



PATIENT INFORMATION SHEET

New Patient Update

Today's Date _____ Please fill out ALL sections completely and legibly.

Your Name _____ Your Age _____ Your Birth Date Month | Day | Year

Patient's Social Security Number _____ Referring Physician _____
 Mailing Address _____ City _____ State ____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 How long have you lived in the area? Years | Months Single Married Divorced Widowed Separated
 Employer _____ Occupation OR STUDENT How Long Employed Years | Months
 Employer's Address _____ City _____ State ____ Zip _____

Spouse/Parent's Name _____ Spouse/Parent's Birth Date Month | Day | Year
 Spouse/Parent's Social Security Number _____
 Mailing Address _____ City _____ State ____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Employer _____ Occupation OR STUDENT How Long Employed Years | Months
 Employer's Address _____ City _____ State ____ Zip _____

ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

THIS SECTION MUST BE FILLED OUT COMPLETELY OR INSURANCE CANNOT BE BILLED.

Primary Policy Holder's Name _____ Policy Holder's Birth Date Month | Day | Year
 Policy Holder's Social Security Number _____ Self Spouse Parent Other
 Mailing Address _____ City _____ State ____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Primary Insurance Company _____ ID No. _____
 Policy Holder's Employer _____ Group No. _____
 Claim's Address _____ City _____ State ____ Zip _____

Secondary Policy Holder's Name _____ Policy Holder's Birth Date Month | Day | Year
 Policy Holder's Social Security Number _____ Self Spouse Parent Other
 Mailing Address _____ City _____ State ____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Secondary Insurance Company _____ ID No. _____
 Policy Holder's Employer _____ Group No. _____
 Claim's Address _____ City _____ State ____ Zip _____

Name of Emergency Contact _____ Spouse Parent Other
 Address _____ City _____ State ____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize OB-GYN Associates to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature _____ Date _____ Email: _____



CONSENT TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

(In compliance with the federal HIPAA Guidelines)

Today's Date _____

Your Name _____ Your Age _____ Your Birth Date Month | Day | Year

How we may use and disclose your health information.

Your protected health information will be used by OB/GYN Associates or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

The notice of privacy practices.

OB/GYN Associates is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the **"Notice of Privacy Policies and Practices"** brochure provided to you. Please review it carefully.

You may place restrictions on the use or disclosure of your health information.

You may request a restriction on the use or disclosure of our protected information. However, OB/GYN Associates may or may not agree to your request to restrict the use or to activate this request. Please consult with a practice representative or the Privacy Official if you would like additional information or clarification.

It is a violation of the federal privacy standards if OB/GYN Associates **agrees** and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information prior to the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or the Privacy Official at the location and contact information listed on the back of the brochure.

You may revoke this consent at anytime.

You may revoke this consent at anytime; however, OB/GYN Associates requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect the use and disclosure prior to the date of your request.

Changes to privacy practices.

OB/GYN Associates reserves the right to change or modify the privacy practices outlined in the **Notice of Privacy** brochure. OB/GYN Associates will notify you of any changes of privacy practices either my mail, at your next appointment, or an other pre-approved method that you request.

Signature.

I have reviewed this consent form, received the brochure entitled **"Notice of Privacy Policies and Practices"** and give my permission to OB/GYN Associates to use and disclose my health information in accordance with this consent and the notice provided.

Patient's Name _____ Please Print

Signature _____ Date _____

Patient's Representative _____ Please Print

Relationship to Patient _____

Signature _____ Date _____



GENERAL INFORMATION

OFFICE VISITS:

First Visit: Your first visit is designed to let us get acquainted with you and your pregnancy. We will screen for risk factors pertinent to your health care. We will also perform a complete physical examination. With the information obtained from this interview and examination, we will be able to design an individual plan for your prenatal care.

Subsequent Visits: The frequency of your visits is quite individual. Usually, we like to see you about once every four weeks during the first thirty weeks. Then every two weeks until thirty-six weeks, and weekly thereafter until delivery. This, of course, is a general schedule and may vary according to the patient's specific needs.

CHILDBIRTH CLASSES:

We recommend that you consider taking a childbirth preparation class. Tari Justice R.N. APN offers an excellent class in our office. We have flyers available concerning this class. The receptionist can answer any questions that you may have. Tari's phone number is 972-3107.

HOSPITALS

We are on staff at both Renown Medical Center and Saint Mary's Regional Medical Center.

FEES AND INSURANCE

The business office is located in the lobby. They are available to answer all your questions regarding insurance, billing charges, and payment policies.

On your second visit we ask that you visit our Business Office to discuss your charges and insurance coverage with our OB Financial Coordinator.

Our office is more than happy to work with you and your insurance company to ensure that insurance billing is done in a timely and appropriate manner. It is the philosophy of OB/GYN Associates that the patient is ultimately responsible for all fees related the services received.

GENERAL INFORMATION (Page 2)

MEDICATIONS AND DRUGS

Everyone experiences at least a few of the classic discomforts of pregnancy during her nine months of pregnancy (I.E. morning sickness, back pain, constipation, and heartburn). For everyday ailments, some medications are considered safer than others. Whenever possible, it is best to try appropriate, non-medical remedies first, and avoid any medications during the first trimester. The following is a list of medications that are considered reasonably safe to take during pregnancy:

ANTACIDS

Maalox
Roloids
Tums
Riopan
Mylanta
Gelusil

COLDS

Actifed
Tylenol
Robitussin
Sudafed
Chlor-Trimeton
Sucrets Lozenges
Cepacil Lozenges

LAXATIVES

Doxidan
Metamucil
Milk of Magnesia
Senokot
Colace
Peri-Colace
Citucel

DIARRHEA

Immodium AD
Kaopectate

HEMORRHOIDS

Preparation H
Anusol

NAUSEA

Vitamin B-6 50mg twice daily



OB/GYN ASSOCIATES

INTRODUCES:

PREPARED CHILDBIRTH CLASSES

**INSTRUCTOR: TARI JUSTIS, R.N., APN
775-972-3107**

THIS CLASS COVERS: NUTRITION, EXERCISE, WARNING SIGNS, PREGNANCY DISCOMFORTS AND COMFORT MEASURES, WHAT TO EXPECT DURING LABOR, DELIVERY AND POSTPARTUM, BREATHING, RELAXATION AND PAIN RELIEF TECHNIQUES, AND MORE!!!

SIX WEEK PRENATAL SERIES - MORE THAN 20 WEEKS PREGNANT

EVERY WEDNESDAY NIGHT FOR SIX WEEKS

7:00 P.M. TO 9:00 P.M.

FEE: \$75.00 PER COUPLE - INCLUDES 6 WEEK SERIES

LOCATION: OB/GYN ASSOCIATES LOBBY



PATIENT HISTORY QUESTIONNAIRE

PATIENT'S NAME _____

DATE OF BIRTH ____/____/____

The PROGRAM Genetic History Questionnaire for Prenatal Patients

- The answers to these questions will help in the care of your pregnancy
- Please answer these questions to the best of your knowledge. All answers are confidential.
- If you need help answering the questions, please ask.

1. When your baby is born, will you be 35 years of age or older? No Yes Not sure

Where your ancestors came from may sometimes give us important information about the health of your baby.

2. Is your family or your baby's father's family from:
- Southeast Asia, Taiwan, China, or the Philippines? No Yes Not sure
- Italy, Greece, or the Middle East? No Yes Not sure
- African American/Black? No Yes Not sure
3. Is your family or your baby's father's family:
- Eastern European (Ashkenazi) Jewish? No Yes Not sure

The next ten questions will be about you, your baby's father, or both of your families. When we say "blood relative", we mean your child, (or unborn baby), mother, father, siblings, grandparents, aunts, uncles, niece, nephew, or cousin.

4. Were you or any of the baby's blood relatives born with an opening in the back or spine (also called Spina Bifida)? No Yes Not sure
5. Was there ever a baby (or unborn baby) in your family or the baby's father's family who had an opening in the head, (also called anencephaly)? No Yes Not sure
6. Is any blood relative in your family or baby's father's family mentally retarded? No Yes Not sure

PATIENT HISTORY QUESTIONNAIRE (page 2)

7. Have you or your baby's father, or any blood relative had an unborn baby or child who had Down Syndrome? No Yes Not sure
8. Do you or your baby's father, or any blood relative have any other chromosome problems? No Yes Not sure
9. Do you or your baby's father, or any blood relative have:
- a. Cystic Fibrosis (CF) No Yes Not sure
 - b. Fragile X Syndrome No Yes Not sure
 - c. Muscular Dystrophy No Yes Not sure
 - d. Hemophilia, Von Willebrand, or any other bleeding disorders No Yes Not sure
 - e. Huntington Disease No Yes Not sure
 - f. Neurofibromatosis No Yes Not sure
10. Were you or your baby's father or any blood relative born with:
- a. Heart Defects No Yes Not sure
 - b. Cleft Lip or Palate No Yes Not sure
 - c. Any other birth defects No Yes Not sure
11. Have you ever had:
- a. A miscarriage No Yes Not sure
 - b. Two or more miscarriages No Yes Not sure
 - c. Stillborn baby No Yes Not sure
12. Are you and the baby's father related by blood? No Yes Not sure
13. Do you have Diabetes? No Yes Not sure
14. Do you have, or have you ever had treatment for PKU (phenylketonuria) or Hyperphenylalaninemia (hyperphe)? No Yes Not sure
15. During this pregnancy, have you used or taken:
- a. Medication for seizures? No Yes
(EX. Dilantin, Valproic Acid, Depakene, Tegretol, Mysoline, Tridione)
 - b. Acne Medication? No Yes
(EX. Accutane, Isotretinoin)
 - c. Medication for depression? No Yes
(EX. Lithium, Eskalith, Lithobid, Lithonate)
 - d. Alcohol No Yes

Completed by _____

Date ____/____/____

Signature _____



INFORMED CONSENT FOR ULTRASONOGRAPHY

Your physician has requested that you have an ultrasound examination of your pregnancy. This information sheet will answer several important questions about this diagnostic procedure.

WHAT IS ULTRASOUND AND WHAT CAN IT SHOW ABOUT MY PREGNANCY?

Ultrasound uses the same principle as sonar. Sound waves (far beyond the range of hearing) from the ultrasound probe, bounce off your uterus and your developing baby producing echoes which a computer converts into detailed images.

IS ULTRASOUND SAFE?

There has been extensive evaluation of the safety of ultrasound over the course of 15 years. There is no evidence that diagnostic ultrasound causes harm to either the mother or the fetus.

TYPES OF EXAMS

A **basic or standard sonogram** provides information concerning placental location, fetal position, twin pregnancies, gestational age, and the possible presence of fetal malformation.

A **complete or extensive sonogram** is a more detailed exam providing not only the information of a basic scan, but in addition, a more specific evaluation for fetal growth and/or fetal abnormalities.

A **vaginal sonogram** is when a special ultrasound instrument, about the thickness of a tampon, is inserted into the vagina. It is occasionally used to provide extremely detailed views of the uterus, ovaries, or portions of the fetus that are low in the pelvis. This may also be used to see the heartbeat or the location of a very early pregnancy, or to evaluate the placenta or birth canal. As with other ultrasound exams, the procedure is safe. It is generally less uncomfortable than a Pap smear.

DOES A NORMAL ULTRASOUND PROVE THAT MY BABY WILL HAVE NO ABNORMALITIES?

While a basic sonogram will detect many abnormalities, it is not definitive for fetal malformations. Despite a normal interpretation of the test, some babies may be born with anomalies not identified by the examiner during the study. You should realize that even with a complete sonogram, the examiner may still be unable to find fetal abnormalities which are later discovered after birth. Thus, although ultrasonography is a very helpful diagnostic tool, it should not be considered an absolute proof of the absence of fetal defects.

Should you have any questions concerning ultrasonography, do not hesitate to discuss them with your doctor or ultrasound technologist before undergoing the procedure.

CONSENT

You are requested to sign this document prior to the performance of your ultrasound examination, and thereby acknowledge that you have read and understood the information contained herein and have given an informed consent to this procedure.

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE



TO OUR NEW OB PATIENTS

Once it has been determined you are pregnant, it is the policy of this office that you remain under the care of the physician that you are currently seeing to continue continuity of care. Depending who is on call, there is a chance that a different physician may deliver your child; However, we strongly discourage patients from switching physicians within this office.

If you have any questions regarding this policy, please discuss them with your physician.

I have read and understand this policy

Initials

At some point prior to the delivery of your child, the physician's nurse may give you copies of your own medical records to take to the hospital when you go into labor. This saves time and ensures that the records are available to the physician when you are ready to deliver. Your signature is required to provide you with a copy of these records.

Signature

Date

Please Print Name



HEALTH HISTORY UPDATE

Today's Date _____ Please fill out ALL sections completely and legibly.

Your Name _____ Your Age _____ Your Birth Date Month | Day | Year

Primary Care Physician Other than OB/GYN Preferred Lab Preferred Hospital

Total # Pregnancies Total # Births Last Period Mo. | Day | Yr. Hysterectomy Month | Year. Have you had any of the following Health Screening Tests? Mammogram, Colonoscopy, Bone Density, Lipid/Cholesterol.

Are you Allergic to any Medications? Are you Taking any Medications? ALL PRESCRIPTION AND NON-PRESCRIPTIONS DRUGS AND VITAMINS

What is the Reason for your Visit today? Annual Exam, Urinary Problems, Other, Vaginal Discharge or Infection, Possible Pregnancy, Abnormal Bleeding, Hormone Problems, Contraception, Infertility, Pelvic Pain, Consultation.

What is your Method of Contraception? Sterilization, Natural Family Planning, Birth Control Pills, Diaphragm, Condoms, Rhythm, IUD, Other, Depo Provera.

Since your last visit, have there been ANY CHANGES in your MEDICAL OR SURGICAL HISTORY? Cancer, Stroke, Heart Disease, Diabetes, Migraine, Hypertension, Asthma, Diabetes, Other.

Since your last visit, have there been ANY CHANGES in your FAMILY HISTORY? Cancer, Stroke, Heart Disease, Blood Clots, Asthma, Diabetes, Hypertension, Other.

Social History: Married, Single, Separated, Do you smoke tobacco?, Are You Sexually Active?, Do you drink alcohol?

Review of Systems: Constitutional, Breasts, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Integument, Neurologic, Psychiatric, Heme-Lymph, Other.



FINANCIAL POLICIES

- ✓ OB/GYN Associates strives to provide the very best level of care and service to our patients. This includes working with many insurance companies and plans. In order to facilitate insurance billing, we require the most up-to-date insurance information so that we may bill all services in a correct and efficient manner. We do bill the insurance for services; however the patient is responsible for knowing her coverage and benefits. OB-Gyn Associates has a foremost relationship with our patients, and the patient is ultimately responsible for payment of services. We will honor accurate contractual adjustments (discounts) from your health plan; however the patient may be billed up to the correct contractual allowance. The patient responsibility for payment supersedes any agreement OB-Gyn Associates may have with any insurance network, plan or carrier. Additionally, each plan has varying requirements for prior authorization for services that are subject to change. OB-Gyn Associates will help with medical information to obtain prior authorization, but it is the patient that is ultimately responsible for understanding the authorization requirements for her plan and obtaining the same. All copays/deductibles/co-insurance or other patient financial responsibilities are due at the time of the appointment.
- ✓ A current copy of the insurance card is required at every service, and is vital in ensuring that services are billed correctly. If a patient does not have a current copy of her insurance card, she has the option of paying in full for that day, and we will promptly refund the patient once the service has been paid by the insurance company.
- ✓ In order to ensure that all of our patients are seen in a timely manner, we ask that you please cancel or reschedule your appointments at least 24 hours prior to your appointment time. If an appointment is missed or cancelled without prior notification, the patient may incur a fee for the missed appointment.
- ✓ Part of our service to you is to complete FMLA/disability paperwork and we will have it returned to you within 3 business days. In order to maintain this level of service, we charge a fee of \$20, which is due upon our receipt of the paperwork.
- ✓ We accept personal checks; however should any checks come back to us as non-sufficient funds, we will charge a \$20 fee to cover the bank charges, and we will ask for all subsequent payments to be made by cash or credit card. We can not hold checks for a later deposit date, so please make sure there are sufficient funds in your account prior to writing us a check.

Authorization for Treatment & Financial Agreement

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct, unless notification is received in writing within 30 days of statement issue date. I agree to pay all charges within 15 days of statement issue date. I agree to assign my insurance benefits to OB/GYN Associates, if applicable, for today's service, and any subsequent services with OB/GYN Associates. I am aware that if I fail to pay any overdue balances and/or fail to commit to a pre-arranged payment plan, my account may be forwarded for further collection action, which may include, but is not limited to, late fees, attorney fees, and possibly third party collection agencies. In the event amounts become overdue, I agree and understand that credit reports and/or credit history may be obtained from credit reporting agencies. All costs associated to this action will be the responsibility of the patient or financially responsible guardian.

Authorization for Release of Medical Information

I authorize any holder of medical information about me to release said information requested by insurance companies with whom I have coverage or any public agents for the purpose of payment, treatment, or operations for services provided. Release of information for any other purposes will require written consent from the patient/guardian/parent.

I have read and understand these policies and hereby acknowledge receipt of a copy of this form, and agree to it's terms

Please Print Name

Signature

Date

Patient Name (if different)

RNOB-012 (12/08)