

**THANK YOU FOR CHOOSING OUR OFFICE
IN ORDER TO SERVE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION.**

Last Name: _____ First Name: _____ MI: _____

Maiden: _____

DOB: ____ / ____ / ____ SS# ____ - ____ - ____ Ethnicity: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Marital Status: Single Married Student: (Y/N)

Whom may we thank for referring you: _____ Doctors Name: _____

Address: _____

Phone: (____) _____

Fax: (____) _____

Employer: _____ Work Phone: (____) _____ Ext: _____

Employer Address: _____

Cell Phone: (____) _____ Email Address: _____

Alt. Contact Name: _____ Phone: (____) _____ Relationship: _____

Responsible Party (fill out only if other than the patient)

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Zip: _____

City: _____ State: _____ DOB: ____ / ____ / ____ SS# ____ - ____ - ____

Employer: _____ Work Phone: (____) _____ Ext: _____

Employer Address: _____

CONSENT FOR TREATMENT:

I hereby authorize the provider for the Center for Maternal-Fetal Care, P.A., to treat myself for anything deemed medically necessary. I can refuse treatment at anytime.

POST PARTUM DEPRESSION AND PARENTS OF NEWBORN CHILDREN PACKETS:

I hereby state that I have received the Pregnancy, Parenting and Depression Resource List as required by law through House Bill 341. Furthermore I have received the information packet regarding Parents of Newborn Children as required by law through Senate Bill 316.

Patient's Signature: _____

Date: _____

Financial Policy

Thank you for choosing the Center for Maternal-Fetal Care, P.A. as your health care specialist. We are committed to providing you the best medical care. Our personnel will be pleased to discuss our fees and policies with you at any time.

All patients are financially responsible for payment of charges related to the professional services rendered by Center for Maternal-Fetal Care, P.A. Payment for professional services, is expected at the time of the services are rendered.

Center for Maternal-Fetal Care, P.A. has entered into a number of contractual relationships with various Managed Care Organizations. The practice will use its best efforts to fully comply with all the rules and regulations covering physician, Managed Care Organization and patients responsibilities related to these plans. In adherence to these responsibilities, patients are expected to pay co-payments and deductibles at the time services are rendered; and to pay any remaining account balances as allowed under plan guidelines.

In the event that the practice provide services in cases involving non contracted insurance plans, patients acknowledge their responsibility for the timely and complete payment of charges for professional services rendered. The office will assist in providing the necessary information for patients to obtain reimbursement from the third party, however; the patient expressly agrees that this assistance in no way shifts the reimbursement responsibility from the patient.

Appointment Cancellation / No Show Policy

It is the patient's responsibility to notify the office at least 24 hours in advance if the patient will not be able to attend their scheduled appointment. Failure to appropriately notify the office will result in the **assessment of a \$50.00 no show fee.** Future appointments may not be scheduled until the patient pays the no show fee. If a second no show occurs the practice may initiate termination of your care.

Statement of Financial Responsibility

I understand and affirm that I am financially responsible for the payment for all charges related to the professional services rendered by Center for Maternal-Fetal Care, P.A. on my behalf.

Patients Signature _____ Date _____

Release and Assignment of Benefits

I request payment under any medical insurance program/company including Medicaid to be made to Center for Maternal-Fetal Care, P.A.

I hereby authorize Center for Maternal-Fetal Care, P.A. to release any information including diagnosis and records of any treatments or examinations rendered to my insurance as necessary to have my insurance claim paid.

A xerographic copy of this authorization shall be considered as effective and valid as the original.

Patients Signature _____ Date _____

General Information Regarding Ultrasound and Amniocentesis

Diagnostic ultrasound uses high frequency, but low power sound waves. Unlike X-ray, there is no radiation involved.

Ultrasound can provide your physician with useful data about your baby and its anatomy. While many defects can be seen on ultrasound, it is important to understand not all problems or defects will be identified. Fetal position, gestational age, maternal size, placental location, the amount of amniotic fluid, and prior maternal surgeries limit ultrasound studies. These factors can result in either incomplete, or non-visualization of fetal anatomical structures. Please be aware that a normal ultrasound does not guarantee the absence of a birth defect or a chromosomal abnormality.

Center for Maternal-Fetal Care, P.A. welcomes up to two family members to share in your ultrasound experience. Their members will be allowed in the exam room to watch your ultrasound procedure.

If you are having an amniocentesis you will need to avoid strenuous work or physical activity for the remainder of the day on which the procedure is performed. You will be able to resume normal activity the following day.

Ultrasound Authorization

I have read the information presented above and give my permission for an ultrasound exam to be performed on me. I understand that this procedure may have limitations due to the above variables, and thus cannot guarantee the absence of fetal defects or abnormalities.

Patients Signature _____

Date _____

Patient's name: _____ Birth date: _____ Today's date: _____

At which hospital will you deliver? _____ Your doctor's name: _____

PLEASE RECORD THE NUMBER OF EACH THAT APPLIES TO YOU:

Pregnancies (including this one): _____ Elective Abortions: _____ Miscarriages: _____
Premature births (less than 37 weeks): _____ Live Births: _____ Living children: _____

FOR EACH PAST PREGNANCY PLEASE COMPLETE THE FOLLOWING INFORMATION:

	Birth date	Weeks Pregnant	Baby's Weight	Male or Female	Type of Delivery Vaginal or C-Section	Medications and/or Epidural	Preterm Labor Y/N	Complications such as diabetes, high blood pressure, preeclampsia etc
1								
2								
3								
4								
5								
6								
7								
8								

Dr's Comments:

Have you been immunized for Hepatitis B? (series of 3 injections) YES NO

Have you been exposed to someone with Tuberculosis? YES NO

Do you or your partner have a history of genital herpes? YES NO

Have you had a rash or viral illness during this pregnancy? YES NO

Have you ever had a Sexually Transmitted Disease? YES NO

If yes, please identify: Gonorrhea Syphilis HPV/Venereal Warts Chlamydia Herpes Other: _____

Patient's name: _____ Birth date: _____ Today's date: _____

Please circle if any of the following symptoms apply to you now or since adulthood:

1. Constitutional weight loss, weight gain, fatigue
2. Eyes double vision, spots before eyes, vision changes, glasses/contacts
3. Ear, Nose, Throat earaches, ringing in ears, hearing problems, sinus problems, sore throat, mouth sores, dental problems
4. Cardiovascular chest pain or pressure, difficulty breathing on exertion, swelling of legs, rapid or irregular heartbeat
5. Respiratory painful breathing, wheezing, spitting up blood, shortness of breath, chronic cough
6. Gastrointestinal frequent diarrhea, bloody stools, nausea/vomiting/indigestion, constipation, involuntary loss of gas or stool
7. Genitourinary involuntary/unintended urine loss, urine loss when coughing or lifting, abnormal bleeding, painful periods, PMS, painful intercourse, abnormal vaginal discharge
8. Musculoskeletal muscle weakness, muscle or joint pain
9. Skin rash, sores, dry skin, moles (growth or changes)
10. Breasts pain in breast, nipple discharge, lumps
11. Neurologic dizziness, seizures, numbness, trouble walking, memory problems, frequent headaches
12. Psychiatric depression or frequent crying, anxiety
13. Endocrine hair loss, heat/cold intolerance, abnormal thirst, hot flashes
14. Hematologic/lymphatic frequent bruises cuts that do not stop bleeding, enlarged lymph nodes (glands)

Dr's comments:

Patient's name: _____ Birth date: _____ Today's date: _____

Medical allergies? (please circle) NO YES if yes, please state name of medication and reaction:

Your blood type: _____ If negative, have you received Rhogam in this pregnancy? _____

Operations in lifetime (please list dates and procedures):

Problems with Anesthesia? NO YES (if yes, please explain):

YOUR MEDICAL HISTORY: (if nothing applies you may leave it blank)

Problem	YES	Date Diagnosed	Treatment including meds	Who in your family has this diagnosis?
Infertility				
Diabetes				
High blood pressure				
Heart disease				
Autoimmune disorder				
Kidney disease				
Urinary tract infections				
Neurologic/epilepsy				
Mental illness/depression				
Blood clots in lungs or legs				
Varicose Veins				
Thyroid dysfunction				
Trauma or domestic abuse				
Hepatitis/liver disease				
Breast surgeries/cancer				
Uterine surgeries				
History of abnormal pap smear				
Respiratory disease, asthma, TB				

Tobacco use: _____ How many cigarettes per day? _____ How many years? _____

Alcohol use: _____ How many drinks per day? _____ How many years? _____

Street drug use: _____ Name of drug(s): _____ How many years? _____

GENETIC SCREENING / COUNSELING

Patient's name: _____ Birth date: _____ Today's date: _____

Patient's AGE as of today: _____

HAS ANYONE IN EITHER FAMILY OF BABY'S MOTHER OR FATHER EVER BEEN BORN WITH ANY OF THE FOLLOWING CONDITIONS?

CONDITION	YES	SPECIFY AND STATE RELATIONSHIP
Neural Tube Defect such as anencephaly, meningomyelocele or Spina bifida		
Congenital HEART defect		
Any other birth defect		
Any other chromosomal birth defects		
Down's Syndrome		
Sickle Cell disease or trait		
Hemophilia / blood disorders		
Muscular Dystrophy		
Cystic Fibrosis		
Mental Retardation / Autism		
Are you of Jewish, French Canadian, Cajun or Mediterranean decent?		
Has the mother or father of this baby ever had a child with a birth defect not listed above?		

Acknowledgment Form

I understand that as part of my healthcare Center for Maternal-Fetal Care, P.A. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment understand that this information serves as:

- *A basis for planning my care and treatment*
- *A means of communication among the many health professionals who contribute to my care*
- *A source of information for applying my diagnosis and surgical information to my bill*
- *A means by which a third-party payer can verify that services billed were actually provided*
- *And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgement. I understand that Center for Maternal-Fetal Care, P.A. reserve the right to change its practices and to make the new provisions effective for all protected health information maintained by Center for Maternal-Fetal Care, P.A.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Center for Maternal-Fetal Care, P.A. is not required to agree to the restrictions requested. Center for Maternal-Fetal Care, P.A. will not use or disclose your health information without your authorization, except as described in the Notice of Privacy Practices.

Center for Maternal-Fetal Care, P.A. records may contain information created by an entity other than Center for Maternal-Fetal Care, P.A. Center for Maternal-Fetal Care, P.A. is not responsible for the information contained therein (including the accurate completeness, relevance, legibility or like thereof of such incorporated records). Patient expressly requests release of all records maintained by Center for Maternal-Fetal Care, P.A. concerning patient, including incorporated records. Patient acknowledges that Center for Maternal-Fetal Care, P.A. has no and assumes no duty to patient regarding the content of or omissions from such incorporated records.

Patient's Signature

Date

Center for Maternal-Fetal Care, P.A. Witness Signature

Date