FLORIDA PERINATAL CENTER

CHRISTINE EDWARDS, MD FACOG
LAURA WALSH LAFFINEUSE MD FACOG

WELCOME TO FLORIDA PERINATAL CENTER, LLC.

We welcome you to our practice and look forward to providing you with the best possible care. Your physician has referred you for either routine obstetrical screening/consultation or for high risk perinatal services. We work in conjunction with your obstetrician who remains your primary medical provider. We provide ultrasound and consultation services, we do not offer delivery services. Florida Perinatal Center (FPC) is a separate entity from your physician's practice.

The information below will help to make the process smoother. If you are a new patient, please arrive 20 mins before your appointment to complete the paperwork if not previously completed (forms can be downloaded from our website www.myfpcbaby.com)

If you are more than 15 mins late for your appointment, you may be asked to reschedule, in order to prevent long waits for our other patients.

We offer many different services, patients may be called out of order, depending on the type of the service they are scheduled for.

Please bring the following items for your visit:

- **Completed new patient forms**
- **Current insurance card**
- **Photo ID**

Please ensure we have your referral/authorization if your insurance requires one. Insurance- copay, coinsurance and/or other payment responsibilities are expected at the time of service.

1. If you have insurance and you have a copay, payment is expected at the time of your visit (this is a contractual agreement with your insurance company and can only be modified by them).

2. Please make cancellations at least 24 hours before your scheduled appointment-this ensures that other patients who may need an appointment can get access.

3. Please advise the office BEFORE your next appointment if you change insurance companies, or we may have to reschedule you (some insurance companies require preauthorization prior to your visit).

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4. If your insurance requires an authorization, it is your responsibility to ensure it is in our office before your appointment.

5. Advise the office immediately of any change in address, or telephone number.

6. Should you change your obstetrician, please advise the front desk and sign the "Notice of Change of OB" form provided.

7. This office does work by appointments, however, due to the nature of our practice, we sometimes experience delays. Please be patient as we give every patient the same careful attention.

8. Prescription refills and insurance questions may only be addressed during regular office hours.

9. The doctors do not discuss financial matters. If you need special arrangements to be made, please speak with our Billing Coordinator or Office Manager.

10. Children under 6 years old are not allowed without an accompanying adult (in addition to the patient).

We look forward to making your experience with us a pleasant one!

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NEW PATIENT'S INFORMATION SHEET

Please print clearly. Please complete ALL information so that your claim can be processed quickly and efficiently. Thank you!

Patient information:

Full Name: _____ Referring Doctor:_____
Last First

Date of Birth:___/___/___ Age:_____ Marital Status (circle): S M W D

Address:_____ Apt#:_____ City:_____

State:_____ Zip:_____ Phone # H:_____ Cell #:_____

Email address:_____ Social Security#:_____

Driver's License #:_____ State:____ Employer:_____

Work #:_____ Ext:_____ Work Address:_____

City, State, Zip: _____ Job Title:_____

Student (circle): Full time/Part time School Name:_____

Responsible Party/Spouse Information:

Name:_____ Relationship to Patient:_____

Address:_____ Apt #:_____ City:_____ State:____

Zip:_____ Phone #:_____ Date of Birth:___/___/___

Driver's License#:_____ State:_____

Employer:_____ Work #:_____ Ext: _____

Work Address:_____ City, State, Zip:_____

Emergency contact:_____ Phone #:_____

Relationship:_____

Primary Insurance Information:

Do you have Medicare Insurance?: Y N

Insurance Company:_____ Phone #:_____

Insurance Address:_____

City, State, Zip:_____ Certificate, Policy or ID#:_____

Group #:_____ Insured's Name:_____

Relationship to Patient: Self Spouse Child / Other:_____

Insured's Employer:_____ Phone:_____

Employer's Address:_____ City, State, Zip:_____

Insured's Social Security#:_____ Date of Birth:___/___/___ Sex: M F

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NEW PATIENT'S INFORMATION SHEET

Please note Medicaid will not cover your claims if you have another active insurance. Patients are expected to pay their Specialist Office Copay at each visit. If your yearly deductible has not been met, you are expected to pay the fees that are due at each visit. If applicable, you will also receive a statement for co-insurances, balance on deductible and any unpaid procedures performed in the office, which amount will be due on receipt of statement.

If you need special arrangements to be made or have any questions regarding this, please speak to the Office Manager or Billing Co-ordinator.

We are Maternal Fetal Medicine Specialists and are not part of the Global Package. We bill and are reimbursed separately from your OB/GYN office.

Patient balances which exceed 60 days, are sent to our Collections Agency.

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO FLORIDA PERINATAL CENTER, LLC. ALL OF MY RIGHTS, TITLE, AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS. UNDER MY INSURANCE POLICY. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO DETERMINE THESE BENEFITS. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL WRITTEN NOTICE IS GIVEN BY ME REVOKING SAID AUTHORIZATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE.

Patient's Signature:_____

Date:___/___/___

MYFPCBABY.COM
INFO@MYFPCBABY.COM

9750 NW 33RD STREET | SUITE 120 | CORAL SPRINGS, FL 33065 | TELEPHONE: 954 255 5799 | FAX: 954-255-1989
9325 W GLADES ROAD | SUITE 206 | BOCA RATON, FLORIDA 33434 | TELEPHONE: 561.488.5015 | FAX: 954-255-1989

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ULTRASOUND CONSENT

Your physician has requested an ultrasound (sonogram), to evaluate your baby. There are presently no known risks to the fetus from ultrasound. However, we cannot predict any future developments in this area, thus we will only perform medically indicated studies.

LIMITATIONS

Ultrasound technology has advanced significantly, and we are able to see more detailed structure. However, it is very important to understand that a fetus that appears to be "normal" on an ultrasound, may in fact have birth defects. These may include, but is not limited to mental retardation, or other abnormalities that cannot be detected by current technology.

The ability to diagnose many birth defects, particularly those involving the brain, spine, face, heart and extremities, is also limited by the gestational age at examination, the fetal position, the amount of amniotic fluid present, and the mother's body type and composition. Additionally, some birth defects may not be apparent at early gestational ages, and may only become sonographically identifiable as the pregnancy progresses. This is especially true for brain, heart and gastrointestinal defects. Chromosomal abnormalities such as Down syndrome cannot be diagnosed or ruled out usingultrasound alone. Procedures such as CVS (chorionic villus sampling), done in the first trimesteror amniocentesis (performed in the 2nd trimester), will more reliably make this diagnosis.

Ultrasound also does not guarantee the gender of your baby. The sex of your baby can only be confirmed after birth. A normal ultrasound does not guarantee a healthy baby and does not rule out some birth defects.

The ability to complete the ultrasound and see the anatomy that is necessary to complete the scan can also be limited by the fetal position, gestational age and maternal body habitus. It may become important to return to complete the rest of the anatomy scan.

This information is not meant to cause concern, it simply makes you aware of the limitations of ultrasound. If the sonogram appears to be normal, the baby will most likely not have a significant birth defect.

If you have any questions about the performance of the sonogram, please ask. We will be happy answer your questions. Please be advised that the sonographers are not able to discuss medical to issues or concerns.

We will be happy to provide ultrasound pictures of your baby. Per our practice policy, NO taking pictures or videotaping is allowed.

PELVIC EXAMINATION CONSENT

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include thehealth careprovider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I authorize the employed and/or contracted medical personnel of Florida Perinatal Center as deemed necessary by my treating physician to perform a pelvic examination, including vaginal sonography, as described above.

ACKNOWLEDGEMENT

I have read the above information and I understand the limitations of ultrasound to diagnose birth defects and other abnormalities of my baby. I have had all my questions answered and agree to have the ultrasound and accept its limitations.

Patient Signature:_____

Date:_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFO

With my consent, Florida Perinatal Center, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Florida Perinatal Center LLC, for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Florida Perinatal Center, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Florida Perinatal Center.

With my consent, Florida Perinatal Center, LLC may call my home or other designated location and leave a message on voice mail/answering machine or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Florida Perinatal Center, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential.

With my consent Florida Perinatal Center, LLC may email me (there is some risk that any protected health information contained in such email may be disclosed to, or intercepted by, unauthorized third parties), any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items and any item pertaining to my clinical care, including laboratory results among others.

With my consent Florida Perinatal Center, LLC may text me in reference to any items that assist the practice in carrying out TPO, such as appointment reminders.

I have the right to request that Florida Perinatal Center, LLC restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Florida Perinatal Center, LLC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent Florida Perinatal Center, LLC may decline to provide treatment to me.

_____ _____

Signature of Patient/Legal Guardian Print Name of Patient/Legal Guardian

Patient's Name:_____ Date:_____

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CO-INSURANCE AND DEDUCTIBLE RESPONSIBILITY

Date of Service: _____ Account # _____

Regarding: Co-Insurance, CoPay and Deductible Responsibility

I _____ am aware that I am responsible for any CoPay, Co-Insurance and Deductible due as determined by my insurance policy. (This information is obtained from my insurance company _____ when our office calls to verify eligibility and benefits). Payments are expected at the time of service.

Florida Perinatal Center does not accept secondary insurance.

Deductible $ _____Co-Insurance $ _____, CoPay $ _____

Patient's Signature: _____

Witness Signature: _____

Deductible: ***the amount you are contracted to pay for your healthcare before your insurance company will cover any cost. (eg: a $1000 deductible means you must pay $1000 to your provider before your insurance carrier will pay any charges).***

Co-Insurance: ***the percent of the charges you are expected to pay (eg: 20% coinsurance means that your insurance will pay 80% of your bill and you are responsible for the remaining 20%).***

CoPay: ***an amount determined by your insurance to be paid to the provider, often this varies depending on whether or not it is your primary care provider, a subspecialist, if you have an office visit, or for certain procedures.***

Deductibles, Co-Insurance and CoPays apply to telemedicine visits.

Prior to your office visit we contact your insurance company to determine if any of the above applies.

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MEDICAL INFORMATION RELEASE

I,_____ agree to the doctors discussing my information/giving results of tests to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature:_____ Date:_____

CONSENT FOR EMAIL COMMUNICATION

Email messaging allows Florida Perinatal Center's health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email messaging is not a completely secure means of communication because these messages can be addressed to the wrong person o accessed improperly while in storage during transmission.

If you would like to exchange email messages that contain your health information, please complete and sign this Consent below. You are not required to authorize the use of email messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of your email, we will continue to use telephone, fax or US mail to communicate with you.

Name: _____ DOB: _____

Patient Signature:_____ Date:_____

Email: _____

Florida Perinatal Center LLC

Dr. Christine Edwards · Dr. Laura Laffineuse

Transvaginal Ultrasound Informed Consent/Decline Form

Name: _____Date: _____ DOB: _____

What is a transvaginal ultrasound? An ultrasound test uses high-frequency sound waves to create images of your internal organs. Imaging tests can identify abnormalities and help doctors diagnose conditions. A transvaginal ultrasound, also called an endovaginal ultrasound, is a type of pelvic ultrasound used by doctors to examine female reproductive organs. This includes the uterus, fallopian tubes, ovaries, cervix, and vagina.

"Transvaginal" means "through the vagina." This is an internal examination. Unlike a regular abdominal or pelvic ultrasound, where the ultrasound wand (transducer) rests on the outside of the pelvis, this procedure involves your doctor or a technician inserting an ultrasound probe about 2 or 3 inches into your vaginal canal.

What happens during a transvaginal ultrasound? When it's time to begin the procedure, you lie down on your back on the examination table and bend your knees. There may or may not be stirrups. Your doctor covers the ultrasound wand with a condom and lubricating gel, and then inserts it into your vagina. Make sure your provider is aware of any latex allergies you have so that a latex-free probe cover is used if necessary. You might feel some pressure as your doctor inserts the transducer. This feeling is similar to the pressure felt during a Pap smear when your doctor inserts a speculum into your vagina. Once the transducer is inside of you, sound waves bounce off your internal organs and transmit pictures of the inside of your pelvis onto a monitor. The technician or doctor then slowly turns the transducer while it's still inside of your body. This provides a comprehensive picture of your organs. If there is any pain or discomfort please let us know immediate and we will stop the exam.

When is a transvaginal ultrasound performed?

Common reasons to recommend a transvaginal ultrasound during pregnancy are to:

- monitor the heartbeat of the fetus/diagnose a possible miscarriage
- look at the cervix for any changes that could lead to complications such as miscarriage or premature delivery
- examine the placenta for abnormalities and location
- identify the source of any abnormal bleeding
- confirm an early pregnancy
- to evaluate a structure in the fetus that cannot be obtained abdominally

I understand that a transvaginal ultrasound could result in an additional cost according to my current insurance policy and that I will be responsible for that cost.

I, _____, have read the information above and have been given the opportunity to have any and all of my questions answered. Should a Transvaginal Ultrasound be recommended for my visit today, I:

____ CONSENT to having a Transvaginal Ultrasound performed.

____ DECLINE having a Transvaginal Ultrasound performed. I understand the risk if I decline and accept the consequences of my decision.

Signature: _____ Date: _____

Florida Perinatal Center LLC
Dr. Christine Edwards · Dr. Laura Laffineuse

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Coral Springs, FL 33065
Tel: (954) 255-5799

9325 W. Glades Rd. Suite 206
Boca Raton, FL 33434
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Consent for Telemedicine Services

Patient Name: _____ Date of Birth: _____

Date: _____

Introduction

Telemedicine is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. Providers may include primary care practitioners, specialists, and/or subspecialists. Electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records
- Medical images
- Interactive audio, video, and/or data communications
- Output data from medical devices and sound and video files

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Potential Benefits:

1. Improved access to medical care by enabling a patient to remain in his/her local healthcare site (i.e. home) while the physician consults and obtains test results at distant/other sites.

2. More efficient medical evaluation and management.

3. Obtaining expertise of a specialist.

Potential Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

1. In rare cases, the provider may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult.

2. The consulting provider is not able to provide medical treatment to the patient through the use of telemedicine equipment nor provide for or arrange for any emergency care that I may require.

3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of equipment.

4. Security protocols could fail, causing a breach of privacy of personal medical information.

5. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I understand and agree to the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting healthcare provider.

4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of telemedicine in my medical care.

Signature of Patient: _____ Date: _____

(or person authorized to sign for Patient):

If authorized signer, relationship to Patient: _____

Witness: _____ Date: _____