FLORIDA PERINATAL CENTER

Christine Edwards, MD FACOG

2023-2026 AIUM Accredited Practice
DETAILED SECOND TRIMESTER OB ULTRASOUND

NEW PATIENT'S INFORMATION SHEET

Patient information: **Referring Doctor:** _____

Full Name: _____ Date of Birth: _____ Age: _____
Last First

Address: _____ Apt#: _____

City/State/Zip: _____

Cell Phone #: _____ Home Phonel#: _____ Marital Status (circle): S M W D

Email address: _____

Driver's License#: _____ State: _____

Employer: _____ Work#: _____ Ext: _____

Work Address: _____ City, State, Zip: _____

Job Title: _____ or Student (circle): Full time/Part time, School Name: _____

***Emergency contact:**

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

Primary Insurance Information:

Insurance Company: _____ Policy ID: _____

Insurance Address: _____ Phone#: _____

City/State/Zip: _____ Group#: _____

Insured's Name: _____ Date of Birth: _____

Sex: M F Relationship to Patient: Self Spouse Child Other

Insured's Employer: _____ Phone: _____

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

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NEW PATIENT'S INSURANCE INFORMATION SHEET

Please note Medicaid will not cover your claim if you have another active insurance. Patients are expected to pay their Specialist Office Visit 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-insurance, balance on deductibles and any unpaid procedures performed in the office, which amount will be due upon 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 Coordinator.
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.
Patients balance 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 REIMBURSMENT 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 AUTHOORIZATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE.

Patient's Signature: _____ Date: _____

CO-INSURANCE AND DEDUCTIBLE RESPONSIBILITY

Date of Service: _____ Account #: _____

Regarding: Co-Insurance, Co-Pay 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: _____ Date: _____

Witness Signature: _____ Date: _____

DEDUCTIBLE: the amount you are contracted to pay for your healthcare before your insurance company will cover any costs.
CO-INSURANCE: the percent of the charges you are expected to pay
COPAY: an amount determined by your insurance to be paid to the provider.
***Deductibles, co-insurance & copays apply to telemedicine visits.**

Prior to your appointment we will contact your insurance company to determine if any of the above applies.

PATIENT REFUND POLICY

In the event you are due a refund from Florida Perinatal Center, LLC after your claim has processed, we will contact you by phone. If we cannot reach you, please indicate below how you would like to receive the refund:

_____ Credit my account at Florida Perinatal Center to be used towards future appointments scheduled

_____ Credited back onto the debit/credit card used at time of the appointment

_____ Returned by Check, mailed to my address on file

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Initial _____**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 detail 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 the brain, heart and gastrointestinal defects. Chromosomal abnormalities such as Down Syndrome cannot be diagnosed or ruled out using ultrasound alone. Procedures such as CVS (Chorionic Villus Sampling), done in the first trimester or 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 to answer your questions. Please be advised that the sonographers are not able to discuss medical 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.

Initial _____**PELVIC EXAMINATION CONSENT**

A pelvic examination is an exam 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 the healthcare providers gloved hand or instrumentation. For purposes of this consent, vaginal sonography 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.

ACKNOWLEDMENT

I have read the above information and 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: _____

Print Patient Name: _____ DOB: _____

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Initial _____**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 more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Florisa 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 locations 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, 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 TOP, 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 use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent 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.

Initial _____**MEDICAL INFORMATION RELEASE**

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Initial _____**CONSENT FOR EMAIL COMMUNICATION**

Email messaging allows Florida Perinatal Center, LLC healthcare 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 or accessed improperly while in storage 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 healthcare 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.

EMAIL: _____

Patient Signature: _____ Date: _____

Print Patient Name: _____ DOB: _____

Florida Perinatal Center LLC
Dr. Christine Edwards

9750 NW 33rd St., Suite 120, Coral Springs, FL 33065 Tel: (954) 255-5799 9325 W. Glades Rd, Suite 206, Boca Raton, FL 33434 Tel : (561) 488-5015

Transvaginal Ultrasound Informed Consent or Decline Form

Patient Name: _____ Date of Birth: _____

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 included 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 or technician 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 or technician 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 doctor or technician then slowly turns the transducer while it is inside of your body. This provides a comprehensive picture of your organs. If there is any pain or discomfort please let us know immediately 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 the 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 risks if I decline and accept the consequences of my decision.

Signature of Patient: _____ Date: _____

(or person authorized to sign for Patient): If authorized signer, relationship to Patient: _____

Witness: _____ Date: _____

Florida Perinatal Center LLC
Dr. Christine Edwards

9750 NW 33rd St., Suite 120, Coral Springs, FL 33065 Tel: (954) 255-5799 9325 W. Glades Rd, Suite 206, Boca Raton, FL 33434 Tel : (561) 488-5015

CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ Date of Birth: _____

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: _____