

## Patient Responsibility Payment Agreement

This is to verify that we have received, read and understand the above financial agreement (dated 2/20/11) and have agreed to fulfill our obligations to Linda Johnson, CNM and/or Mother's Own Birth and Women's Center LLC as stated in the Financial Agreement.

Please complete Option 1 or 2 below

**Option 1** \_\_\_ We are self pay and will not be using insurance, in part or in total, to pay for our care. We understand that if the account is paid in full by the end of the 34<sup>th</sup> week we are eligible for a 10% discount, but the total amount must be paid in full by the end of the 36<sup>th</sup> week. An initial payment of \$100.00 is due at the first prenatal appointment.

Unless otherwise noted, the self-pay full amount of \$ \_\_\_\_\_ is due by the end of the 36th week.  
End of 34<sup>th</sup> week \_\_\_\_\_ End of 36<sup>th</sup> week \_\_\_\_\_

I/we agree to pay the amount due, in the following installments:

Installment 1: \$ \_\_\_\_\_ to be paid by / on \_\_\_\_\_  
Installment 2: \$ \_\_\_\_\_ to be paid by / on \_\_\_\_\_  
Installment 3: \$ \_\_\_\_\_ to be paid by / on \_\_\_\_\_  
Installment 4: \$ \_\_\_\_\_ to be paid by / on \_\_\_\_\_  
Installment 5: \$ \_\_\_\_\_ to be paid by / on \_\_\_\_\_

**Option 2** \_\_\_ We would like to have our insurance billed and understand that the patient responsibility portion of the bill (deductible and co-pay) as determined by Larsen Billing through Verification of Benefits are due by the end of the 36th week unless otherwise noted. We have completed the Payment Plan Agreement with Larsen Billing. An initial payment of \$100.00 is due at the first prenatal appointment.

### Privacy Statement (Insurance)

\_\_\_\_\_ The Notice of Privacy Practices has been provided to me and I have reviewed it before signing this consent. The notice provides information about Mother's Own Birth Center may use and disclose protected health information. As provided in the notice, the terms of this notice may change. If the notice changes, I have been advised that I may obtain a revised copy, by request.

I acknowledge that I have the right to restrict how my protected health information is used or disclosed for treatment, payment, and health care operations. The midwives of Mother's Own Birth Center are not required to abide by these restrictions, but if they do, they are bound by the agreement.

The Notice of Privacy Practices provides information about how Mother's Own Birth Center may use and disclose protected health information about the client. My signature means I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance to my prior consent.

This agreement is made between \_\_\_\_\_, the Clients, and Linda Johnson, CNM / Mother's Own Birth and Women's Center LLC, the Practice.

Client \_\_\_\_\_ Date \_\_\_\_\_  
Spouse or Partner \_\_\_\_\_ Date \_\_\_\_\_  
Practice \_\_\_\_\_ Date \_\_\_\_\_