Steps Ahead

AGREEMENT TO RECEIVE CARE
RELEASE OF INFORMATION

I want to have good health while I am pregnant. I will try to do all things to help my baby to be born healthy.

I have been told that I can choose who will give me prenatal care.

I have chosen ____ (Doctor, midwife, clinic)

His/her address is _______________________________________. I want my baby to be delivered at

____.

I have been told that I can change my mind about this choice within 90 days for any reason.
I have been told that I have the right to change my mind about who gives me care at any time there is a good reason.
I agree to go to doctors, clinics, hospitals and other places for care that are set up for me while I am pregnant and after my baby is born.
I agree to follow the plan of care that has been set up for me by my doctor, midwife or other person who provides my care.
I have been told that a real emergency is when I have a health problem that can cause death or lasting injury to my unborn baby or to me.
I have been told what my rights and responsibilities are under the Medicaid Maternity Care Program.
I have been told what I need to do if I have a problem that I cannot solve on my own.
I have reported other insurance that I have.
I have had the chance to ask questions about anything that I did not understand and to have my questions answered in a manner in which I understand.

I give my permission to Steps Ahead and any and all subcontractors, to perform tests and procedures necessary for my maternity care unless I have a religious or moral belief that prevents me from giving my permission. I give my permission for the release of my health information to providers for treatment purposes or to help with my care. I give my permission for the release of any information including medical records acquired in the course of my enrollment, treatment, or examination to the Alabama Medicaid Agency, my insurance company, or other entities as is necessary for reimbursement purposes.

I have been given a copy of:
____Recipient Rights and Duties
____Agreement to Receive Care/Release of Information
____Enrollment Form (if different)
____Maternity Care Fact Sheet
____Care Coordinator Business Card with her name and telephone number

Name__________________________________ **Medicaid #** ____________ **DOB** ____________

Signature____ **Date Signed** ___________________