friday of the month. Any account that has outstanding claims will not be eligible for a refund.

I certify that I have read and understand this financial policy and that I have had the opportunity to ask questions and all questions have been answered.
Signature:
Date:

Collaborative Care Acknowledgment- Please Read Carefully

- I acknowledge that I am requesting collaborative care only. My outside midwife or other care provider and myself remain responsible for all decisions relating to my pregnancy, labor, delivery, postpartum, and infant care. Antepartum testing, newborn screening, or other results will be sent to my midwife or pediatric provider and they are responsible for all recommendations, management, and follow-up of these results.
- If I am requesting an obstetrics consultation, a report will be provided to my midwife with Dr. Aristizabal's recommendations, however follow-up and decision making regarding those recommendations will be between me and my chosen care provider and not the responsibility of Dr. Aristizabal.
- I understand that Dr. Aristizabal is not responsible for any decision made by myself or my midwife before, during, or after my delivery. She is not responsible for and does not endorse the safety any specific care provided by my midwife, any specific midwife, or even the decision to birth at home. I understand that she does not

employ or supervise my midwife and cannot attest to the quality of care provided by my midwife and is not liable for any care provided by my midwife. I also agree that Dr. Aristizabal is not liable for any consequence of my decision to pursue a homebirth and understand that any recommendations provided are for guidance in decision making between my midwife and I, as a second opinion, and do not constitute approval for my planned homebirth, a recommendation that I pursue a homebirth over a hospital delivery, or guarantee of a safe homebirth. Dr. Aristizabal will not provide care for me outside of her practice facilities or credentialed hospitals and, if I or my midwife determine that I require transfer to physician-led care during my pregnancy or labor process, Dr. Aristizabal must verbally accept my transfer. All decisions and care prior to that acceptance of transfer and my arrival to one of Dr. Aristizabal's credentialed facilities for delivery is the responsibility of my midwife, not Dr. Aristizabal.

- **Back-up physician services are only available directly through Dr. Aristizabal and enrollment for back-up care and payment of the back-up service administrative fee does not guarantee her acceptance of a transfer during labor and delivery.** While Dr. Aristizabal will not enroll a patient for backup services if she knows she has a schedule conflict with their anticipated date of delivery and every effort is made to be available for her enrolled patients, there are some situations in which Dr. Aristizabal may not be available or may be unwilling to accept a transfer of care during labor. Some of these situations include, but are not limited to:
  - personal illness or other personal emergency
  - personal vacations
  - patient care conflict in which she is caring for a patient at a facility other than my identified transfer facility and it is deemed unsafe for me to come to that other facility
  - failure of myself or my midwife to provide appropriate records prior to my labor
  - extreme deviations from standards of care by my midwife during my pregnancy or labor.

- I will not be considered her private patient and should I present to one of her credentialed hospitals without my transfer being accepted verbally by Dr. Aristizabal, I would be cared for by whatever physician is on-call for the hospital for "No Doc Services" and this would not be considered abandonment of my care by Dr. Aristizabal, her practice, or her covering physicians. Dr. Aristizabal's covering physicians, who provide emergency and vacation coverage for her private practice, do not provide homebirth back-up and should another physician be covering for Dr. Aristizabal, they would not accept my transfer or be responsible for my care.
- I understand that enrollment for all collaborative services require physician approval and that completing this registration form does not automatically enroll me in collaborative services. I will be notified of my approval for collaborative services within seven days of form completion and I will be contacted for payment of any required fees or deposits. My enrollment will not be finalized until all fees and deposits are paid. Once my enrollment is finalized, I will be scheduled for care or receive back-up contact information and procedures.
- If I am registered for back-up collaborative care, I or my midwife will ensure that my **prenatal record is provided to Dr. Aristizabal by 37 weeks** and that I or my midwife will notify Dr. Aristizabal when my labor begins and when I am safely delivered at home or when a transfer of care is needed, prior to my hospital arrival.

Signature:

Date: