Valley Perinatal™

PATIENT INFORMATION

Name ______________________ Date ______________________

Address ______________________ Phone ______________________

City ______________________ State __________ Zip Code ______________

Occupation ______________________ Work Phone ______________________

Date of Birth ______________________ Soc. Sec. Num. ______________________

Cell Phone ______________________ Email ______________________

☐ Married ☐ Single ☐ Domestic Partner ☐ Other:______________________

Spouse/Partner ______________________ Phone ______________________

Occupation ______________________ Work Phone ______________________

Emergency Contact ______________________ Relation ______________________

Phone ______________________

Doctor ______________________ Phone ______________________

Type of Doctor: ☐ ObGyn ☐ Family Physician ☐ Other (specify) ______________________

Insurance Information

Subscriber Name ______________________ Relationship To Patient ______________________

Subscriber SSN ______________________ Subscriber Date of Birth______________________

Subscriber Employer ______________________ Employer Phone Number______________________

Name of Insurance Company ______________________ Phone ______________________

Insurance Billing Address ____

ID/Subscriber Number ______________________ Group Or Plan # ______________________

Additional Insurance Information (if applicable)

Subscriber Name ______________________ Relationship To Patient ______________________

Subscriber Soc. Sec. Num. ______________________ Subscriber Date of Birth______________________

Employer ______________________ Employer Phone Number______________________

Name of Insurance Company ______________________ Phone ______________________

Insurance Billing Address ____

ID/Subscriber Number ______________________ Group Or Plan # ______________________

I hereby authorize the release of necessary information to my attending physician. I hereby authorize the release of information necessary to secure the payment of benefits by my insurance company. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

Patient Signature: ______________________

Date: ______________________

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PREGNANCY AND FAMILY HISTORY QUESTIONNAIRE

Although most babies are born healthy, there is a baseline risk for birth defects in every pregnancy. A personal medical and family history is taken to determine if there are any additional risk factors in the pregnancy. Your answers will be reviewed by the genetic counselor/physician and discussed with you during your appointment.

Patient Information

Name: ___________________________________

Birth date: ________________________________

Father of the Baby's Information

Name: ___________________________________

Birth date: ________________________________

CURRENT PREGNANCY HISTORY

Date of last menstrual period: _________________Current maternal weight (if known):______________________
The expected date of delivery is _______________ and is based on (circle one): last menstrual period, date of conception, fertility treatment, early ultrasound.

Did you have fertility treatment? Y N If yes, what type? _______
Did you use donor eggs? Y N If yes, age of donor? _______

During this Pregnancy, have you had or used any of the following?

Alcohol	Y	N	Bleeding or spotting	Y	N
Cigarettes	Y	N	High Fever (more than 101)	Y	N
Recreational Drugs	Y	N	Infections/Rashes	Y	N
X-rays	Y	N	Other concerns?	Y	N
Seizures	Y	N			

If yes, please explain: ____

Please list all medications you have taken since becoming pregnant: __________________________________

Are you currently experiencing any complications? ____

Have you had any pregnancy screening completed in this pregnancy: First trimester or second trimester (AFP, triple, or quad) screen? If so, when was testing performed? ___________________________________

During this pregnancy, have you had any additional ultrasounds done?

____

What is your understanding of the purpose of today's appointment? ________________________________

PREVIOUS PREGNANCY HISTORY

Total number of pregnancies (including this one)	_______	Number of stillbirths	_______
Total number of deliveries	_______	Number of abortions	_______
Number of premature deliveries (< 36 weeks gestation)	_______	Number of ectopic pregnancies	_______
Number of cesarean deliveries	_______	Number of miscarriages	_______

Did you experience any complications in any of your previous pregnancies such as gestational diabetes, high blood pressure, premature labor, incompetent cervix, or birth defects? If yes, please explain: ________________

____

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Family History Questionnaire page 2. Patient's name: ______________________________

MEDICAL HISTORY

Do you have diabetes?	Y	N
Are you treated for epilepsy (seizures)?	Y	N
Do you have high blood pressure or heart problems?	Y	N
Do you have thyroid disease?	Y	N
Does the father of the baby have any health concerns?	Y	N

If yes, please explain: ______________________________

FAMILY HISTORY

Are you adopted?	Y	N
Is the father of the baby adopted?	Y	N
Are you and the father of the baby related by blood to each other (ie: first cousins)?	Y	N

Does the father of the baby have any additional children from a previous relationship? If yes, please list their ages and any health concerns: ______________________________

Is there any personal or family history of the following conditions in your family or the father of the baby's family? (Please consider siblings, nieces, nephews, parents, aunts, uncles, first cousins and grandparents)

Autism	Y	N	Seizures or epilepsy	Y	N
Mental retardation	Y	N	Blindness at a young age	Y	N
Fragile X syndrome	Y	N	Hearing loss at a young age	Y	N
Down syndrome (Trisomy 21)	Y	N	Bleeding/clotting disorders	Y	N
Other chromosome abnormalities	Y	N	Cystic fibrosis	Y	N
Spina bifida/anencephaly	Y	N	Sickle cell disease	Y	N
Heart defect at birth	Y	N	Thalassemia	Y	N
Cleft lip or palate	Y	N	Tay-Sachs disease	Y	N
Hydrocephalus	Y	N	Kidney disease	Y	N
Other birth defects	Y	N	Dwarfism	Y	N
Three or more miscarriages	Y	N	Muscular dystrophy	Y	N
Stillbirth	Y	N	Cancer diagnosis < 50 years	Y	N
Infant/childhood death	Y	N			

If yes, please explain: ______________________________

Do you have any family history of hereditary diseases or genetic conditions? ______________________________

Other concerns? ______________________________

ANCESTRY

In every population, certain hereditary conditions occur more frequently than in others. In some cases, testing is available to determine if a couple is at an increased risk to have a child with certain conditions. Please indicate your ethnic background below.

Patient Ancestry:

European American (Caucasian)	Y	N
African American/ Black	Y	N
Hispanic	Y	N
French Canadian, Cajun	Y	N
Jewish	Y	N
Italian, Greek, Middle Eastern	Y	N
Asian, Indian, Central Asian	Y	N
Native American	Y	N

Other ______________________________

Father of the Baby's Ancestry:

European American (Caucasian)	Y	N
African American/ Black	Y	N
Hispanic	Y	N
French Canadian, Cajun	Y	N
Jewish	Y	N
Italian, Greek, Middle Eastern	Y	N
Asian, Indian, Central Asian	Y	N
Native American	Y	N

Other ______________________________

Patient signature:______________________

Date: ______________________________

Reviewed By: ______________________________

Date: ______________________________

Valley Perinatal™

TO OUR PATIENTS:

The following is an explanation of our policies regarding patient accounts. Please take the time to read these policies, as they will describe your responsibilities for the handling of your account. If you feel that you need additional information or explanation regarding these policies, our manager will be glad to answer any questions.

Valley Perinatal Services charges on a fee-for-service basis. We submit our services to your insurance company as a courtesy to you. However, you are responsible for the balance of the account and any portion not paid by your insurance. Please notify us of any changes in your insurance plan or coverage as soon as possible to help you in receiving benefits from your insurance.
If you are a self-paying patient, you will be required to pay for your office visits and procedures at the time of service. The front desk will be happy to provide you with an estimate of the charges.

You will receive a statement each month letting you know the activity and balance on your account. When your account becomes 60 days past due, you are responsible for the charges. At this time, we ask that you make payment in full. You will need to contact your insurance carrier to find out why they have not made payment.

A monthly billing charge of $10.00 will be applied to your account after 60 days for each outstanding date of service. A service charge of $25.00 will be added on all returned checks.

ACCEPTANCE OF TERMS

I certify that I have read and fully understand the policies of Valley Perinatal Services. I realize that I am responsible for my charges and that any collection of attorney's fees will be charged to me in the event that my account is not paid in full as described in the terms and conditions above.

____ _________________________
Signature (patient or legally responsible party) Date

ASSIGNMENT OF BENEFITS

I authorize Valley Perinatal Services to bill my insurance company and to receive payments on my behalf from them. I authorize the physician to release information required for filing the necessary insurance claim forms.

____ _________________________
Signature of legally responsible party Date

WAIVER OF ASSIGNMENT OF BENEFITS

I understand by not signing the above assignment of benefits, I will be responsible for 100% of all charges incurred at the time of service.

____ _________________________
Signature of legally responsible party Date

Patient Consent— OB

- [ ] Prenatal ultrasound is a powerful method of evaluating the unborn fetus. The vast majority of birth defects occur in patients without a family history or other known risk factors. By undergoing this ultrasound, I understand that it is likely to be reassuring and confirm normal development, but also understand that birth defects may occasionally be detected.

- [ ] Certain "marker" ultrasound findings may also be seen in the minority of normal fetuses. While some of these findings may slightly increase the risk of Down syndrome or other birth defects, they are usually not important in which case they may cause needless anxiety.

- [ ] Dr. Nyberg is an international expert in obstetric ultrasound and fetal birth defects. He continues to conduct clinical research to further improve the accuracy of diagnostic methods. I acknowledge my willingness to participate in clinical research as long as all patient information is anonymous (my name will not be given to others).

- [ ] For quality control and ongoing clinical research, I agree that I or my physician's office can be contacted at a later date to determine the outcome of this pregnancy.

- [ ] Correlation with blood tests or other information may be helpful in interpreting the ultrasound. I give consent to my physician or laboratories to release all information that may assist in interpretation of my ultrasound.

- [ ] An obstetric ultrasound often requires ancillary ultrasound methods including, but not limited to, 3D ultrasound, transvaginal scans, and Doppler studies. I understand these ancillary exams will result in additional charges to the insurance company. Blood tests and consulting fees may also apply when indicated.

SIGNATURE ______________________________ DATE ________________

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Insurance Verification
Patient Information

Patient Name _________________________
Patient DOB: _________________________

Insurance Information
Insurance Company ____________________
Member ID # ____________________ Group # ______________
Customer Svc/Provider Phone # _______________________________

When we bill your insurance company, any deductible and co-insurance charges will apply. Any payment that you make on your visit will be credited to your account. Once the insurance company makes payment, you will be responsible for any and all remaining balances.

*A healthcare deductible is the amount that you must first pay before your insurance will make any payment. For example, if you have a deductible of $1500, and the cost of the medical services is $800, you (**not your insurance company**) will be responsible for $800. Your insurance company deducts this amount from your deductible, and you would have a balance of $700 remaining. Once you have met the full amount of your $1500 deductible, your insurance company will then make payment on future visits to any healthcare provider. The deductible must be paid every year, usually beginning Jan.1st.

**Once your deductible is met, many insurance companies still do not pay 100% of the healthcare cost. If that is the case you would have a co-insurance, which is a partial payment required by you in addition to what the insurance company will pay. It can be from 10-50% of the allowed amount until you have accumulated enough medical bills to meet your yearly out of pocket maximum.

***This is an **estimated** portion that is due. We contacted your insurance company and unfortunately we don't exactly know what your insurance will cover or what you will be billed until your claim is processed.

If you have any questions regarding your financial responsibilities please ask or call our billing department at (888) 279-8040.

Patient Signature ____________________________ Date ____________

NOTICE OF PRIVACY PRACTICES (NPP)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Valley Perinatal Services respects your privacy. We understand that you personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations:

For treatment:

- Information obtained by a technologist, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan;
  - accounting, legal, risk management, and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not requires to grant the request, but we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”).
- Request that you be allowed to see and get a copy of your protected health information
- You may make this request in writing.
- Have us review a denial of access to your health information-except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released.
- It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- For help with these rights during normal business hours, please contact: Valley Perinatal Services, Privacy Officer, 480-756-6000.

Continued ….

Valley Perinatal™

Our Responsibilities
We are required to:
- Keep your protected health information private
- Give you this notice
- Follow the terms of this notice

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Officer at 480-756-6000.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Privacy Officer at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.
We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Notification of Family and Others
- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to assist in disaster relief efforts.
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:
- **With Medical Researchers**. If the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA**) relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law**:
  - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public
  - to public health or legal authorities
  - to protect public health and safety
  - to prevent or control disease, injury, or disability
  - to report vital statistics such as births or deaths
- **To Report Suspected Abuse or Neglect** to public authorities
- **To Correctional Institutions** if you are in jail or prison, as necessary to your health and the health and safety of others.
- **For Law Enforcement** Purposes such as when we receive a subpoena, court order, or other legal process, or you are a victim of a crime
- **For Health and Safety Oversight Activities**. For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks on a job site.
- **To The Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may chare information for national security purposes.

Other Uses and Disclosures of Protected Health Information
- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

We have a website that provides information about us at: www.valleyperinatal.com.
By signing, you acknowledge that we have provided you with this form of our privacy practices.

______________________________ ____________________
Patient's Name Date

Valley Perinatal™

By signing below, I acknowledge that I have been provided with a copy of the Valley Perinatal Services Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Valley Perinatal Services and how I my obtain access and control this information.

- ____
(Signature of Patient or Guardian)

- ____
(Print Patient name or Guardian)

- ____
(Date)

- ____
(Description of Guardian)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1.____

2.____

3.____

Preferred method of contact for test results:

Home#______________________________May we leave a message? YES NO

Cell#_______________________________May we leave a message? YES NO

Work#______________________________May we leave a message? YES NO

Email#______________________________May we leave a message? YES NO