

Client Registration Form (CRF)

Birth Wellness and Women's Center
Carolyn Drake, CPM-TN

Initial exam (Provider's office must complete this box)

- 99205 (60 min-10 body systems-complete medical history-high decision making)
 99204 (45 min-10 body systems-complete medical history-moderate decision making)
 99203 (30 min-6 body systems-pertinent medical history-low decision making)
 This is a returning established patient that I have provided care for in the past 3 yrs.

Date of service: _____ Comments: _____

CLIENT INFORMATION

Name (Last, First, MI) _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone(____) _____ Alternate Phone(____) _____

Email _____ Marital Status: single married widowed separated divorced

Birth date _____ Age _____ Soc. Sec # _____

Due Date _____ LMP _____ First Pregnancy? Yes No Planning: Home Office (Belvoir Home)

INSURANCE INFORMATION

Primary Insurance _____ Plan Name _____ Effective _____

Insurance Address _____ City _____ State _____ Zip _____

Insurance Phone# (for providers) _____ Electronic Payor ID# (5 digits) _____

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber's SS# _____ ID# on Card _____ Group# _____

Employer: _____ Client's Relationship to Subscriber: Self Spouse Child Other

Secondary Insurance _____ Plan Name _____ Effective _____

Insurance Address _____ City _____ State _____ Zip _____

Insurance Phone# (for providers) _____ Electronic Payor ID# (5 digits) _____

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber's SS# _____ ID# on Card _____ Group# _____

Employer: _____ Client's Relationship to Subscriber: Self Spouse Child Other

Notes/instructions regarding this CRF:

Agreement to pay midwife: I hereby authorize my insurance company to make payment directly to my provider, Carolyn Drake. I am financially responsible to the above stated midwife for all charges not covered by insurance benefits.

Records: I give authorization to my provider to release any information to any insurance company or medical group in order to process my insurance claims.

Signature of Client: _____ Date: _____

I choose to verify benefits myself. I understand that I must submit a completed Verification of Benefits form to my midwife as soon as possible in order for Birth Wellness to bill claims on my behalf. If I obtain incorrect benefits information, I will not hold my midwife responsible for the way in which my claims process. If I have trouble with the verification, authorization, or exception processes, I understand that I may choose to pay Birth Wellness \$15 for this service. (Initial) _____