2120 Pacific Avenue SE Olympia, WA 98506 (360) 459-7222

BASIC MATERNITY CARE PACKAGE: $4500.00/$3600.00 if prepaid

Our fee of $4500.00 covers basic prenatal care, labor and birth attendance, basic newborn and postpartum care. Additional charges may be assessed for more involved care. Lab, diagnostic tests, physician fees or hospital costs are not included.

1. MEDICAID: We accept current open DSHS medical coupons as payment in full for services rendered, including birth at home or in the birth center. We also accept most Healthy Options Plans through DSHS. Please bring a current copy of your coupon to every visit. If you are planning a home birth, you will be responsible to pay out-of-pocket for the birth kit, birth assistant fee, and any applicable long distances charges.

________(initials)

2. PRIVATE INSURANCE: Most insurance companies cover midwifery services. Please check with your company to make sure that they cover Licensed Midwives and home birth or birth center birth. You will be responsible for payment of any deductible, co-pay, and for any services not covered by your insurance company. Occasionally, the insurance company will not cover the entire fee as previously verified. Within 30 days of notification, you are responsible for full payment of any portion of the fee your insurance deems your responsibility, in addition to any non-covered services. After 30 days, interest will accrue at 12% annually, if you have not established a payment plan with our office. Because of slow processing of listed insurance claims, the bill may come months, or even a year, after your care is completed.

_______(initials)

3. SELF PAY: If paying in full one month prior to your due date, there is a 20% ($900.00) discount. If you are unable to prepay in full, $2000.00 is due one month prior to your due date, with the remainder due within 45 days of the birth. Any unpaid balance after 45 days postpartum will be assessed at a 12% annual interest rate. We do have a sliding scale and extended payment plan options if you are in need; please make arrangements with us in advance, prior to signing this agreement. In the event of any transfer of care (during prenatal care or during labor) all charges will be reassessed, and fees will be appropriately discounted or refunded. ________(initials)

4. TRANSFER OF CARE: In the case of a transfer either during your pregnancy or during your labor, the following policies apply: If we transfer your care to the hospital while in labor, we will accompany you to the hospital to ease your transition to another provider's care. If you desire, we will stay with you for labor support, information, and advocacy until after the birth of your baby. However, we often are not able to collect any reimbursement from your insurance company for that time spent, nor the time we were with you in labor before going to the hospital. Due to this inequity, we may ask that you compensate us for time spent with you in labor, up to our usual $1200 fee for labor and birth care.

_______(initials)

ITEMS NOT BILLED TO INSURANCE:

Birth Supplies and Home Birth Kit, ~$40: You will be provided with a list of supplies to gather by one month prior to your due date, as well as an order form for a home birth kit to purchase from a local supplier at discounted prices.

________(initials)

Birth Assisting, $250: A professional birth assistant will assist the midwife at your birth. This fee, payable to the birth assistant, is due at your 36-week appointment, and is fully refundable should you transfer out of our care prior to labor.

_______(initials)

Long Distance Fees, $200 (Sliding scale): We charge a long distance fee to travel more than 20 miles from our office to your home. We generally see you in your home 2-4 times over the course of your care, adding significant time and mileage.

________(initials)

PAYMENT AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR BILLING PURPOSES

I have read and accept the financial agreement as written in this document. I understand that the fees listed are based upon basic fees only, and do not include the cost of lab work, diagnostic tests such as ultrasound or amniocentesis, medications, increased monitoring costs and physician's fees or hospital costs, should any of these become necessary. I understand that there may be other unforeseen expenses, in addition to this contract, that may also be my responsibility. I understand that payment in full is due 30 days after receipt of the bill, and any unpaid balance will be assessed at a 12% annual interest rate. I authorize my insurance company or DSHS to make payments directly to ***Around the Circle Midwifery, LLC***, and I authorize ***Around the Circle Midwifery, LLC*** to release my medical records if necessary for the purpose of third-party reimbursement.

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Client's signature Date

Around the Circle Midwifery, LLC

Client Registration Information

Name____________________ Phone #____________ Work # ______________

Cell #____________________ Other # (specify) ______________________

Date of Birth______________ Social Security # ______________________

Address________________________ City__________ State____ Zip __________

E-mail address____

Primary Insurance

If DSHS covers your health care, leave this part blank. Please provide us with a current copy of your medical card every month.

Insurance company name ______________________________________

Insurance company address ____________________________________

Insurance company phone number _______________________________

Subscriber number____________________ Group number ______________

Name of policyholder__________________ Relationship to client ___________

Policyholder's Date of Birth ___________ SS# of policyholder ______________

Effective Dates: Coverage begins_______________ Coverage ends______________

Office use only: DSHS / CHPW / Molina / Regence / GHC dates:________________

DSHS / CHPW / Molina / Regence / GHC dates:________________

DSHS / CHPW / Molina / Regence / GHC dates:________________

Secondary or Change of Insurance

Insurance company name ______________________________________

Insurance company address ____________________________________

Insurance company phone number _______________________________

Subscriber number____________________ Group number ______________

Name of policyholder__________________ Relationship to client ___________

Policyholder's Date of Birth ___________ SS# of policyholder ______________

Effective Dates: Coverage begins_______________ Coverage ends______________