

Patient Responsibility Payment Agreement

This is to verify that we have received, read and understand the above financial agreement (dated 7/09) 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.

___ We will be **self pay** and understand that if the account is paid in full by the end of the 34th week we are eligible for a 10% discount. The total amount we agree to pay is: \$ _____

Unless otherwise noted above, or elsewhere in this agreement, the full amount of \$ _____ is due by the end of the 36th week.

End of 34th week _____ End of 36th week _____

___ We would like to have our **insurance** billed and understand that the patient responsibility portion of the bill (deductible and co-pay) are due by the end of the 36th week unless otherwise noted. We will, by the second prenatal visit, or have already completed, the Client Registration Form from Larsen Billing and will send, or have sent, this form to the appropriate Larsen Billing representative as found on that form.

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.

To be completed after verification of benefits:

Deductible \$ _____ Copay \$ _____ Total amount to be paid \$ _____

I/we agree to pay the deductible and patient responsibility, or the self pay amounts, 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 _____

Please bill these installments using PayPal. The e-mail to use is _____

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 _____