Office use only:
Edd_____

Thank you for the confidence you have placed in the OB/GYN Health Center for your Obstetrical care.

Dr. John Meyers, Dr. Christine DaSilva and Dr. Cynthia Baldwin are the delivering physicians in the Practice.

They deliver at the following hospital:

Halifax Health Medical Center
303 N Clyde Morris Blvd.
Daytona Beach, FL 32114

The Doctors rotate On-Call status throughout the week and weekend. If you deliver after hours, and your Doctor is NOT on-call, you will be delivered by one of the other Doctors in our Practice.

The physicians request that if you are in labor, please notify the office *before* you go to the hospital.

If this is not a satisfactory arrangement, please let us know so we can discuss this matter.

Sincerely,

The OB/GYN Health Center

I have read the above and agree to the arrangement of the practice.

_____ _____
Patient Signature **Date**

Important Insurance Information

Please notify our billing department **immediately** if you will have any changes to your insurance plan or insurance company during your pregnancy. Be sure to bring your new insurance card to your appointment.

Insurances we do not accept for obstetrical care:

- Medicaid
- Cigna
- Advent through employer (Aetna)
- Health First Health Plans
- My Blue
- Blue Select
- Blue Edge (HMO & EPO)
- United Healthcare Oxford

There may be other plans we do not accept. If you wish to continue your obstetrical care with our practice, it is recommended to check with our billing department before changing your insurance. **Our physicians will not be able to continue your care if your new insurance is a plan we do not accept.**

If you have any questions, please contact the billing department. They will be happy to assist you.

(386)-258-0123: Bonnie Ext. 141 or Penny Ext. 111

I have read and understand the above.

_____ _____

Patient's Name: Date

_____ _____

Patient's Signature: Date

RECOMMENDED PRENATAL LABS

(Please read and initial)

CARRIER SCREENING

The carrier screening checks to see if a pregnant patient carries any abnormal genes for a select number of inherited diseases. The test can help determine if a patient has an increased risk of having a child with any one of these diseases. A positive screening result may require the father of the baby also being tested and if both parents are carriers, further testing may be required. Below are the test names of this test for each lab:

LAB: Natera TEST: Horizon

LAB: Quest TEST: Prenatal Carrier Screening

LAB: LabCorp TEST: Inheritest

_____ Consent _____ Refuse

HUMAN IMMUNODEFICIENCY VIRUS TESTING (HIV)

HIV is thought to be the principal cause of Acquired Immune Deficiency Syndrome (AIDS). I am aware of testing, possible alternative methods of diagnosis, and the medical risk of injury, despite precautions, as well as information regarding measures for prevention, exposure, and transmission of HIV. I understand that the HIV testing result will be entered in my medical record. These results will not be release to persons outside of the OB/GYN Health Center or its related affiliated medical institutions, except with permission from me or my legal guardian or as otherwise authorized by law.

****REQUIRED HIV TESTING WITHIN THE PREGNANCY AT HOSPITAL****

_____ Consent _____ Refuse

SICKLE CELL SCREENING

Sickle Cell diseases is an inherited diseases that causes red blood cells to be deformed. These blood cells can become trapped and destroyed by the body. There are no longer enough functioning red blood cells, resulting in anemia. Each parent must be a carrier of the sickle cell trait (or gene) to have an affected child, there is a 25% chance if both parents are carriers of having an affected child. Sickle cell is more prevalent among African American and Latin Americans.

_____Consent _____ Refuse

MATERNAL SERUM QUAD SCREENING

The MSAFP Quad screening testing is a noninvasive blood test available to pregnant women who are between 15-18 weeks of pregnancy. The purpose of the test is to identify pregnant women who may be at risk for having a baby with certain birth defects, such a down syndrome (the presence of an extra chromosome and causes both mental and physical abnormalities) or open neural tube defect (occurring when the spine and brain do not develop completely). The MSAFP Quad screening test will not detect all high-risk pregnancies and very small neural tube defects. Most other birth defects and mental retardation are NOT detectable by this test. High- and Low-test results may require further testing such as ultrasound or more invasive testing like an amniocentesis. Sometimes test results can be high or low for no apparent reason.

_____ Consent _____ Refuse

- **I certify and I have read and understand the above. I acknowledge I have been given all the information and I do not require further explanation or counseling. I understand the decision to have these tests is voluntary and these tests may or may not be covered by my health insurance company.**

SIGNED: _____ DATE: _____

PRINT NAME: _____

Y: front desk originals
recommendprenatallabs

OB-GYN Health Center

769 N. Clyde Morris Blvd
Daytona Beach, FL 32117
O: 386-258-0123 F: 386-258-6464

Cell-Free Testing (Prenatal Genetic Screening)

Lab: Natera Test: Panorama
Lab: Quest Test: Qnatal
Lab: Labcorp Test: MaterniT 21

ACOG recommended

NIPT (non-invasive prenatal testing) uses a blood sample, taken from the mother's arm, to analyze DNA from the placenta and help determine your chance of having a child with chromosomal condition. NIPT poses no risk to your baby, unlike amniocentesis and CVS (chorionic villus sampling), which carry a slight risk of miscarriage.

Insurance companies will usually cover this test for patients who are 35 years or older. **Patients who are *under* 35 years old, your insurance company may not cover this test.** Self-pay rate is approximately $249.00.

Accept _____

Decline_____

_____
Patient Name (Print name)

_____ _____
Patient Signature Date

OB-GYN HEALTH CENTER

Christine DaSilva, MD John Meyers, MD Cynthia Baldwin, MD
769 N Clyde Morris Blvd Daytona Beach, FL 32114
Office: (386) 258-0123 Fax: (386) 258-6464

RISK OF SMOKING/SUBSTANCE ABUSE DURING PREGNANCY

My healthcare provider has recommended that I stop smoking/substance abuse. I understand that if I continue to smoke or abuse substances during pregnancy, I am creating dangers for my unborn baby and myself which include:

- **Increased risk of miscarriage.**
- **Increased risk of stillbirth.**
- **Increased risk of my baby not being able to tolerate labor contractions, leading to cesarean delivery.**
- **Lower than normal birth weight caused by decreased oxygen supply and nutrition to my baby.**
- **Increased risk of premature birth (early labor and delivery).**
- **Increased risk of health problems in infancy and childhood.**

I have read the above risks of smoking and substance abuse. I further understand that if I stop smoking or abusing substances or greatly decrease the amount of my smoking or substance abuse during my pregnancy, these dangers will be greatly decreased.

I give my consent to have random urine toxicology screens performed during my pregnancy.

I understand that the purpose of this testing is to provide better obstetrical care for me and my unborn child. When necessary, referrals to the appropriate agency will be made to treat substance abuse.

_____ _____

Signature of Patient **Date**

_____

Patients Date of Birth

_____

Witness

OB-GYN Health Center

Christine DaSilva, M.D. John Meyers, M.D. Cynthia Baldwin, M.D.
769 N. Clyde Morris Blvd, Daytona Beach, FL 32114
O: 386-258-0123 Fax: 386-258-6464

Date: _____

RE: Birth Plans

Dear OB patient:

If you are planning on having a birth plan, please submit the plan to your doctor no later than your 20th week gestation. A sample of a birth plan can be found on our website, **obgynhealthcenter.org**, *Patient Resources, Patient Forms, Birth Plan*.

Keep in mind that not all Birth Plans will be accepted. The doctor will review & discuss your birth plan with you. Keep in mind that your doctor's goal is to have the safest possible delivery for you and your baby.

I have read and understand the requirements for submitting a birth plan.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date