Service Contracts

Service Agreement

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This service agreement is dated _____ and is between:

CLIENT INFORMATION		SERVICE PROVIDER INFORMATION	
Full Name		Full Name	Hanna Davis
Address		Address	106 W 1st St.
City	State / Province	City	State / Province
		Ogallala	NE
ZIP / Postal Code	Phone	ZIP / Postal Code	Phone
		69153	308-284-1069

Collectively, the "**Client**" and the "**Service Provider**" will be referred to as the "**Parties**".

The Client wishes to retain the Service Provider for the provision of professional birth and postpartum doula services as set out below, and the Service Provider wishes to supply such services.

The Parties therefore agree as follows:

1.Term

This Agreement commences on the date first written above and ends 8 weeks postpartum, that is 8 weeks after the delivery of the infant.

2. Services

a) The Service Provider shall perform "**Services**" as described below in accordance with this Agreement and in a professional manner with the Client's best interests in mind. As a trained birth and postpartum doula, the Service Provider will support the Client before, during, and after the birth of the Client's infant(s). The Parties will remain in touch by telephone and/or e-mail communication as well as through scheduled in person or virtual meetings.

Before Birth

The Service Provider will meet with the Client (and the Client's partner if applicable) before labor to become acquainted with the Client and to build a relationship. Before the birth services can include but are not limited to the following:

- discussing the Client's preferences and priorities as well as any fears or concerns
- prenatal education classes ran by the Service Provider to present evidence-based information on the benefits and risks of common interventions and procedures used during childbirth
- discuss and develop a birth plan together

During Labor

The Service Provider requests that the Client calls when she thinks she is in labor, even if she does not yet need the Service Provider. This gives the Service Provider time to make arrangements and clear their calendar. The Service Provider can provide guidance over the phone and the Parties can decide together when the Service Provider should travel to be with the Client in person. The Service Provider can meet the Client at the Client's home or at the planned place of birth. The Service Provider will provide in person labor support within one hour of the Client requesting in person support (except under extraordinary circumstances). The Service Provider will remain with the

Client throughout the duration of labor and delivery (unless otherwise agreed upon by the Parties and/or under extraordinary circumstances). During labor services can include but are not limited to the following:

- the Service Provider can facilitate communication between the Client and their care provider with the purpose of communicating the Client's previously discussed preferences and wishes
- the Service Provider can answer questions for the Client and their partner
- the Service Provider will provide reassurance and encouragement throughout labor and delivery
- the Service Provider can make suggestions that may help the Client improve discomfort and/or progress labor
- the Service Provider can provide massage and hands on techniques to help the Client with relaxation and discomfort
- the Service Provider can bring equipment including but not limited to a TENS machine, exercise ball, birthing pool (these items will be agreed upon prior to)

Immediately After Birth

The Service Provider will remain with the Client for one to two hours after the birth. The Service Provider will be available to answer questions about the birth and/or the baby. The Service Provider will schedule the first postpartum meeting within a 24-48 hours to visit the Client and the baby, review the birth, and get feedback from the Client.

Postpartum Services

The timeframe of the first meeting is based on the preference of the Client and can be determined before the Client goes into labor. As a postpartum doula the Service Provider is flexible to provide a wide range of services depending on the Client's preferences and priorities. As a postpartum doula the services provided can include but are not limited to:

- infant latch and breastfeeding support (such as providing education, practical advice and support, referrals as needed)

- baby bonding and infant sleep support (such as infant soothing techniques, providing information and resources,
- basic newborn care (such as diapering, bathing, feeding, soothing, swaddling, baby wearing techniques, providing information and resources)
- emotional and physical wellbeing support (such as recommended resources, providing time and space to rest, monitoring for signs of postpartum depression and/or anxiety, referrals as needed)
- education on signs and symptoms of infection and what to monitor for post vaginal and/or cesarean delivery
- household management (such as light housekeeping, light meal preparation, running errands)
- sibling care
- other referrals as required or requested (such as local parent groups, Facebook or other social media groups, lactation consultants, parenting classes or resources

As a full spectrum doula, the Service Provider does not:

1. Perform any medical or clinical tasks, such as monitoring fetal heart rate, vaginal exams, administering drugs, and/or wound care. The role of the Service Provider is to provide evidence based education as well as physical comfort and emotional support to the Client.
2. Make any decisions for the Client. It is the Service Provider's intention to get the Client the information they need to make an informed decision.
3. Provide medical advice. The Service Provider can direct the Client to resources and qualified medical professionals that might help answer the Client's questions.

b) The Service Provider is competent and fully qualified to perform the Services outlined above.

3. Client Responsibilities

The Client must inform the Service Provider of any conditions or other special circumstances the Client might have or acquire throughout the Term of this Agreement. The Client will keep the Service Provider informed of any concerns or recommended procedures by the Client's healthcare provider. The Client will inform their healthcare provider that they have hired a doula to be present at the birth. If the Client, for any reason, decides to not use the services outlined in this Agreement after the Client has signed this contract, kindly inform the Service Provider as soon as possible.

4. Confidentiality

The Client gives the Service Provider permission to keep professional records, including personal health information about the Client and/or the infant. The Client's records will be shared with the backup doula if the backup doula is called in to participate in any part of the Services outlined in this Agreement. The Service Provider agrees to keep the Client's personal and health information confidential.

By signing this Service Agreement it is declared that the Terms of this Agreement are fully understood by the Client and the Service Provider.

Client's Name (Please Print)

Service Provider's Name (Please Print)

Date (Month/Day/Year)

/ /

Date (Month/Day/Year)

/ /

Client's Signature

Service Provider's Signature

This financial agreement is dated _____ and is between: _____ (Client) and _____ (Service Provider).

Changes to Services and/or Birth Plan

a) If the Client plans for a vaginal delivery and a cesarean section is performed for any reason, the Service Provider will continue to support the Client before, during and after the cesarean section (as permitted by hospital policies). Under these circumstances, the fee schedule would not change.

b) If the Client requires an unplanned transfer to a hospital or medical facility the Service Provider will accompany the Client and continue to provide doula support.

c) Any extenuating circumstances (for example illness, weather, hospital policy, the Client failing to inform the Service Provider of labor, or rapid labor) that prevent the Service Provider from attending the birth will result in a refund of fees provided.

If the Client voluntarily terminates this Service Agreement for any reason after it has been signed then no refund will be provided.

FEE STRUCTURE

This amount is due in full the same day this Agreement is signed by the Client and the Service Provider.

Pricing

- $50 discount for clients that are being seen for chiropractic care throughout their pregnancy at HD Chiropractic
- $350 for clients delivering in Ogallala Community Hospital
- $400 for clients delivering 1 hour away from Ogallala (North Platte)
- At any time the Client may request additional hours from the Service Provider. Depending on availability, the Service Provider will allow for flexibility and try their best to accommodate the additional requested time. If requested and the Service Provider can stay it will be $20 an hour.
- There is a $100 deposit due on the date this Agreement is signed. This is a non-refundable deposit and will be applied to the last week of the Term.
- The Client will pay the Service Provider weekly, starting at 36 weeks unless other arrangements have been made.

Payment of Fees

The Parties will agree upon a fee based on the fee schedule above and any additional costs or visits required. The agreed upon birth doula fee as well as the postpartum services deposit is due on the date of this signed Agreement, unless otherwise agreed upon in writing. If a payment plan or other alternate means of payment are to be used, they must be in writing before signing this Agreement. The Service Provider accepts cash, check, or Venmo as means of payment.

Client's Name (Please Print)

Service Provider's Name (Please Print)

Date (Month/Day/Year)

/ /

Date (Month/Day/Year)

/ /

Client's Signature

Service Provider's Signature

Liability Release Agreement

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The Client acknowledges that receiving services from the Service Provider does not prevent the potential of an adverse event from happening during pregnancy, labor, or postpartum. As outlined in the Service Agreement, the Service Provider will not give medical advice and/or make medical decisions on behalf of the Client. It is solely the responsibility of the Client to seek medical care as needed.

The Client (and anyone claiming on the Client's behalf) agrees to not make a claim or take proceedings against the Service Provider (and any affiliates, successors, employees, representatives, or partners; collectively referred to as the **"Released Parties"**) for any reason. The Client and all relevant parties intend this Agreement to be a complete release and discharge the Service Provider of all liability of any damages which may accrue as a result of using the birth and postpartum doula services of the Service Provider.

The Client and all relevant parties forever discharge the Service Provider and all Released Parties from any and all claims, liabilities, obligations, promises, agreements, disputes, demands, damages, causes of action of any nature and kind, known or unknown, which the Client has, ever had, or may in the future have against the Service Provider or any of the Released Parties.

This release may not be altered, amended or modified, except by a written document signed by both parties. Both parties represent they fully understand their right to review all aspects of this Release with attorneys of their choice.

Client's Name (Please Print)

Service Provider's Name (Please Print)

Date (Month/Day/Year)

/ /

Date (Month/Day/Year)

/ /

Client's Signature

Service Provider's Signature

Media Release Form

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I authorize _____ to take photographs of me and my infant in connection with the outlined birth and postpartum doula services

☐ Yes, I authorize _____ to use photographs of me and/or my infant, with or without my name, for any lawful purpose including but not limited to advertising, publicity, website content, and educational purposes. The images may be used on social media sites including but not limited to Instagram, Facebook, and Pinterest. I hereby waive the right to royalties or other compensation related to the use of any photographs taken by the Service Provider.

I prefer that with an image of me:

◯ My full name is used ◯ Only my first name is used ◯ No name is used

☐ No, I do not authorize _____ to use photographs of me and/or my infant, with or without my name, for any lawful purpose.

I have read this form in it's entirety before signing and I understand the contents of this release.

Client's Name (Please Print)

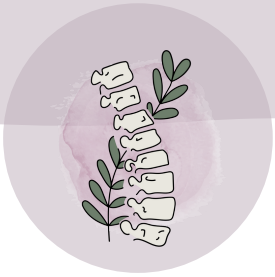
Client's Signature

Date (Month/Day/Year)

/ /

Intake Forms

Intake Form



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Date (Month/Day/Year)

/ /

CLIENT INFORMATION

Full Name

Phone Number

Address

Email Address

City

State / Province

Preferred Pronouns

ZIP / Postal Code

Phone

Estimated Due Date

PARTNER INFORMATION

Full Name

Phone Number

Preferred Pronouns

Email Address

EMERGENCY CONTACT

Full Name

Phone Number

Relationship

Email Address

Birth Details

Planned Birthing Location

Healthcare Provider (HCP)

Birthing Location Address

Have you taken a tour of your birthing location?

City

State / Province

Who will be attending your birth (partner, parent, photographer, etc.)?

ZIP / Postal Code

Phone

PREGNANCY HISTORY

Previous Pregnancies

Previous Births

Child(ren) Name(s) and Age(s)

Any Previous Complications?

CURRENT PREGNANCY

Have you been diagnosed with any of the following medical conditions during this pregnancy?
Check all that apply or Write (Y) for 'Yes' and (N) for 'No'

- Pre-eclampsia
- Gestational Diabetes
- Group B Strep
- Anxiety
- Depression
- Rh Incompatibility
- Heartburn
- Severe Insomnia
- Back, sciatic, or pubic pain
- Headaches
- Pica
- Gestational High Blood Pressure
- Anemia
- Hyperemesis Gravidarum
- Planenta Previa
- Vena Cava Compression
- Other:

All About You

MEDICAL HISTORY

Allergies (food and/or medications)

Diagnosed Health / Medical Conditions

Current Medications, Vitamins, and Supplements (please include herbs and essential oils if applicable)

OVERALL WELLBEING

How has your sleep been during pregnancy?

Have you been able to prioritize regular physical activity during this pregnancy? If so, please describe type and frequency.

Please describe your emotional prenatal experience so far.

Services

Please indicate which topics you would like to discuss. Check all that apply or Write (Y) for 'Yes' and (N) for 'No'

- [ ] How to prepare physically for childbirth
- [ ] How to create a Birth Plan
- [ ] Early labor signs / Stages of labor
- [ ] Water labor / birth options
- [ ] When to transfer to hospital
- [ ] Natural pain management strategies
- [ ] Breathing / Lamaze Techniques
- [ ] Effective positions to progress labor
- [ ] Common medical interventions while in labor
- [ ] Effective positions for the push phase of labor
- [ ] Assisted vaginal delivery techniques
- [ ] Cesarean Section delivery indications and process as well as C-Section recovery
- [ ] Common medical interventions immediately post-birth
- [ ] Newborn interventions
- [ ] Postpartum support planning / expectations
- [ ] Postpartum healing stages
- [ ] Preparing for breastfeeding / infant feeding
- [ ] Information on postpartum mood disorders
- [ ] Postpartum nutritional needs
- [ ] Baby wearing techniques
- [ ] Infant soothing techniques
- [ ] Gentle newborn sleep support
- [ ] Herbal remedies for postpartum healing
- [ ] Other (please indicate below any additional topics you would like to discuss)

Birth Preparation

Have you made a birth plan? (If no, this is something we can create together)

Have you had any regular wellness appointments (for example, physiotherapy, naturopathic health, chiropractor, acupuncturist)?

Have you shared your birth preferences with your healthcare provider (midwife or OBGYN)?

Have you and your healthcare provider discussed protocols if you go past your estimated due date?

Have you read any books to prepare for labor, childbirth, breastfeeding, etc.? If so, please indicate which books

Have you shared your birth preferences with your healthcare provider (midwife or OBGYN)?

Have attended any prenatal or childbirth education classes? If so, please indicate which one(s)

Have you packed your labor & delivery bag yet? If no, we can do this together

Please describe what you have been doing to prepare yourself, both physically and emotionally, for your birth (for example, stretching, meditation, physical activity, birth affirmations, etc.)

Expectations

What do you anticipate will be your greatest challenge? (during pregnancy, birth, or postpartum)

What do you anticipate will be your greatest strength? (during pregnancy, birth, or postpartum)

What are your fears or concerns regarding pregnancy, birth, or postpartum?

What do you find comforting? (what type of environment, music, meditation, etc.)

What type of support would you like from a doula? Is there anything you would not want?

What is the most important thing for you and your partner regarding birth doula support?

What do you envision for your labor and delivery? Please describe what you would like your birth to look like and feel for you (try to use at least 5 descriptors, for example, peaceful)

Preferences

PAIN MANAGEMENT

Please indicate which pain management techniques you would like to discuss. Check all that apply or Write (Y) for 'Yes' and (N) for 'No'

- [ ] Meditation and/or Visualization
- [ ] Physical Movement / Positions / Walking
- [ ] Massage and/or Acupressure points
- [ ] Rebozo techniques
- [ ] Laughing Gas
- [ ] Guided breathing techniques
- [ ] Heating pads and/or cold compress
- [ ] Music and/or dancing
- [ ] Shower / bath
- [ ] TENS machine
- [ ] Essential oils
- [ ] Counterpressure (by doula or partner)
- [ ] Other (please indicate any other pain management techniques that you would like to discuss)

EARLY LABOR PREFERENCES

Please indicate which items you prefer during early labor. Check all that apply or Write (Y) for 'Yes' and (N) for 'No'

- [ ] Labor at home as long as possible
- [ ] Labor in hospital
- [ ] Wear my own clothing
- [ ] Continue eating
- [ ] Ice and/or popsicles available
- [ ] Vaginal checks limited to as few as possible
- [ ] Vaginal check frequency based on HCP protocol
- [ ] Distractions
- [ ] Focal Points (such as printed affirmations)
- [ ] Continuous Fetal Monitoring
- [ ] Medications offered (for example, an epidural)
- [ ] Medications not offered by HCP
- [ ] Epidural and/or other pain medication
- [ ] Dim lighting
- [ ] Use of Pitocin / Elective Induction
- [ ] Use of birth ball for positioning
- [ ] Aromatherapy / Essential Oils
- [ ] Other (please indicate anything else you would like for your early labor)

Preferences Continued

ACTIVE LABOR PREFERENCES

Please indicate which items you prefer during active labor. Check all that apply or Write (Y) for 'Yes' and (N) for 'No'

- [ ] Choose the birth position(s)
- [ ] Perineal Massage
- [ ] Prefer to tear over an episiotomy
- [ ] Episiotomy
- [ ] HCP chooses birth position(s)
- [ ] Pictures taken during active labor
- [ ] Video taken during active labor
- [ ] Other (please indicate any other preferences you have for your active labor)

POST BIRTH PREFERENCES

Please indicate which items you prefer after your baby is born. Check all that apply or Write (Y) for 'Yes' and (N) for 'No'

- [ ] Delayed cord cutting
- [ ] Cord cut by partner
- [ ] Cord cut by HCP
- [ ] Save the placenta
- [ ] Save the cord blood
- [ ] Announce the sex of the baby
- [ ] Place baby immediately on birth parent's chest
- [ ] Clean baby before giving them to birth parent
- [ ] Delay newborn procedures for one hour
- [ ] Deliver placenta without intervention
- [ ] Other (please indicate anything else you would like post birth)

NEWBORN PROCEDURES

If you are unsure or have questions about any of these procedures we will discuss them at a prenatal visit so you feel equipped to make an informed decision. Check all that apply or Write (Y) for 'Yes' and (N) for 'No'

- [ ] Waive infant eye ointment
- [ ] Waive Vitamin K shot
- [ ] Waive PKU test
- [ ] Waive Glucose test
- [ ] Waive Hepatitis B vaccine
- [ ] Elective circumcision

Postpartum

IMMEDIATELY POSTPARTUM

Please indicate your postpartum preferences below. Check all that apply or Write (Y) for 'Yes' and (N) for 'No'

- [ ] Discharge the same day (if applicable)
- [ ] Consultation with a Lactation Consultant
- [ ] Postpartum doula care

- [ ] Other (please indicate any other things you may want or need 24-48 hours postpartum)

THE FOURTH TRIMESTER

Do you have any fears or concerns regarding the fourth trimester (three months after birth)?

What type of support do you have in place for the fourth trimester (food, errands, cleaning, etc.)?

Have you and your partner discussed a policy regarding guests during the fourth trimester?

ANYTHING ELSE?

Please feel free to share anything else that I may have missed asking about. I look forward to working with you!

Next Steps

308.284.1069

You've made it this far - now what? Email me a completed copy of this intake form and I will be in touch shortly!

YOU'VE GOT THIS MAMA!

www.hdchiropracticogallala.com
hdchiropracticogallala@gmail.com

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