Birth Center Informed Consent & Plan for Hospital Transport

Midwives with admitting privileges at the Puget Sound Birth Center (PSBC) are expected to adhere to the Midwives’ Association of Washington State (MAWS) Standards for the Practice of Midwifery (www.washingtonmidwives.org) in identifying “significant deviations from normal” and to consult with or transfer care to a hospital accordingly. Your midwife is also expected to maintain an active license to practice in Washington State, to be a member of MAWS, and carry appropriate malpractice insurance.

If, during your stay at PSBC, your midwife determines the need for consultation or transport to a hospital, options are dependent on the clinical circumstances and are generally as follows:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Mode of Transport</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergent labor (antepartum) or postpartum transfer</td>
<td>Private automobile</td>
<td>Evergreen Hospital (Kirkland) Valley Medical Center (Renton) University of Washington Swedish First Hill (Seattle) Overlake (Bellevue)</td>
</tr>
<tr>
<td>Non-emergent neonatal transfer of a stable infant</td>
<td>Private automobile</td>
<td>Evergreen Hospital (Kirkland) Valley Medical Center (Renton) Children’s Hospital (Seattle)</td>
</tr>
<tr>
<td>Emergency transfer- time is of the essence, additional medical procedures needed en route or additional emergency assistance required</td>
<td>Medic Unit (911)</td>
<td>Evergreen Hospital (Kirkland) Valley Medical Center (Renton)</td>
</tr>
</tbody>
</table>

- I/We have chosen to birth our baby at the Puget Sound Birth Center attended by a midwife with admitting privileges.
- I/We understand that admission to PSBC in labor is contingent upon the normal progress of this pregnancy, compliance with routine prenatal care and upholding the client responsibilities as outlined and discussed with me by my midwife.
- I/We understand that narcotic and epidural pain medications, vacuum extractor, forceps and Cesarean Section are not available at PSBC and need for any of the above are indications for transport to hospital.
I/We understand that there are medications available at PSBC for the control of shock, seizure, and post-partum hemorrhage and newborn resuscitation equipment is on site. Emergency medications may be used in addition to transport to hospital.

I/We understand that birth is not without risk and that there is no guarantee of the outcome of birth in any setting, in or out of the hospital.

I/We understand the potential risks, benefits, and responsibilities involved in choosing an out-of-hospital birth at PSBC and am/are willing to accept these.

I/We understand that PSBC cannot be held responsible for the clinical care provided by my midwife.

Client’s signature __________________________________________________  Date ______________________

Partner’s signature ________________________________________________     Date ______________________
Informed Consent for Midwifery Care and Out of Hospital Birth

1) I hereby authorize Puget Sound Midwives and/or such associates as may be selected by them to:
   • provide prenatal care, prenatal education and instruction;
   • perform physical exams to evaluate my general health and pregnancy status;
   • to obtain blood, urine, vaginal, cervical, or rectal samples for laboratory tests;
   • assist during my labor and the delivery of my baby;
   • provide immediate newborn and postpartum care, and any other procedures related to childbearing as needed.

2) **SCREENING CRITERIA:** I understand that the services of the Licensed Midwife will be provided for normal, healthy women who meet the definition of low-risk maternal client, and their families.

   Washington State law defines a "low-risk maternal client" as someone who:
   
   (a) Is at term gestation, in general good health with uncomplicated prenatal course and participating in ongoing prenatal care, and prospects for a normal uncomplicated birth as defined by reasonable and generally accepted criteria of maternal and fetal health;
   (b) Has no previous major uterine wall surgery, cesarean section, or obstetrical complications likely to recur;
   (c) Has no significant signs or symptoms of anemia, active herpes genitalia, placenta praevia, known noncephalic presentation during active labor, pregnancy-induced hypertension, persistent polyhydramnios or persistent oligohydramnios, abruptio placenta, chorioamnionitis, known multiple gestation, intrauterine growth restriction, or substance abuse;
   (d) Is in progressive labor; and
   (e) Is appropriate for a setting where methods of anesthesia are limited.

   If, at any time, the midwife feels it is necessary for my well being or that of my baby, she will consult and/or refer to an appropriate health care provider and/or physician.

   I agree to:
   • call the midwife immediately if I experience any of the warning signs listed on the "signs and symptoms to immediately report to the midwife" form;
   • plan a natural birth without medication;
   • transfer my care or my infant's care to a hospital or physician if the midwife thinks it is necessary;
   • attend childbirth classes or read recommended books about childbirth;
   • arrange for someone to be at home with me to help after the birth of my baby;
   • establish care with a pediatrician for my baby by 2 weeks of age;
   • notify the midwife if I cannot keep an appointment or make payments on time.

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3) **SERVICES PROVIDED:** The midwife will:

- provide normal prenatal and postpartum care;
- be in contact and/or present during my labor, and present during delivery;
- examine my baby at birth, 1-3 days, and 7-14 days of age;
- provide postpartum exams at approximately 1-3 days, 2 and 6 weeks, or more if needed.

In the unlikely event that the midwife should not be available, she will arrange for another midwife to provide these services.

4) **PHYSICIAN AND HOSPITAL CARE:** Conditions may develop during my pregnancy, labor and delivery, after delivery, or in my infant’s first hours of life that may need to be evaluated and treated by a physician and may require transfer to a hospital. The midwife has explained these conditions to me and if needed will arrange for a consultation with a physician, transfer of my prenatal care to a physician, or transfer of my infant or myself to a hospital. In the case of an emergency, the midwife will facilitate a transfer of my care to the closest hospital where she may or may not have an established consulting relationship with the doctor on call. In the case of a non-emergent transfer, arrangements will be made to transfer to a hospital where there is an established relationship between the midwife and hospital staff. If admitted to a hospital, care will be delivered by the hospital medical staff.

5) **CONSUMER HISTORY:** I understand the midwife will rely on my medical history and information about myself that I provide. I state that such information is complete, correct, and accurate, to the best of my knowledge. I also acknowledge that in midwifery care I am part of the healthcare team and I must enter into the decision making process.

6) **STUDENT MIDWIVES:** I understand that there may be times when a student midwife may be involved in my care as an integral part of the midwifery team and that student participation occurs under the supervision of the licensed midwife. It has been explained to me that if at any time I am not comfortable with the student's participation I need only bring it to the midwife’s attention and other arrangements will be made.

I/WE, THE PARENTS, HAVE CHOSEN TO HAVE AN OUT OF HOSPITAL BIRTH. I/WE UNDERSTAND THAT THERE ARE SPECIAL RESPONSIBILITIES AND RISKS THAT ARE ATTACHED TO SUCH A DECISION. ALTHOUGH MANY POTENTIAL PROBLEMS CAN BE FORESEEN AND/OR SCREENED FOR, THERE ARE SOME COMPLICATIONS WHICH CAN NOT BE PREDICTED EITHER IN OR OUT OF THE HOSPITAL. EMERGENCY MEDICATIONS FOR THE CONTROL OF HEMORRHaGE, SHOCK AND SEIZURE ARE AVAILABLE AS WELL AS RESUSCITATIVE EQUIPMENT. NARCOTICS, EPIDURAL ANESTHESIA, BLOOD TRANSFUSION, VACUUM EXTRACTOR, FORCEPS AND CESAREAN SECTION ARE NOT AVAILABLE IN AN OUT OF HOSPITAL BIRTH SETTING. SHOULD A NEED FOR THOSE ARISE, THE CLIENT WOULD NEED TO BE TRANSPORTED TO A HOSPITAL.

I certify that the licensed midwife has informed me of the nature and character of the proposed services.

I certify that I have had the opportunity to ask questions and have had all aspects of licensed midwifery services explained to my satisfaction and I consent to midwifery care and out of hospital birth.

client: __________________________ date: __________________________

partner: __________________________ date: __________________________.

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Financial Contract

This document describes our policies regarding payment for professional and facility fees:

- **Medicaid** – We accept Medicaid as payment in full for professional and facility services rendered. If you are using Medicaid, you must present your coupon to us at each visit. If you have questions about qualifying for or enrolling in Medicaid, please ask at the front desk or contact your local DSHS office.

- **Private Insurance** – We will bill your insurance company for services rendered after your initial clinical visit and after the birth of your baby or upon termination of care. You are responsible for all deductibles, co-pays, and/or co-insurance as allowed under your health policy. For health plans with which we have provider contracts, we cannot, per our contract, collect payment from you until your health plan has been billed and has provided us with an Explanation of Benefits (EOB). We will mail a bill to you at that time if appropriate. Payment for the balance is due within 30 days. If we do not have a provider contract with your plan, all co-pays, deductibles and co-insurance are due by the six week postpartum visit.

- **Private Pay** – If you do not have health insurance, are not eligible for Medicaid, or your plan does not cover our services, you may private pay. We accept cash, personal check or credit cards for payment. Payment for professional service (the midwives) and the facility fee (birth center) must be paid in full by week thirty six of your pregnancy or care will be terminated. If you are experiencing financial hardship, please call our insurance biller, Victoria at 206-932-0870.

Additional clinical services, including laboratory fees and ultrasound, are not included in our fees and will be billed separately by the service provider.

- **Discontinuation of Care** – If you are referred to the care of another practitioner and do not continue care with us, or choose to discontinue care with us for any reason prior to the onset of labor, the fee for our services will be recomputed to reflect the cost of care provided to that point. Your insurance company will be billed for all care received by our midwives up to the point of transferring care to another provider. If you paid cash in advance, you will be reimbursed on a prorated basis.

- **Collection of Overdue Accounts** – If payment is not made in a timely manner and we have been unable to collect a balance due, we will send your overdue account to collections. You, the client, are responsible for all reasonable collection and/or attorney fees incurred.
Acknowledgement and Insurance Payment Authorization

I certify that the information in this form is correct to the best of my knowledge. I hereby authorize the Puget Sound Midwives & Birth Center or any of its representatives be paid directly by my insurance company. I hereby authorize Puget Sound Midwives & Birth Center or any of its representatives to release any information necessary to process my insurance claim.

The undersigned have read and understand this contract and have had full opportunity to have all questions answered. I/we understand that insurance coverage is not a guarantee of payment and that ultimately I am responsible for paying my bill.

________________________________________                     ________________
Signature of client                                           Date

______________________________________________________                          _____________________
Signature of spouse, partner, or guardian (if client is a minor)                                      Date
Signs or Symptoms to Immediately Report to Your Midwife:

- Vaginal Bleeding
- Leaking of fluid from your vagina
- Chills and/or fever
- Continuing severe headaches, vision changes or dizziness
- Unusual or sudden swelling or puffiness, especially of the hands or face
- Sharp or continuous abdominal pain or cramping
- Severe vomiting or diarrhea lasting more than 24 hours
- Burning, pain or discomfort while urinating
- Any lesions or sores around genitals
- Sudden or unusual decrease in the movement of the baby
- Uterine contractions: 4-6 in an hour, if less than 37 weeks

How to reach the Midwife on call:

Dial
425-823-1919
Follow the prompts to page your midwife

This number should always work, however, if you are left on hold for longer than a few minutes, hang up and try again.

We have created 2 back up plans in case of unforeseen complications with the answering service or phone lines. If you are not able to connect with a person by following the above instructions, call the answering service directly at
1-800-280-5819

If this still does not connect you to a human, call (425) 883-1919 for further instruction and back up numbers. NOTE: If you are not able to get in contact with us, or if you think this is a medical emergency, please call: 9-1-1
Private Practice

Private Practice is the electronic medical records software used by Puget Sound Midwives & Birth Center. When you start care, you will be sent an email inviting you to make your profile on Private Practice and fill out your intake paperwork.

Throughout your care, you will have secure access to your medical records, labs results, forms, and correspondence with your midwives.

Online correspondence is to be used solely for non-urgent questions or follow up, allowing 2-3 business days for a response.

**If you have urgent and clinical concerns, please contact your midwives by phone:**

(425) 207-8769 (Renton) or (425) 823-1919 (Kirkland)

**DO NOT** send urgent concerns via email.

I understand that the messaging system on Private Practice is to be only for non-urgent matters.

Signature _________________________________ Date ________________.
Non-covered Services Agreement

Below are the fees associated with midwifery care at the birth center or in your home that are not covered by health insurance.

1. **$300 birth assistant fee**

   Your midwives prefer to have three attendants at every birth, the Licensed Midwife, matriculated student midwife and/or a professional birth assistant. Health insurance plans do not cover the $300 fee for a professional birth assistant and this fee is **not** included as part of another service.

   _____ I acknowledge that $300 will be billed to me after the birth of my baby to cover the birth assistant fee. *Please initial here to acknowledge that you understand and accept this policy.*

2. **$500 transfer fee**

   Midwifery support and advocacy during and after a hospital transfer is not covered by any health insurance plan and is **not** included as part of another service. In the event that you (prior to or after delivery) or your baby need to be taken to the hospital, this fee covers the services of your midwife professionally orchestrating the transfer, accompanying you to the hospital, relaying your medical, pregnancy and labor history to the doctor and nursing staff, and staying for up to **2 hours** to facilitate you and/or your baby get settled in your new surroundings.

   _____ I acknowledge that $500 will be billed to me in the case of a hospital transfer during or after my labor or for my baby. *Please initial here to acknowledge that you understand and accept this policy.*

Payment plans are available; if these fees represent a hardship, please call our billing specialist at 206-932-0870 to discuss non-covered service payment options.

______________________________  _____________________
Signature of client                                      Date

______________________________
Name of client
Leaving Messages

We recognize that clients have a wide range of preferences regarding how to handle phone calls from us. By default, the federal health privacy rules allow us to only leave a basic message asking you to call us back if we cannot reach you in person. However, we realize that receiving such messages can cause undue stress.

Please consider the following options and let us know your preferences.

If we call you, what would you like us to do if you cannot be reached in person?

☐ Leave detailed health information
   For example: “Your iron levels are low. Please call so we can discuss iron supplements.”

☐ Leave a summary of health information
   For example: “Your blood test results are in. Please call so we can discuss.”

☐ Leave minimal information
   For example: “This is Susan at (425) 823-1919 with a message for <name>. Please return my call.”

Using which of the following methods:

☐ On your home voicemail
☐ On cell phone voicemail
☐ On work voicemail
☐ Given as a message to your partner
☐ Given as a message to ______________________

Birth Announcements

After your baby is born, may we:

☐ Put a card on the announcement board at the birth center
☐ Post an announcement on www.birthcenter.com
☐ Post an announcement on our Facebook page

Announcements will include your first names and your baby's name, weight, and date of birth, and online may include a photo of you and your baby.

Print Name _______________________________ Date ____________________
Signature __________________________________________________________________________
Acknowledgment of Receipt

I have been provided with a copy of PSMBC’s HIPAA Notice of Privacy Practices which describes how my health information is used and shared. I understand that PSMBC has the right to change this Notice at any time.

I have been provided with a copy of PSMBC’s Client Bill of Rights, which lists my rights as a client.

I may obtain a current copy of both documents by contacting PSMBC or by visiting www.birthcenter.com

________________________________________             ___________________
Your signature             Date

________________________________________
Print your name
Dear Expectant Mother,

This letter is to inform you of a project being conducted by the Midwives Alliance of North America, called the MANA Statistics Project or MANA Stats. Your midwife contributes data to this project. After reading this letter, you will have the opportunity to ask questions and, if you so choose, to give your midwife verbal permission to enter information about your pregnancy and birth into the MANA Stats data collection system. No names or other identifiers are collected in this data registry.

**Purpose.** The Midwives Alliance conducts the MANA Stats Project in an effort to document the processes and outcomes associated with midwifery models of care, and to provide midwives with information they can use to maintain and improve the quality of their practices. These data may also be used for research.

1. **Activities.** In MANA Stats, each client that consents to participation is registered in an online system at the beginning of care. Your midwife then fills out an online data form describing your particular course of care.

2. **Time.** Your estimated time commitment to participate in the project is 15-20 minutes, and only involves this consent process. Your midwife enters all other data on your behalf.

3. **Risks.** Participation in this project poses no foreseeable risks to you.

4. **Benefits.** We do not expect you to benefit directly from participating in this project. However, we do expect that findings from research conducted using the MANA Stats database will help to improve maternal and infant health practices, and to guide the development of midwifery care policies in the United States and abroad.

5. **Alternatives.** There are two levels of participation in this project. First, you can choose to allow your midwife to enter your data only for her own internal quality assurance and improvement processes. In that case, your midwife would be the only person to see your data, and she would use it to do things like track her cesarean rate over time. Or, you may additionally consent to have your data included in the research database for this project. In this case, researchers who use the MANA Stats data (see #4, above) would have access to your de-identified data—however, when results are published, your data would not be reported individually, but rather in what we call “aggregate” form. For instance, the research paper might report that 93% of women had a spontaneous vaginal birth, or that 956 women used a shower during labor for pain relief. Finally, you could just opt not to have your data in MANA Stats at all. If you choose this last option, you can still get prenatal care with your current midwife.

6. **Confidentiality.** The confidentiality of your health-related information will be carefully protected. To protect your identity, your midwife will create a code for your birth (e.g., “birthcode123”), rather than using your name. Data will be kept secure to the extent permitted by the technology being used. Information collected online can be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses.

7. **Contact Information.** If you have any questions about this study, please contact the MANA Division of Research—the entity that oversees this project. (See below for contact information)
8. **Voluntariness.** If you choose to participate in the project, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to participate. You can stop at any time and still keep the benefits and rights you had before volunteering. Your decision will not affect your care or your relationship with your midwife. You may withdraw your data from this project any time prior to the final submission of the data form by your midwife to the database by contacting your midwife; she will then inform the MANA Division of Research of your withdrawal from the project.

9. **Funding.** This study receives ongoing internal funding from the Midwives Alliance Board of Directors, and varying sources of external funding, including the Foundation for the Advancement of Midwifery, Transforming Birth Fund, other foundations, and federal agencies.

10. **Conflict of Interest.** Members of the Division of Research (DOR) may also be researchers who access the data for research purposes. MANA DOR members and researchers accessing the data may also be midwives themselves or otherwise involved as midwifery or birth professionals.

Please ask any questions of your midwife about this project before making your decision about whether or not to allow your data to be entered. You may also contact the MANA Division of Research with your questions using the contact information below.

Thank you for your consideration,

*The MANA Division of Research: The MANA Statistics Project*

PO Box 373, Montvale, NJ 07645

research@mana.org or 844-626-2674

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**Dear Midwife,**

*Please retain this portion in the chart so that you can log your client if she consents. You do not need to mail this form to MANA*

**Verbal Consent (midwife reads to client)**

Do you give your consent for your midwife to enter your clinical data into the MANA Statistics Project for quality insurance and quality improvement measures? Yes or No? ___yes _____no

Record date:

Do you give your consent for your midwife to enter your clinical data into the MANA Statistics Project for research purposes? Yes or No? ___yes _____no

Record date:

Birth Code __________________ (for identifying client’s record later when recording consent and entering data)

Thank you!
(Remember: You do not need to mail this page to MANA)