PATIENT REGISTRATION FORM

North Jersey Midwifery Care, L.L.C.
Donna Tabas, CNM, M.S.
3196 Kennedy Blvd., Box 10
Union City, NJ 07087
Telephone # 845-639-3098
Fax # 845-639-3159

Date____/____/_____

Name_____

SS # _____Date of Birth_____

Age_____ Religion_____Race/Ethnicity_____

Home telephone_____ Cell#_____work#_____

Address_____

Birthplace_____ Email:_____

Occupation_____Education_____

Marital Status: Married____ Single____ Divorced____Separated____Widowed___ Domestic Partner___

Husband/Co-Parent/Father of Baby:

Name_____

Tel #_____

Emergency Contact (Name, Relationship, #)_____

_____

Pharmacy_____ Pharmacy tel #_____

Primary Insurance & plan name_____

Account #_____Group #_____

Insurance Address:_____

Insurance telephone # for Providers_____

Insurance Subscriber's Name_____M/F_____

Subscriber's Birthdate_____ Subscriber's SS#_____

Subscriber's relationship to patient_____

Secondary Insurance & plan name_____

Account #_____Group #_____

Insurance Address:_____

Insurance telephone # for Providers_____

Insurance Subscriber's Name_____M/F_____

Subscriber's Birthdate_____ Subscriber's SS#_____

Subscriber's relationship to patient_____

AUTHORIZATIONS/HIPAA INDIVIDUAL CONSENT

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of the information. We must obtain your one time written consent before we treat you, obtain payment for our services, and conduct health care operations at this office. Please read carefully the information below before signing this form.

Notice of Privacy Practices: We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail and we encourage you to read it. We want you to know, however, that the Notice of Privacy Practices is subject to change. If it is changed, you may ask for a copy of the revised notice at your next visit or call the office at 845-639-3098.

_____I have been presented with a copy of the Notice of Privacy Practices (please initial)

Revoking Consent: You have the right to revoke this consent at any time; except to the extent that we have already taken action based upon your consent. For example, if you revoke your consent after we have provided you with treatment, the office will be permitted to use or disclose your protected health information to bill for that treatment. To revoke this consent, please write to our office.

Scope of Consent: By signing this consent form, I hereby authorize Donna Tabas, CNM to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment, facilitating the payment for such treatment and for normal business operations.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Relationship to Patient

CONSENT TO CONTACT ADDITIONAL INDIVIDUALS (Will be contacted *only* if permission is given to do so.)

Spouse_____ Doula/ _____
Name and Number Labor support Name and Number

Other_____
Name and Number

LAB RESULTS AND CLINICAL DETAILS

____I authorize that lab results/clinical details may be left on my voicemail / answering machine/via text

____I do not authorize lab results/clinical details to be left on my voicemail / answering machine/via text

ASSIGNMENT OF BENEFITS FOR OBSTETRICAL PATIENTS

I, the undersigned, hereby assign my insurance reimbursement claim to Donna Tabas, CNM and authorize and request my health insurance carrier to make payment directly to my provider for credit to my account due for services rendered and to be rendered associated with the above pregnancy and birth.

I understand that this assignment is for my convenience and does not relieve me of ultimate payment for services provided and to be provided by my provider.

Signature:_____ Date:_____

RELEASE OF INFORMATION: I certify that the information on the Patient Registration Form is correct.

I authorize the release of any medical or other information necessary to process the claims generated by my care.

Patient's Name (Print)_____

Patient's Name (Signature)_____

Date:_____

AUTHORIZATION TO APPEAL CLAIMS: I authorize New Jersey Midwifery Care, L.L.C., to appeal all claims submitted to my insurance company on my behalf that are denied. I understand that insurance companies will not give any information to out of network providers without my signature as authorization.

Insured's or authorized person's: name: (Print)_____

Insured's or authorized person's: name Signature)_____

Date:_____ Insurance ID #_____