GENERAL INFORMED CONSENT AND AGREEMENT

INFORMATION

Childbirth is one of life's peak experiences, and should be viewed as a healthy process. It is a family experience that is shared emotionally, physically and spiritually as the whole family joins together in welcoming its newest member.

It is the responsibility of the Brooklyn Birthing Center (BBC or 'birth center') and health care providers to inform childbearing families of their options in birth settings and the risks and benefits of choosing any of these settings. The setting chosen must be one considered safe and satisfying in meeting the needs expressed by the family.

We offer birthing in a freestanding childbearing center. All care is provided by a team consisting of midwives, their physician consultants, medical director, midwifery director and trained birth assistants. When you register for care you can expect that your prenatal care, birth and postpartum care will be provided only by the staff midwives. Should problems arise which require medical care, your care may be managed collaboratively by the midwives and the physician consultant, or an obstetrician you have chosen may take over your care.

It is the policy of BBC that the family may choose an out-of-hospital birth if:

1. The expectant mother has an uncomplicated medical and obstetrical history
2. The expectant mother has a present pregnancy that is proceeding normally
3. Both partners are in complete agreement about the site of birth
4. The expectant mother and her family have chosen to assume the added responsibilities that go along with an out-of-hospital birth.

It is important that the expectant mother and her family understand that all childbirth carries some risk to mother and baby, regardless of site of birth. Certain hazards that exist when birth occurs in a hospital do not exist in alternative settings. Likewise, certain hazards that exist when birth occurs in alternative settings do not exist in the hospital.

Studies of different birth settings have indicated that the outcomes for low-risk women are comparable when birth occurs in or out of the hospital. The staff at Brooklyn Birthing Center has taken every reasonable precaution, however complications may arise suddenly and unpredictably. The following are medical problems which could occur in any birth, regardless of the site of birth.

Major Complications

1. Fetal Distress—lack of oxygen for the baby while he or she is still in the uterus
2. Neonatal asphyxia—lack of oxygen for the baby after birth

3. Maternal hemorrhage—excess blood loss during labor or after
4. Preeclampsia or toxemia (pregnancy-induced high blood pressure)
5. Amniotic fluid embolism—a drop of amniotic fluid enters the mother's bloodstream causing clots
6. Uterine rupture—uterus splits open
7. Cardiac arrest—heart stops beating

Complications Involving the Placenta

1. Placenta Previa—placenta partially or completely covers the opening of the uterus
2. Placenta abruption—placenta separates from wall of uterus before baby is born
3. Retained placenta—all or part if placenta remains inside uterus for an extended time after birth

Complications Involving the Pelvis

1. Cephalopelvic disproportion—baby is too large to fit through mother's pelvis
2. Shoulder dystocia—baby's shoulders become lodged in mothers pelvis after baby's head is born

Complications Involving the Baby

1. Rupture of membranes without labor—amniotic fluid sac breaks prior to onset of labor and labor does not spontaneously begin
2. Cord prolapse or other cord problems—umbilical cord is compressed cutting off oxygen to baby
3. Multiple gestation—presence of more than one baby (twins, triplets, etc.)
4. Malpresentation—baby is in some position other than the normal head-first position
5. Stillborn—baby dies in mother's uterus before birth
6. Meconium—stained amniotic fluid-baby has bowel movement inside uterus
7. Congenital anomalies—birth defects
8. Immaturity or post-maturity—baby is born too early or too late
9. Hyperbilirubinemia—jaundice (yellow skin) in newborn caused by too much bilirubin in baby's body after birth

CONSENT AND AGREEMENT

1. Physical Examination

I authorize the midwives, and birth assistants to perform, according to the expertise of each discipline, examinations upon my person to confirm general health and pregnancy status, obtain the usual specimens and perform the usual diagnostic procedures, including, but not limited to: 1) drawing blood, 2) pregnancy tests, 3) urinalysis, 4) determination of blood pressure, 5) internal examination, with and without instruments, 6) obtaining rectal, vaginal, and cervical specimens, including Pap smear. I understand that, even when the above are properly and correctly done, there is potential for infection, tissue damage and other unpredictable medical conditions. I agree that the nurse-midwives, medical consultants and nurses shall be responsible for the performance of their own professional acts only, and the test results shall be the responsibility of those who perform them.

2. Authority to Treat

I authorize the midwives, their physician consultants and nurses to treat, administer and provide as necessary or available to me and by baby: 1) health care, including prenatal education; 2) physical examinations as necessary, 3) diagnostic test and procedures by the obtaining of blood or other specimens; 4) oral, intramuscular, subcutaneous and intravenous medications and local anesthesia; 5) intravenous infusions; 6) delivery of my baby; 7) episiotomy with repair, and/or repair of laceration; 8) postpartum care, including home visits; 9) newborn care initially after birth,

including Vitamin K injection and the application of Erythromycin ointment to infant's eyes; 10) other procedures related to childbirth as may be deemed necessary. The administration of this care may be in the office, birth center, and elsewhere in hospital. I grant to the midwives full authority or administer and perform all drugs, treatments, diagnostic procedures, examinations and ministrations to or upon me and my baby, with the assist of the birth assistants.

In case of emergency, I authorize these professionals to take appropriate measures. When specialized equipment or hospitalization is required, I authorize these professionals to transfer me and / or my baby to the hospital from home or birth center.

All of the above is to be performed as deemed necessary or advisable by the midwives, their medical consultants and birth assistants, in the exercise of their professional judgments.

3. Transfer

I understand that the BBC staff will, during my prenatal period, attempt to recognize signs which may indicate that the course of pregnancy might significantly deviate from normal, even though such deviation may not necessarily affect the outcome of pregnancy adversely. If such is the judgment of the midwives, the management of my pregnancy shall be transferred to the physician of my choice or my care will be managed collaboratively by the midwives and their physician consultants.

4. Complications of Pregnancy and Birth

I have read and understand the list of complications of pregnancy and birth and discussed them with the midwives. I am aware that the birth center staff has taken every reasonable precaution to insure my safety, comfort and satisfaction. I do understand that these complications may arise suddenly or unpredictably. I am aware that the practices of midwifery, medicine and nursing are not exact sciences. I acknowledge that no guarantees or assurances have been made to me concerning the results of treatment, examinations and procedures to be performed.

5. Preparation

I agree to prepare ourselves for pregnancy and childbirth through attendance at childbirth classes. This includes preparation to perform emergency childbirth should labor proceed rapidly. I will prepare myself, to the extent possible, to go through birth without narcotic analgesics, sedatives, tranquilizers or anesthesia.

6. History and Rights to Withdraw

I understand that the safety of care by the midwives and their consulting physicians and out-of-hospital birth depends upon my medical history and the information which I provide about me. I affirm that such information is, and will be, accurate and complete to the best if my knowledge. In addition, I agree to follow all the rules, regulations and policies of the birth center. I also understand that I may voluntarily choose not to remain at the Brooklyn Birthing Center and transfer care to a hospital; for myself and / or my baby. If done so at 26 weeks gestation or beyond, the BBC reservation agreement will apply.

7. Research

In an effort to support the development of birth center and midwifery care, I consent to the sharing of information from my medical records for statistical reporting and publication, as long as my confidentiality is insured. I also understand that the Brooklyn Birthing Center may, from time to time, be used for the purpose of teaching student nurse-midwives. I have the option of permitting,

limiting or refusing student participation in my care --see Consent to Participate in Student Training.

8. Transfer to the Hospital

I agree to transfer from the birth center to a hospital-based practice (usually Maimonides Medical Center) in the event of a circumstance in which the midwife feels that hospital care is required or advised. Should hospitalization become necessary, my records may be made available to the doctor and/or hospital staff. In the event of an emergency, I understand that I will be transferred to the hospital and the physician considered appropriate by the midwife, according to the standard procedures. Depending upon the nature of the complication, and the hospital to which I am transferred, my care at the hospital will be managed either by a midwife, an affiliated midwife, an affiliated midwife in collaboration with the obstetrician, or exclusively by an affiliated obstetrician. All hospital and physician expenses incurred at that time, or any other time, shall be my obligation and are not included in the birth center fees.

9. Postpartum Responsibilities

I understand that the birth center staff will provide all normal postpartum care, including a home visit within 24-72 hours after birth. The nurse of midwife will perform an initial newborn physical assessment. It is my obligation to arrange for pediatric care to begin immediately upon discharge of the infant from care of BBC. I understand that, if my baby is born at the birth center, my pediatrician/family physician/nurse practitioner must be seen of the infant birth within 72 hours. I will provide the name and phone number of my chosen pediatrician to the birth center staff by 35 weeks gestation. If my baby is born in a hospital, a pediatrician/family physician will manage the baby's care in the hospital.

I understand that childbirth and the early postpartum period are stressful times for families, both physically and emotionally. I agree to provide for necessary assistance during the birth and the first week postpartum. This includes obtaining a support person for any older sibling who will be present for the labor and/or birth. I understand that if I am unable to make these arrangements, I will not be eligible for an out-of-hospital birth.

10. Wheelchair Accessibility

I understand that the Brooklyn Birthing Center's wheelchair lift is presently out of service. I understand that the birthing center floor is six steps above the sidewalk level, and the midwifery group's office is six steps below the sidewalk level. Brooklyn Birthing Center and Brooklyn Midwifery Group staff members are willing to assist guests with limited mobility whenever safety and staffing allow. I will contact the staff to discuss any concerns about building accessibility.

11. Miscellaneous

Brooklyn Birthing Center presently has capacity to care for three laboring, delivering, or postpartum clients simultaneously. In the extremely unlikely event that BBC is at capacity when I require admission, I understand that my care provider will make arrangements for me to be cared for Maimonides Medical Center by an affiliated midwife or an affiliated physician consultant.

Affirmation

I have toured the Brooklyn Birthing Center and have attended a required orientation session conducted by the BBC staff. I have read the *General Informed Consent and Agreement* packet and the Orientation Packet, including the *Statement of Client's Rights and Responsibilities* and the section titled, *Financial Obligation of the BBC Client.* I know that I may request another copy of these documents for my records if I so choose.

I have read all of the above thoroughly and carefully, as well as reviewed it with a staff midwife provider, and allowed to ask any questions which have been fully satisfied. I hereby give consent for treatment and care for myself and my baby.

_____ _____
Signature of Patient* Witness (support person, if any)

_____ _____
Signature of Partner (if present) Date Signed

_____ _____
Signature of Staff / Midwife Date Signed

Orientation Date _____

***Important Note**
When a patient is unable to sign, a legally authorized person should sign on the patient's behalf and complete the following with their own information. If more than one person is signing, each person should fill out the information below (attach additional pages, if necessary):

Patient's Representative (print name):* _____ Date: _____

Patient's Representative (sign here): _____

Relationship to patient: _____

If person signing is not nearest relative, print name, address and/or phone number of nearest relative.

Patient Information:

Name:	Date Of Birth:	SSN:
Address:	City:	Zip:
Primary Phone:	Other Phone:	Email:

Marital Status: Married___ Single___ Widowed___ Divorced___	Do you live with your partner? Yes___ No___
Ethnicity (optional, check all that apply): __ Hispanic or Latina __ Native American __ Black or African American __ Other: _____ __ White, Non-Hispanic __ Multiracial: _____	If Hispanic/Latina (optional, check all that apply): ___ Puerto Rican ___ Cuban, Dominican, or other Caribbean ___ Mexican ___ Central American: _____ ___ South American: _____

Pharmacy Name/Phone Number:	Date of Last Period:	Estimated Due Date:

Partner's Information (If applicable):

Name:	Phone Number:

Emergency Contact (After partner):

Name:	Relationship:	Phone Number:

Insurance:

Do You Have Insurance?	Insurance Name:	Provider ID#:
Policy Holder Name:	Date Of Birth:	Relationship:
Address (if different from above):	City:	Zip:

Communication:

Primary Language:	Can You Read English? Yes__ No __	Need An Interpreter? Yes__ No__

Laboratory Testing: We provide our patients with a medical assistant to draw your blood. Your current insurance information, if any, will be sent to the designated lab by your insurance company. You will receive a separate bill for the laboratory services for which you or your insurance will be responsible.
Pregnancy: You have a choice to see any or all midwives during your pregnancy. Only the midwives scheduled to be on call for the Brooklyn Birthing Center and the hospital will attend your delivery.
Payment: We do not accept assignment of insurance unless we participate as a provider in your insurance company. Therefore, if you do not have insurance or we are not in your insurance company's network, payment is due at the time of your visit and a receipt will be provided for you to submit to your insurance for reimbursement. If we accept your insurance, your insurance information must be presented at the time of visit or you will be held liable for untimely filing. Please pay your co-payment at the time of your visit. There will be a $25 charge for any returned check. **You will be responsible for the balance if your insurance denies a payment.**

My signature below indicates that I agree to release any information requested for insurance purposes and to assign any and all insurance benefits to the above providers. I also agree that in the event my insurance allows balance billing, denies payment for non-eligibility, or does not cover a procedure or test, I will be responsible for any remaining balance.

Patient Signature _____ Date_____

Phone: (718) 336-4119 **Fax:** (718) 336-4113 **Address:** 2183 Ocean Avenue, Brooklyn NY 11229

Patient Privacy Notification Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Notice Section

This form declares Brooklyn Birthing Center, Inc. (BBC) Privacy Notice policies. BBC, as a Covered Health Care Entity under the Health Information Portability and Protection Act of 1996 (HIPPA), is obligated to protect the privacy of your health information to the best of its ability. Under the provisions of HIPPA, we are authorized to use your Patient Health Information (PHI) for routine treatment, payment, and health care operations without your explicit consent. This type of disclosure must be part of approved routine business transactions relating to payment, treatment, or health care operations, excepting psychotherapy notes, which may not be released. These transactions will normally be with other hospital or insurer business associates, who may have already obtained patient consents in these instances, or already have a direct or indirect treatment relationship with the individual.

Other instances when disclosure does **NOT** require your explicit consent:

- The disclosure is made under an HHS-approved exception, such as to parents of a minor or an individual authorized to act on behalf of another individual.
- You yourself make and official disclosure request.
- The requester is an approved government entity of health oversight agency.
- The law requires the disclosure.
- The disclosure relates to public health activities.
- The entity has reason to believe the individual may be a victim of abuse or neglect.
- The disclosure relates to judicial or administrative proceedings.
- The disclosure relates to law enforcement purposes.
- The disclosure relates to workers' compensation.
- The situation is an emergency. Consent must be obtained as soon as is reasonably possible.
- Consent has been attempted and has been determined impossible to obtain, but may be reasonably inferred or expected given the circumstances.
- **Joint Consent:** If BBC has already entered into a Consent Agreement with the patient as part of a Joint Consent authorized for another health care entity, we will be considered as authorized regarding the provisions of that Disclosure Consent Notice.

Any other use of disclosure of your health information requires your direct written consent. Should BBC require your consent, you will be notified and asked to sign a Patient Disclosure Authorization. You may refuse to sign this authorization. BBC will not condition treatment, payment, enrollment, in a health plan, or eligibility for benefits on the individual's providing authorization for the requested use or disclosure. Subsequent to signing the Patient Disclosure Authorization, you may

revoke such authorization by notifying us in writing at any time. Should you do so, any action taken by us prior to revocation that relied upon the patient's consent shall still be considered valid, to the extent that it was relied upon. Your authorization may also contain an expiration date or event limiting the duration of the authorization.

You, the patient may also request stricter restrictions regarding the routine business transactions (payments, treatment, and health care operations) described above. BBC is **NOT** required by law to agree to these restrictions, but will consider each request individually.

BBC also reserves the right to change the terms of this privacy notice at any time. You may obtain a copy of this Notice at any time, by mail, e-mail or other electronic means. This Notice is effective April 14, 2012.

Patient Access Request Section

Your medical Record is the physical property of our medical concern. You do, however, have rights with respect to your health information. Your have the right to:

- Review this Notice of Privacy Practices.
- Authorize uses and disclosures of health information for purposes other than treatment, payment and health operations.
- **Opt-out of disclosure of information to family members or others who may be assisting with your care.**
- Request restrictions on certain uses and disclosures of your health information (however our office is not required to agree to such restrictions).
- Inspect and copy your own heath information within reasonable times and availability, and upon proper written notice signed by you, which could incur a charge as allowed by state law.
- Under certain circumstances, to appeal denials of access to your own health information.
- Amend incorrect or incomplete health information, subject to certain limitations.
- Obtain an accounting of disclosures of your health information disclosed after April 14, 2003, subject to certain limitations including a request in writing by you.
- Request communication of your health information by alternative means or at alternative locations. For instance, you may ask that messages not be left on voice mail or correspondence not be sent to your address.
- Revoke your authorization to use or disclose your health information.
- File a complaint with this office or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated.

Service Delivery Sites to which this notice applies:

Brooklyn Birthing Center, Inc. 2183 Ocean Avenue, Brooklyn, NY 11229
Maimonides Medical Center, 4802 10th Avenue, Brooklyn, NY 11219

Our Pledge

Your privacy is important to us. BBC will do its utmost to protect your Patient Health Information both internally and externally, and adhere to federal privacy guidelines. For comments, questions, privacy concerns, or complaints, please contact our Director of Midwifery, Linda Gaglioti, 2183 Ocean Avenue, Brooklyn, NY 11229. Tel 718-336-4119; E-mail: lgaglioti@brooklynbirthingcenter.com

Patient Disclosure Authorization Form

Date: _____

I acknowledge Brooklyn Birthing Center (BBC) has provided me with the BBC HIPAA Privacy Notification Form, which details my rights under the Health Information Portability and Accountability Act of 1996 (HIPAA).

I hereby give authorization to disclose my Protected Health Information (PHI) only in the specific manner and to the specific individual(s) directed below.

Recipient of Information:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

Manner(s) of communication allowed regarding my PHI:

□ Telephone
□ Fax
□ Mail
□ Email

Restrictions to Disclosure:

□ Access all medical records
□ Last visit only
□ Test results only
□ Other _____

I understand this authorization provides that:

- I have the right to access any protected health information to be used or disclosed.
- I may revoke this authorization at any time by contacting your office in writing or email.
- Information used of disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected by HIPAA rules.
- BBC will not condition treatment on my providing authorization of the requested use.
- I will receive a copy of this completed and signed authorization form.

Patient Signature: _____ Date: _____

Patient Health Questionnaire

	Not at all	Several days	More than half the days
1. Little interest or pleasure in doing things	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○
4. Feeling tired or having little energy	○	○	○
5. Poor appetite or over-eating	○	○	○
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○
8. Moving or speaking slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	○	○	○
9. Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○

Name: _____ Date: _____

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Nutrition Assessment Form

Name: _____ Age: _____ Pre-pregnancy weight: _____

Current weight: _____ Weeks gestation: _____

Please circle any digestive problems you have: Nausea Vomiting Diarrhea Constipation
Chewing / Swallowing difficulty Lack of appetite Heartburn / Indigestion Reflux

How do you deal with this problem? _____

Do you currently take any medications/vitamins/supplements/herbals? _____

Do you smoke/drink alcohol/use drugs? If yes, indicate amount _____

Do you now or have you ever suffered with eating disorders / weight / nutrition problems? If yes, describe:

_____

Do you have enough money to buy food for yourself? _____

Who shops for food? _____ Who cooks your food? _____

Typical method of preparing your food: bake broil boil steaming frying

Do you have facilities available to cook your food? _____

How many times per week do you eat out? _____ Types of food you eat when out? _____

Do you keep a special diet (vegetarian / vegan / gluten free, etc.)? _____

How would you describe your daily activity level: _____

Do you exercise regularly? (type, how many X per week for how long) _____

Do you drink water regularly? _____ # of glasses of water per day _____

Circle meals you eat regularly: Breakfast Lunch Dinner

Do you skip meals regularly? _____ How often? _____

In a typical day how often do you snack? _____ Examples of snacks: _____

Do you typically (circle): eat dinner with family eat in front of TV eat in bed eat on the run

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24-hour Diet Recall

Please list the type of food and the amount eaten in the past 24 hours.

Breakfast:

Lunch:

Dinner:

Snacks:

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LEAD SCREENING EVALUATION FORM

Name:

You may be exposed to high levels of lead without knowing it. Please answer the following questions.

1. Do you live in a house that was built before 1960 with recent or ongoing renovations, including painting, sanding or remodeling?
_____ Yes _____ No _____ Don't know

2. Do you or others in your household have a job that may involve lead exposure? (Examples: automotive repair workers, motor vehicle worker, industrial machinist, oil field workers, storage battery or battery recycling workers, glass makers, pottery makers, plumbers, brass/copper casters, valve and pipe fitters, battery worker, inorganic pigment users, smelting, foundry, and refining workers, firing range workers, elevated highway constructors, building renovation or demolition, bridge/tunnel construction.)
_____ Yes _____ No _____ Don't know

3. Do you have any traditional folk remedies or cosmetics that are not bought in a regular drugstore? Or are homemade, such as Alkohl, Azarcon Bali-goli, Ghazard, Greta, Suma, and Paylooah?
_____ Yes _____ No _____ Don't know

4. Have you had the urge to eat things other than food, like clay, dirt, plaster, paint chips, or ice?
_____ Yes _____ No _____ Don't know

5. Do you or others in your household have a hobby or activity likely to cause lead exposure? (Examples: making stained glass, copper enameling, bronze casting, pottery making, jewelry making, casting ammunition/fish weights, collecting and other fine arts, liquor distillation, hunting and target shooting?)
_____ Yes _____ No _____ Don't know

6. Do you use leaded crystal glassware or pottery that was handmade or homemade?
_____ Yes _____ No _____ Don't know

7. Does your house, school, workplace, or other site you frequent contain lead pipes, solder, or have lead in the water?
_____ Yes _____ No _____ Don't know

Interviewer's signature _____
Serum Level indicated: _____ Yes_____ No_____ Refer to M.D.

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MEDICATION HISTORY AUTHORITY

I hereby give my permission for Birthing Medical Group and Brooklyn Birthing Center to obtain my medication history from the last 13 months using our national pharmacy registry. I understand that this information will be automatically uploaded into my electronic medical records (chart).

_____
Name

_____
Signature

_____
Date

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Informed Consent to Perform HIV testing

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.

- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or becoming infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling sex or needle-sharing partners of possible exposure. I may revoke my consent verbally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my record.

Patient Name: _____ Date: _____

Signature: _____

Important Note: When a patient is unable to sign, a legally authorized person should sign on the patient's behalf and complete the following with their own information. If more than one person is signing, each person should fill out the information below (attach additional pages, if necessary):

Patient's Representative's Name: _____ Date: _____

Patient's Representative's Signature: _____ Relationship to patient: _____

If person signing is not nearest relative, print name, address, and telephone number of nearest relative.

CONSENT TO PARTICIPATION IN STUDENT TRAINING

In an effort to ensure the new providers are trained in the midwifery model of care, Brooklyn Birthing Center (BBC) seeks your cooperation in preparing the nursing and midwifery students who intern with us. Their role range from observation to full participation in all aspects of client care. Students are closely supervised by certified midwives at all times.

No student may be involved in your care without your express permission. We ask that you let us know whether you give such permission and to what extent. If you wish to refuse any student involvement, you should feel free to do so. Should you, at any time, change your mind about student participation, please let us know.

We hope that you will consider helping us educate the care providers of the future in our unique setting.

_____ I agree to full participation.
_____ I agree to limited student participation in my care. Please specify:

_____ I refuse student participation in my care.

Date: _____

Signature of Mother: _____
Signature of Midwife: _____

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Out-of-Network Consent Letter

Brooklyn Birthing Center is a participating provider in many health insurance plan networks. In order to assist you in determining whether the Brooklyn Birthing Center accepts your insurance plan, please see the list of insurance plans that the Brooklyn Birthing Center participates with on our website at www.brooklynbirthingcenter.com. Some plans use smaller networks for certain products they offer, so it is important to check whether the Brooklyn Birthing Center participates in your specific plan.

In addition, we ask that you to verify whether we accept your insurance plan by requesting a Verification of Benefits through Digital Billing, our billing service. For a Verification of Benefits report, please e-mail Molly at digitalbillingcorp@gmail.com. Please note that Digital Billing charges $25.00 for this service. Digital Billing will help you to understand any anticipated out-of-pocket costs, such as co-pays and deductibles, and will help you to obtain any special authorizations that may be required by your insurance plan.

It is also important for you to know that any laboratory services you receive at the Brooklyn Birthing Center are not included in the birthing center's charges. Laboratories bill for their services separately and may or may not participate in the same health plans as the birthing center. You may contact the lab directly at any time for a list of their fees and accepted insurances.

We anticipate that you will need the services of other facilities, such as sonographers or other allied providers. It is **your responsibility** to contact the facility regarding their fees and accepted insurances. For your convenience, the names of some of the facilities that we frequently use are listed below.

List of Physicians or Facilities:

New Beginnings: 8405 Fort Hamilton Parkway Brooklyn, NY 11209 **Phone:** 718-745-6500
MMC Perinatal Center: 5014 Fort Hamilton Parkway Brooklyn, NY 11219 **Phone:** 718-283-7979
Sunrise Lab: 800-782-0282
Quest Lab: 800-223-0570

Client name: _____ Date: _____

Signature of Acknowledgement: _____

Lactation Information and Consent

Brooklyn Birthing Center provides breastfeeding classes and individual breastfeeding counseling to all of our expecting mothers and their families. Breastfeeding is a skill that takes knowledge and practice to be successful. All clients are required to attend one of our prenatal breastfeeding classes or an individual consultation with one of our lactation consultants. These sessions provide women and their families an opportunity to learn about how their breasts produce milk, how to breastfeed their babies, and how to make sure their babies are getting the breastmilk they need to grow and thrive. In our group classes, clients have a chance to learn from each other's questions and to have conversations about their fears and aspirations about breastfeeding their baby.

The individual or one-on-one breastfeeding counseling sessions allow patients to ask specific questions about her anatomy and physiology and to get feedback on the struggles she may personally face. It is also a time to discuss the support systems in the patients' life and who is going to care for the breastfeeding mother and baby.

Before scheduling an appointment for either our breastfeeding class or a one-on-one breastfeeding session, please call your insurance to make sure this service is covered. Brooklyn Birthing Center can provide you with a list of insurances that may cover the class or session if you ask, however this is not a guarantee that your insurance will pay. Please note that our breastfeeding classes and breastfeeding one on one sessions are at a fee of $55 each visit for mom, and a one-time fee of $55 for baby. This will be the patients' responsibility to pay in the event your insurance does not cover the service.

Patient Signature: _____ Date: _____

Phone: (718) 336-4119 **Fax:** (718) 336-4113 **Address:** 2183 Ocean Avenue, Brooklyn NY 11229

Notification of Baby's Insurance

Please note that by 37 weeks, you must have insurance set up for your baby. Medicaid patients should already have a Medicaid number and card for the baby. Patient with private insurance will have mom's insurance put in the baby's chart at delivery; however, it is your responsibility to notify the insurance company of birth within 24 hours. We need to have this information on file in order to bill in a timely manner for any and all services after delivery, including the 2-Day Postpartum Visit and lactation services. Failure to give this information or notify the insurance on time will result in a bill to you for all services. This will be your responsibility to pay. It may be possible to be reimbursed from your insurance company after they add the baby to your insurance plan. Therefore, we will supply you with a receipt at the time of payment.

Patient Signature_____

Date_____

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FOR CLIENTS COVERED BY THE HEALTHFIRST INSURANCE PLAN ONLY

Healthfirst Notification of Baby's Insurance

Please note that by 37 weeks, you must have insurance in place for your baby. Healthfirst patients should already have a Medicaid number and card for the baby. It is your responsibility to call your insurance before birth to start the process of registering your baby for Healthfirst. You will also be responsible for notifying Healthfirst of the birth within 24 hours. We need to have this information on file in order to bill in a timely manner for any and all services after delivery, including the 2-Day Postpartum Visit and lactation services. Failure to notify the insurance on time or failure to register your baby with Healthfirst will result in a charge of $1500 to you for all services not covered, which Health First would otherwise pay for if notified in a timely manner. This will be your responsibility to pay.

Patient Signature_____

Date_____

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BIRTHING CENTER RESERVATION AGREEMENT

Reservation Agreement made on this date between Brooklyn Birthing Center, Inc., a licensed facility under Article 28 of the New York State laws having its location at 2183 Ocean Avenue, Brooklyn, NY 11229, and Client referenced below who is desirous of birthing at BBC,

Whereas Brooklyn Birthing Center (BBC) is a facility providing basic maternity level of care to low risk women birthing at its free standing birth center;

Whereas, BBC is limited in its capacity to accept and birth clients within the facility, such limitation results in women unable to register for their birth at BBC;

And whereas, Client wishes to make a commitment to birth at BBC by making a reservation, such reservation will be binding, except in the event of any unforeseen circumstances of her risk assessment changing her status from low risk thereby medically necessitating her delivery at a hospital, in accordance with the provider providing prenatal to Client;

Therefore, in consideration of a reservation payment in the amount of Five Hundred ($500.00), BBC and Client agree to the following terms and conditions;

1. **In the event that Client electively decides to change her birth site plan of delivering at BBC at any time after she has reached 26 weeks and 0 days of pregnancy, specifically to a location of a hospital or homebirth, then payment shall be due hereunder;**

2. In such an event**, Client authorizes Brooklyn Birthing Center to charge a $500.00 fee to her credit or debit card.** This fee is non-refundable.

It is understood that this fee will not be due or charged to Client in the event of a non-elective event precipitating a change in Client's plan to birth at BBC, including non-authorization by Client's insurance plan to pay for the birth center facility fee, or any other circumstance beyond Client's control.

Client agrees that in the event the credit card is charged, then Client will not dispute the validity of the charge based on this Agreement. If the credit/debit card is declined, Client agrees to furnish a payment in the amount of $500.00 forthwith in the form of a check made payable to Brooklyn Birthing Center, Inc. or immediate funds.

This Agreement constitutes the entire understanding between the parties, shall be binding upon the parties and governed by the laws of New York.

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Brooklyn Birthing Center, Inc.
Authorization to Charge Credit Card

Client Name (Print) Signature Date

Expected Due Date _____

I authorize the charge of Five Hundred ($500.00) as per this Agreement.

Credit or Debit Card Information

Full name as it appears on card: _____

Signature: _____

Card number: _____

Expiration date: _____ CVV code: _____

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