

Financial Agreement and Payment Plan

Full name: _____
Today's Date: _____

Due Date: _____

I am contracted with Regence, Premera, First Choice, DSHS, and Molina. I work with a billing service who will file your claims after the birth and you will be invoiced for any deductible, co-pay and co-insurance amounts. By entering into this contract, you authorize *Midwife Billing & Business, LLC* to release health information to your insurance company or health carrier for the purpose of processing your claims. For any other insurance carrier, I am considered an out-of-network provider and a deposit in the amount of \$500 is due before the 36th week of pregnancy. My billing service will file your claims after the birth of your child; after the claims are processed, you will either receive a refund, or you will be responsible for any remaining deductible, co-pay and co-insurance. Any refund you receive cannot exceed the amount of your deposit.

When we bill clients directly, we standardize all services into a \$3100 package fee. However, when we bill insurance and health carriers, my billing service itemizes and codes services per standard billing practices and per the insurance carrier's specifications. This itemization may result in claims totaling more than the package fee. It may also result in reimbursement of more than the package fee. We have the right to accept insurance reimbursement from insurance carriers that exceed the package fee of \$3100. Due to claims follow up and tracking expenses, it is more costly to bill insurance companies than it is to collect directly from our clients.

I, _____, have read and understand Moonrise Health and Birth's **Financial Agreement**. I agree to pay Dr. Brandy Ross, ND, LM for her services according to the following payment option. *(Please check and initial one of the following plans.)*

- Insurance:** I want Moonrise Health and Birth to file a claim with my insurance company. I will pay either a \$500 deposit or my deductible, whichever is larger, if it is a non-contracted insurance company. I also understand that I am still financially responsible for any charges not paid in a reasonable amount of time by my insurance company. Therefore, I agree to pay any fees not covered by my insurance policy. I understand that the discounted global fees in these plans **do not cover additional lab work, medical care by a physician or hospital, medications, ultrasounds, or my birth kit**. Should the need for additional care arise, I agree to pay for any additional expenses incurred.
- Partial Self-Pay:** understand that my insurance may not cover an out-of-hospital delivery but will pay for a portion of my care. I agree to pay the \$1500 birth fee by the 36th week of pregnancy. Please indicate schedule of payment below.
- Self-Pay Plan:** The full fee for midwifery care is \$3100. This includes all routine prenatal visits, attendance at your labor and birth, and routine postpartum visits. It **does not cover any additional lab work, medications, ultrasounds, or the birth kit**. I understand that this fee is due by the 36th week of pregnancy. I understand that my fee is subject to change if I do not keep the terms of my self-pay contract. Please indicate schedule of payment below.

After 36 weeks gestation, I understand that the midwife is fully retained for her services. If any medical situations arise during the intrapartum or postpartum period requiring the mother or newborn to be transported to the hospital, I will not be entitled to a reimbursement, and any refunds made after this date are solely at the discretion of the midwife. I understand that midwives cannot guarantee that circumstances will always allow for birth to occur at home or that physician and/or hospital care will not be necessary for the mother or newborn following the birth.

- I will be making a deposit/payment of \$_____ today by check, cash, PayPal.

This box is for Self Pay and Partial Self Pay ONLY (check and initial)

After I make my initial deposit, my remaining payments will be in the amount \$_____ and will be paid _____ (monthly, weekly, other). If you will also be making a balloon payment, please indicate the amount and approximate date of that payment here: _____.

I will pay by check, cash, PayPal (please check all that apply)

Signature of Parent 1 _____

Date _____

Signature of Parent 2 _____

Date _____

Moonrise Health
16825 48th Ave W, Suite 460
Lynnwood, WA 98037

Dr. Brandy Ross, ND, LM
425-670-6752
info@moonrisehealth.com

Signature of Midwife _____

Date _____