PATIENT AGREEMENT FORM

Thank you for choosing **Beautiful Beginnings & Beyond Midwifery, LLC** as your OB/GYN provider. We are committed to providing health care you can afford.

We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. I _____ (patient name) give permission for **Beautiful Beginnings & Beyond Midwifery, LLC** to give me medical treatment.

2. I understand the **Beautiful Beginnings & Beyond Midwifery, LLC** accepts patients **with** and **without insurance** benefits. I understand it my responsibility to provide my insurance information, if I wish to have my insurance billed for my visit. I understand a claim for insurance benefits to pay for my care I receive will not be submitted unless I authorize that I wish for my insurance to be billed.

   I understand that:
   - All services I receive must be paid by cash, debit, or credit care in full at the time of service, if I am electing **Self Pay services**.
   - In the event my insurance does not pay the claim submitted for my services, or if I do not have insurance, I understand I am responsible for payment in full. (Knowing your insurance benefits is your responsibility. Please contact your insurance with any questions you may have regarding your coverage to receive the maximum benefit.)
     - ***There is a $10 fee for returned checks or insufficient funds***
   - **Missed appointments:** It is our goal to give you the best care possible. You can help us serve you better by keeping your regularly scheduled appointment. In the event you are unable to make your appointment, please allow us 24hr notice.
     - ***Missed appointment without calling to cancel (no call/no show) will be assessed a fee of $25 for all patients ***

3. I understand:
   - I have the right to refuse any procedure or treatment
   - I have the right to discuss all medical treatments with my healthcare provider
   - I have the right to request to be seen or referred to another healthcare provider such as a physician or nurse practitioner.

_____ _____
Patient's Signature Date

_____ _____
Parent/ Guardian Signature (for minors under 18) Date

_____ _____
Print Name Date