Counter Culture Midwifery Services
(941) 264-6084

Confidential Legal Information

Legal Name: _____

First Middle Last Maiden

Birth date: _____ Age: _____ Social Security Number: _____ Legal Marital Status: S M D W

Race: _____ Religion: _____ Highest Level of Education; _____

Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Mailing address (if different): _____

Preferred Phone: _____ Additional Phone: _____

Email: _____ Do you live in city limits? _____

State (or foreign country) you were born: _____ Occupation: _____

Husband or Partner's Full Legal Name: _____

Birth date: _____Age:_____ Social Security Number: _____

Race: _____ Religion: _____ Highest Level of Education; _____

Mailing address (if different from spouse or partner):_____

State (or foreign country) you were born: _____ Occupation: _____

How did you hear about this practice? _____

In Case of Emergency, Contact: _____

Phone: _____ Relationship: _____

Address: _____

Health Insurance Company: _____Policy #:_____

Policy Holder: _____Group #:_____

Phone #: _____Address: _____

Payment is due at the time of service unless other arrangements are made in advance.

I authorize payment directly to Counter Culture Midwifery Services or to the Midwife of Counter Culture Midwifery Services for the medical care and pregnancy benefits otherwise payable to me. I understand that I am financially responsible to Counter Culture Midwifery Services for charges not covered by insurance. I authorize the release of my medical information to my insurance company necessary to review this claim. If I do not have insurance I understand that I am solely responsible for all payments that full payment for services is due 8 weeks before my due date.

_____ _____

Signature of Client Date

_____ _____

Signature of Midwife Date

_____

Name of Client Date of birth