Geneva Woods Midwifery PC

2400 E 42nd Ave
Anchorage, Alaska 99508

CLIENT INFORMATION:

NAME (Last, First, MI) _____ Today's Date _____

Physical Address _____ City _____ State _____ Zip _____

Mailing address if different: _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ Social Security Number _____ Marital Status _____

Email Address: _____ Referred by: _____

Emergency Contact _____ Relationship _____ Phone _____

PRIMARY INSURANCE INFORMATION

Primary Insurance _____ ID Number _____ Group Number _____

Insurance Address: _____ City _____ State _____ Zip _____

Subscriber's Name _____ Date of Birth _____ Social Security _____

Relationship to client _____ Subscriber's Employer: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance _____ ID Number _____ Group Number _____

Insurance Address: _____ City _____ State _____ Zip _____

Subscriber's Name _____ Date of Birth _____ Social Security _____

Relationship to client _____ Subscriber's Employer: _____

I certify by signing below that the information above is, to the best of my knowledge, accurate.

Authorization to Release Information: I give consent to GWM, to release the above personal data as required in the course of examinations and treatments. I give consent for information relating to my pregnancy (anonymously) to be submitted to the American Associations of Birth Centers (AABC) 'PDR' study for the evaluation of midwifery care outcomes and the promotion of midwifery care.

I authorize Geneva Woods Midwifery to verify my insurance benefits on my behalf. I hereby authorize my insurance company to make payment directly to my provider should claims be filed. I give authorization to my provider to release any information necessary to process my benefits or insurance claims. I understand the final outcome for my insurance benefits level and the processing of my claims is under the discretion of the insurance company. I will not hold GWM or my midwife responsible for the information reported on this verification or the manner in which my claims process.

Assumption of Financial Responsibility: I, by signing below, assume financial responsibility for payment of fees stemming from care rendered or services provided by GWM to the client named above. Insurance or other coverage may pay for part of these charges and I assume responsibility for any unpaid portion.

Signature of Client _____ Date _____