Rose Midwifery Practice
4545 E 9th Ave, Ste. 502
Denver, CO 80220
P: 303-320-2944
F: 303-320-2947

Patient ID Sticker

PATIENT DEMOGRAPHICS

Today's Date : _____/_____/_____

PATIENT INFORMATION

(Legal) Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Apt # _____

City _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____ Other Contact Option: _____

Employer: _____ Work Phone: _____

Date of Birth: _____ City, State, Country of Birth: _____

Age at today's visit: _____ Social Security Number: _____ -- -- _____

1st day of last period: _____ □ N/A Marital Status: □ Single □ Married □ Divorced □ Other

Estimated Due Date: _____ □ N/A Race: _____

Reason for visit (circle): Routine | Pregnant | GYN Religious Preference: _____

RESPONSIBLE PARTY (who should receive the bill's)

Name _____ Phone Contact: _____ Other: _____

Street Address _____ City: _____ State: Zip Code: _____

Social Security Number _____ Date of Birth _____

Employer _____ Work Phone _____

Relationship to Insured / Responsible party (Circle One) : Self | Spouse | Child | Other: _____

INSURANCE INFORMATION (We will need to make a copy of your card and your ID)

Primary Insurance _____ Secondary Insurance _____

ID / Policy Number _____ ID / Policy Number _____

Group Number _____ Group Number _____

Claims Address _____ Claims Address _____

City / State / Zip _____ City / State / Zip _____

CONSENT FOR TEST RESULTS

I give Rose Midwifery permission to leave all radiological, lab results, testing results, and other medical information and advice on: (circle any / all that apply)

Answering Machine at home | Cell Phone voice-mail | Work voice-mail

Other number: _____ | Do Not leave any messages at any numbers

EMERGENCY CONTACT INFORMATION

Name: Relationship: Phone:

Address: City: State: Zip:

PHARMACY INFORMATION:	Name:	Phone:

Rose Midwifery
HealthONE Clinic Services

Rose Midwifery

PATIENT CONSENT FORM

(Please Read and Sign)
I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Rose Midwifery** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Rose Midwifery** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notices of Privacy Practices.

A Photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Rose Midwifery**.

I acknowledge that I have been given the Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initial:** _____

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

_____ _____

Patient (or Responsible Party) Signature ***Date***

Rose Midwifery

HealthONE Clinic Services

Financial Policy:
In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you; and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service.

For you convenience we will accept VISA, MasterCard, Discover, and American Express, as well as cash, check or money order.

About Health Insurance:
Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer HealthOne will refund any overpayment to you.

About Participating Health Plans:
We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment **at the time of service**.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”; you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

For all service rendered to minor patients we will look to the adult accompanying the patient and parent or guardian with custody for payment. It is your responsibility to verify that this office participated with your insurance. If we do not participate with your insurance, you will likely be responsible for all charges out of pocket.

By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature **Date**

_____ _____

Printed name if signed on behalf of patient Relationship to Patient

Rose Midwifery

Please let us know how you found us!

a) Planned Parenthood □
b) Previous Client □
c) Friend or Family □
d) Rose Midwifery Website □
e) Haven House □
f) Insurance Website □ Insurance Provider _____
g) Healthcare Provider □ Name: _____
h) Internet Search Engine:
- Google Places Page □
- Healthgrades.com □
- Vitals.com □
- Yelp.com □
- Zoc Doc □

i) Rose Medical Center Website: □
j) Rose Referral Line □
k) Advertisement □ Where: _____
l) Other □ Please explain: _____

Thank you!

Appointment Time Expectations

Rose Midwifery Practice is dedicated to respecting your time for prenatal care. We ask that you check in 10 minutes prior to your appointment time to leave a urine sample, and clarify current demographics. We respectfully ask if you are going to be late, please call us @ 303-320-2944 as we may need to reschedule your appointment. If you will be later than 10 minutes, we will offer you the option of rescheduling to a more convenient time, or we will see you on a "work in" basis allowing time for your appointment after clients who arrived for their scheduled appointment times.

Signature: _____ Date: _____