Alice Norris, RN, IBCLC
PO Box 72 - Huntington, VT 05462

HypnoBirthing® Childbirth Educator
An affiliate of the HypnoBirthing® Institute

Patient's Last Name: ______________________ First: ____________________ Initial: _____

DOB: ___/___/_____ Relationship to Subscriber: ____________________________________

Address: ______________________ City: ______________ State: _____ Zip: __________

Phone: ________________________ Subscriber: ___________________________________

Referring Physician/CNM: ____________________________ Due Date: _________________

Insurance Carrier: ____________________________ Ins.ID #: _________________________

Coverage Code: __________________________ Group: _____________________________

RELEASE: ***I authorize the undersigned health care provider to release any information acquired in the course of my examination or treatment.***

SIGNED: ____Date: ______________________
(Insured or Authorized Person)

Diagnosis	**V22.2**

Service(s) provided	**CPT Code**	**Fee**
Childbirth Education Classes: Group	**99078**	
Childbirth Education Classes: Private	**99342**	
Educational Supplies (books, tapes, etc. provided for the client's education at cost to the educator)	**99071**	

Total Fees: ___________ **Amount Paid:** ____________ **Balance Due:** ______________

Provider's Signature_______________________________ **Date of Service**_____________

Instructions to client for filing insurance claims: Complete the patient information section at the top of this form. Attach this to your own insurance carrier's claim form and submit directly to your insurance company.