

INFORMED CHOICE AND DISCLOSURE STATEMENT

The following information is provided in order for the consumer to make an informed decision concerning a licensed midwife's scope of practice. Texas Occupations Code Ch. 203 requires midwives to disclose in oral and written form to prospective clients the limitations of skills and practices. This form may be obtained in Spanish if needed. In accordance with the Texas Midwifery Act:

MIDWIVES WILL/MAY

- Assist normal childbirth except in an emergency situation
- Provide prenatal, postpartum, and newborn care or refer to another provider
- Use the title NARM Certified Professional Midwife (CPM) and Licensed Midwife (LM)
- Advise a woman to seek medical care if complications arise
- Administer the prescription drug oxygen and prophylactic eye medication when needed

MIDWIVES WILL NOT

- Use forceps or surgical instruments
- Remove the placenta by invasive techniques
- Advance or retard labor or delivery by using medicines/mechanical devices
- Administer a prescription drug without orders of a licensed physician
- Falsify a birth certificate

LEGAL REQUIREMENTS IN TEXAS

- The law requires newborns to be screened for 27 diseases. Midwives are trained to perform the newborn screen or you may choose to have this test administered by your pediatrician.
- Eye prophylaxis is required to prevent possible blindness from infection.
- Blood tests for syphilis, hepatitis B, and HIV are recommended during pregnancy.
- Communicable diseases must be reported to Department of State Health Services.
- Midwives register births and deaths.
- Midwives comply with the Dangerous Drug Act and the Controlled Substances Act.
- Midwives do not practice medicine and do not carry medical malpractice insurance.
- The Texas Midwifery Act; Texas Occupations Code; Ch. 203;(E)(203.202) requires midwives to advise their client of the following information regarding complaints against midwives:

An individual who wishes to file a complaint against a midwife may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

or call 1-800-942-5540 for additional information concerning complaints.

REQUIRED STATISTICS

- Expiration of Cardiopulmonary Resuscitation Certification: 01/2009
- Expiration of Neonatal Resuscitation: 01/2009
- Expiration of Licensure: 02/28/2009
- The midwives with Texas Midwives Group do not have formal back-up arrangements with physicians. In the event of a transport from home or birth center, the mother and/or infant would be transferred to the hospital of choice by private vehicle or EMS would be activated.
- Midwives are in compliance with the educational requirements of the Texas Midwifery Board.

Births Attended/Training: 300+ Births as Primary Midwife/Training: 100+ Births Attended by Midwives: 600+

The above has been disclosed to me and I understand the purpose of this informed consent.

Client's Signature: _____ Date: _____

HIPAA Authorization

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Texas Midwives Group and their agents, to use and/or disclose certain protected health information (PHI) about me to my insurance company.

This authorization permits and Texas Midwives Group to use and/or disclose the following individually identifiable health information about me. The type of information that will be disclosed are data such as date(s) of services, type of services, level of detail to be released, origin of information, etc. The information will be used or disclosed for the following purpose:

- To collect insurance reimbursement for services performed by a midwife with **Texas Midwives Group**
- To communicate with another health care provider on your behalf

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire after insurance claim is satisfied and payment has been made.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the private health information concerning my pregnancy.

I do not have to sign this authorization in order to receive treatment from Texas Midwives Group. I understand that I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Texas Midwives Group
P.O. Box 461501
San Antonio, Texas 78246
FAX: 210-481-0992

Signature of Client _____

Print Client's Name _____ Date _____

Client Registration

Name	First	Middle	Last	Maiden?	Date	Phone (home) (work)
Race	Religion	Yrs Educ	Marital Status	Occupation/Type of Business	Date of Birth	State of Birth
Address: Street				City	Zip	Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No
Father of Baby: First				Middle	Last	Race
Address (if different from above)				Yrs. Educ	Date of Birth	State of Birth
Partner/Husband (if different from Father)					Phone(work) (home)	Occupation/type of business
Method of Payment: <input type="checkbox"/> Medicaid <input type="checkbox"/> Other : <input type="checkbox"/> Cash				Insurance Information: Copay _____ Policy # _____		Name of Policy Holder: _____ Group # _____
Social Security Number	Father's SSN		SSN Requested for baby <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred by: _____		
Another person to contact in emergency				Name: _____		Phone: _____
				relationship: _____		

Please answer the following questions which will help determine if there are potential problems which should be discussed further. This information is completely confidential.

FAMILY HISTORY – Indicate if anyone in your immediate family has ever had any of these, who; when.

- High Blood Pressure _____
- Cancer _____
- Diabetes _____
- Twins _____
- Severe emotional problems _____
- Alcohol/drug abuse _____
- Other _____

FATHER OF BABY – Indicate if the baby's father has ever had of these; when.

- Sexually transmitted diseases _____
- Herpes: Genital Oral
- Severe emotional problems _____
- Alcohol/drug abuse _____
- Tobacco use _____
- Other _____

YOUR MOTHER'S HISTORY – Please answer the following regarding your mother:

- No. of pregnancies _____
- No. of births _____
- Miscarriages _____
- Any complications _____
- Your weight at birth _____
- Did she take DES with you?
 Yes No

PREVIOUS PREGNANCY OUTCOMES Please complete this table regarding your own pregnancies (from earliest to most recent)

Date	#Weeks	Birth/Miscarriage/Termination	Comments/Problems

- Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?
- Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?
- Yes No Are you and the FOB related by blood? (e.g., cousins)
- Yes No Are you or the FOB from any of these ethnic/racial groups? (circle)
Jewish Black/African Asian Mediterranean
- Yes No Have you or the FOB ever had hepatitis or jaundice?
- Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?
- Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?
- Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
- Yes No Do you think you are at increased risk for AIDS/HIV?
- Yes No Have you ever experienced dramatic fluctuations in your weight?
- Yes No Have you ever had anorexia, bulimia or other eating problems?
- Yes No Is there anything about the development of your sexuality that you'd like to discuss?
- Yes No Have you ever been in an abusive relationship, including now, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will)?
- Yes No Have you ever had severe emotional problems?
- Yes No Have you ever been on any medication for psychological problems?
- Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?
How did you hear about us? _____

NAME _____

MEDICAL HISTORY Please indicate if you have ever had any of these; when:

- | | |
|--|---|
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Bowel problems/colitis |
| <input type="checkbox"/> Eye/vision problems | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Ear/hearing problems | <input type="checkbox"/> Gall bladder problems |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bladder infection |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Urinary surgery |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Urethral dilation |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Aching joints |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pelvic/back injuries |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Hospitalizations |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other |

Do you have any allergies? Yes No
 Please list: _____

GYNECOLOGIC HISTORY

Age at first period _____ When was your last Pap smear? _____
 Cycle length (days) _____
 Regular? Yes No Have you ever had an abnormal Pap? (dates) _____
 Duration _____ Please describe _____

Please indicate if you have ever had any of the following; when:

- | | |
|---|--|
| <input type="checkbox"/> Yeast | <input type="checkbox"/> Cervicitis |
| <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Cervical surgery |
| <input type="checkbox"/> Group B Strep | <input type="checkbox"/> Cervical polyp |
| <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Ovarian cyst |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> PID/Pelvic infection | <input type="checkbox"/> Uterine surgery |
| <input type="checkbox"/> Genital Sores | <input type="checkbox"/> Breast lump(s) |
| <input type="checkbox"/> Herpes: <input type="checkbox"/> Genital | <input type="checkbox"/> Breast surgery |
| <input type="checkbox"/> <input type="checkbox"/> Oral | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Condyloma (warts) | <input type="checkbox"/> Other |

Are there any particular ethnic, cultural or religious preferences for your care during pregnancy and birth that you'd like to discuss?

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? Yes No
 Suspected date of conception _____
 Pregnancy test (date) _____
 Planned pregnancy? Yes No
 Feelings about pregnancy _____
 Father's/Partner's feelings _____
 Most recent birth control used _____
 Contraception used in past; what, when, any problems?

Please indicate if you've had any of the following problems during this pregnancy:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Urinary complaints |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal/pelvic pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Vaginal bleeding/spotting |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Family/relationship problems |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diarrhea | |

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

- | | |
|--|--|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Herbs |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Fumes/sprays |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Measles/Viruses |
| <input type="checkbox"/> Street drugs | <input type="checkbox"/> Travel |
| <input type="checkbox"/> Other meds | <input type="checkbox"/> Vaccinations |
| <input type="checkbox"/> Non-pres. drugs | <input type="checkbox"/> Cats |
| <input type="checkbox"/> Vitamins | <input type="checkbox"/> Other |

Planned place of birth:

- Home Birth Center Hospital

If home, please indicate if you have:

- Water Electricity Telephone

Please use this space to add any other information regarding any of the above:

HB341 -- Resource List for Parenting and Postpartum Depression Counseling

The Texas Legislature passed HB 341, Parenting and Postpartum Counseling Information, in the 78th Regular Legislative Session (2003). This law, effective Sept. 1, 2003, requires physicians, midwives, hospitals and birthing centers that provide prenatal care to a pregnant woman during gestation or at delivery to provide the woman with a current resource list of professional organizations that provide postpartum counseling and assistance to parents.

The list has been developed and will be maintained by the Texas Department of State Health Services (DSHS). It must be documented in the client's chart that she received this information and the documentation must be retained for a minimum of three years. It is recommended that the information be given twice, once at the first prenatal visit and again after delivery.

Information about HB341 (including the list and a PDF version of the legislation) is currently available at <http://www.tdh.state.tx.us/mch/default.htm>.

For more information on HB341 or postpartum depression, please contact Chan McDermott, Perinatal Health Program, at 512-458-7796 or chan.mcdermott@dshs.state.tx.us.

Health & Human Services Commission
Information & Referral information
Website: www.hhsc.state.tx.us/tirn/tirnhome.htm

Postpartum Support International
1.800.944.4773
For Local Contacts:
Website: www.postpartum.net/texas.html

Texas Department of State Health Services
Family Health Services, Information & Referral Line
Phone: 1-800-422-2956

Center for Parent Education, University of North Texas
Contact: Arminta Jacobson at 888-662-7457
Email parenting@unt.edu or fax 940-369-7955
Website: www.unt.edu/cpe

Bexar County Depression Resources for Post Partum Mood Disorders

<p>Alamo Area Home Counseling Services P.O. Box 500064 San Antonio, TX 78280 (210) 521-6392</p>	<p>Family Service Association 230 Pereida San Antonio, TX 78228 (210) 226-3391 Counseling, groups</p>
<p>Alpha Omega In-Home Services 4538 Centerview Dr., Ste. 218 San Antonio, TX 78228 Toll-Free # 1-866-730-2674 Counseling</p>	
<p>Avalon Social Services 3707 N. St. Mary's San Antonio, TX 78212 (210) 735-7275 In home counseling, psychosocial</p>	<p>Jewish Family & Children's Services 12500 NW Military Hwy San Antonio, TX 78231 (210) 302-6920 Counseling, groups</p>
<p>Benitia Family Center 4650 Eldridge Ave San Antonio, TX 78237 (210) 433-9300 Counseling</p>	<p>Mental Health Association of Greater San Antonio 8431 Fredericksburg Road, Suite 110 San Antonio, Texas 78229 210-614-7566 Office healthymindconnection.org</p>
<p>Community Counseling Service of Our Lady of the Lake University 590 N. Gen McMullen San Antonio, TX 78228 (210) 434-1054</p>	<p>Mexican American Unity Council 2300 W. Commerce, Ste 200 San Antonio, TX 78207 (210) 978-0500 Counseling</p>
<p>Ecumenical Center for Religion & Health 8310 Ewing Halsell San Antonio, TX 78258 (210) 616-0885</p>	<p>Methodist Women's Center 803 Castroville, Ste. 131 San Antonio, TX 78207 (210) 575-0355 Groups every Tuesday 1-2</p>
<p>Family Life Center One Camino Santa Maria San Antonio, TX 78228 (210) 436-3133</p>	<p>St. Peters St. Joseph 919 Mission Rd San Antonio, TX 78210 (210) 533-6545</p>
<p>Postpartum Depression Center of San Antonio 921 Proton San Antonio, TX 78258 (210) 490-4540</p>	

Transfer of Records Authorization

Patient Information:

Print name: _____ Date of Birth: _____

SS# or Medical Record #: _____ Phone : _____

Please release my healthcare
information from:

Please send my healthcare
Information to:

Facility/Provider: _____

TEXAS MIDWIVES GROUP

Address: _____

P.O. BOX 461501

City/State/Zip _____

SAN ANTONIO, TEXAS 78246

Phone Number: _____

FAX: 1-210-481-0992

Fax Number: _____

Information Authorized to Be Released

- Most recent 2 years of information (OB Flow Sheet, chart notes, lab results, ultrasounds and special tests)
- All medical records
- Records related only to the following date(s) of service _____
- Specific information (please specify) _____

Purpose for which disclosure is being made:

- Sharing with other health care providers
- I am transferring my care to a new health care provider
- Personal use
- Other: _____

Patient Authorization

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing though that revocation will not cancel any action already taken on the original Authorization of Release of Information. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

AUTHORIZATION EXPIRE 30 DAYS FROM THE DATE SIGNED

Insurance Billing Financial Agreement

1. Parties

This agreement is made between _____
Client(s), and **Texas Midwives Group** for purposes of insurance billing.

2. Private Insurance

Client agrees to Midwife submitting insurance claim in Client's behalf for reimbursement. Billing service may bill your insurance company for the following services related to your care including, lab work, birth assistance fee, and newborn labs.

The client is responsible for paying the practice \$3500.00 fee.

3. Disclaimer

I relieve the practice of any financial responsibility arising when outside medical care is sought. I understand that if I fail to meet my financial obligations to Texas Midwives Group as outlined in the terms of this agreement, a midwife cannot attend my birth unless other arrangements are made in writing.

This is to verify that we have read and understand the above financial agreement and have agreed to fulfill our obligations to **Texas Midwives Group** as stated above.

Client Signature: _____ Date _____

Spouse/Partner Signature: _____ Date _____

Practice Signature: _____ Date _____

In-Network Exception Request Form

Insurance Code 1301

§ 1301.004. COMPLIANCE WITH CHAPTER REQUIRED.

Each preferred provider benefit plan offered in this state must comply with this chapter.

§ 1301.005. AVAILABILITY OF PREFERRED PROVIDERS.

(a) An insurer offering a preferred provider benefit plan shall ensure that both preferred provider benefits and basic level benefits are reasonably available to all insured's within a designated service area.

(b) If services are not available through a preferred provider within the service area, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

(c) Subsection (b) does not require reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience.

Added by Acts 2003, 78th Leg., ch. 1274, § 3, eff. April 1, 2005.

§ 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES.

An insurer that markets a preferred provider benefit plan shall contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities.

Added by Acts 2003, 78th Leg., ch. 1274, § 3, eff. April 1, 2005.

Insurance Code 1301 requires preferred provider benefit plans are required to offer all specialties "in-network." If they do not have a Licensed Midwife "in-network" according to Insurance Code 1301.005: **"If services are not available through a preferred provider within the service area, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider."**

Name of Insurance Company _____

Member Identification Number _____

Date/Time of Call _____ Customer Service Representative _____

1. Is my plan self-funded? _____

2. Does State or Federal law apply? _____

Wait while they find the answer. This information will be valuable in the event a waiver request is denied. Keep good notes with dates, times and the Customer Service Representative's name that you spoke with. (This is a must for a written appeal.) We have found that the most efficient way to notify your insurance company that you are aware of the regulations requiring them to pay your midwife at in-network levels is to have a three-way call with you, your midwife and your insurance company. Having all three parties present reduces the "run-around."

Call the Customer Service number on the back of your insurance card. Ask if they have a Care Coordination Department. If so, ask them to connect you and say the following: "I would like a predetermination of benefits. I want to use a Licensed Midwife and I do not see any in-network."

They will check on their computer for any contracted midwives in your area. They will probably find at least a few hospital-based CNMs – Certified Nurse Midwives – and will tell you that if you use the CNM, it will be at in-net but if you choose to use a LM, it will be at out-of-network level. Your response to this is: **"These are two different types of providers. If you do not have a LM in-network, I need the address or fax number to submit a written request that my PPO abide by Insurance Code 1301. Please put in a request for an in-network exception. If you cannot, I need the reason in writing or I need to speak with your supervisor."**

Do not let them say "Let me talk to my supervisor and call you back." They won't. Tell them you will hold or would like to speak to the supervisor yourself. If Customer Service will not submit your request for a waiver, call your Human Resource contact through the employer that has your health benefits.

Dates of waiver should be from your initial visit through 8 weeks AFTER your due date. Be sure newborn care is covered by this exception.

Authorization # or pending #: _____

Midwife's Name: _____ with Texas Midwives Group,

P.O. Box 461501, San Antonio, TX 78246; EIN 20-5823317

Space provided to document phone call.