GENTLE BIRTH CARE

1024 North Blvd., Suite 208, Oak Park, IL 60601

Patient information

Date_____ Date of Birth _____ Age _____

Name _____

Home Phone _____ Cell Phone _____

Home Address _____

City _____ State _____ Zip Code _____

Marital Status _____ Student: Full / Part Time

Social Security _____

Primary Physician _____

Employer _____

Employer Address _____

City _____ State _____ Zip Code _____

Work Phone _____ Email_____

Email: _____

Insurance Policyholder

Name _____ Relationship to Patient _____

Date of Birth _____ S.S. Number _____

Home Phone _____

Home Address _____

City _____ State _____ Zip Code _____

Work Phone _____

Insurance Information

Primary Insurance Company _____

Group Number _____ ID Number _____

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE X

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179

FORM HCFA-1500 (12-90)
FORM OWCP-1500
FORM RRB-1500
#29428

Use with Envelope #14145 (numbered) or #14146 (self-seal)

Gentle Birth Care, Inc.
Women's Health Care & Homebirth Midwifery
1024 North Blvd., Ste 208, Oak Park, IL 60301
ph 708.488.1004 fax 708.488.1009

CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I ***consent*** to have Gentle Birth Care, Inc. Certified Nurse Midwives and staff examine me, perform tests and procedures as they feel in their judgment are reasonable and necessary in the diagnosis and treatment of my case. No test or procedure will be performed without informed consent and prior approval by me. I acknowledge that no guarantees will be made to me as to the result of treatments and examinations done.

I ***assign*** to Gentle Birth Care. the medical and/or surgical benefits to which my dependents or I are entitled under my health insurance plan. I also agree if any insurance benefits due to my dependents or me is insufficient to cover the professional fees of our care, that I will be responsible for the payment of the difference, including any deductibles and co-payments. If insurance coverage is insufficient, denied, or otherwise unavailable, I agree to pay for all the charges not covered by the insurance or third party payor(s).

I ***consent*** to the use or disclosure of my protected health information by Gentle Birth Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Gentle Birth Care.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed. Gentle Birth Care is not required to agree to my requested restrictions, however, if Gentle Birth Care agrees, then the restriction is binding on Gentle Birth Care, Inc.

I ***understand*** I have the right to revoke this consent, in writing, at any time, except to the extent that Gentle Birth Care has taken action in reliance of this consent.

I ***understand*** I have the right to review Gentle Birth Care's Notice of Privacy Practices prior to my signing this document. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Gentle Birth Care. The Notice of Privacy Practices also describes my rights and Gentle Birth Care's duties with respect to my protected health information.

Gentle Birth Cares reserves the right *to change anytime* the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

With this consent, Gentle Birth Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

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CONSENT FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

With this consent, Gentle Birth Care may e-mail or mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder cards, patient statements, any health promotions for disease management, preventive care, and wellness programs pertaining to my clinical care as long as they are addressed personally to me.

Please identify by name any family members, a relative, or any other person we may disclose your protected health information who might directly be involved in your health care.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative — Date

Description of Personal Representative's Authority

Joint Acknowledgement of Receipt of Gentle Birth Care, Inc. Notice of Privacy Practices

I acknowledge that I received Gentle Birth Care Notice of Privacy Policies. I understand that the Notice describes the uses and disclosures of my protected health information by Gentle Birth Care and informs me of my rights with respect to my protected health information. For more information, please contact Hillary Kieser, privacy officer, (708-228-6065).

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative — Date