Pembroke Perinatal CENTER

Pembroke Perinatal Center Policies

Patient Name: _____ Date of Birth: _____

Thank you for choosing Pembroke Perinatal Center. Our goal is to provide the highest quality of care for all our patients in a timely manner. In efforts to provide you with the best care and minimize your wait time, our office has implemented the following policies.

Late Policy

Your appointment time is specifically reserved for you. If a patient is late for an appointment, the appointment may need to be rescheduled. This is to ensure that patients that do arrive on time do not wait longer than necessary to be seen. You may be given the option to wait if another appointment has become available for that day. We will try to accommodate late patients as best as possible, however cannot compromise on the quality of care to other patients. If you are late, you will be charged a fee of **$50**.

No Show Policy

We understand that situations arise in which you must cancel your appointment, therefore we request that you provide us with 24-hour notice so that we may offer that appointment to another patient. A no-show fee of **$50** will be charged to patients that do not show for their appointment or have a same day cancellation.

Payment Policy

Copays, deductibles, co-insurances and balances are due at the time of service. We will contact you once your benefits have been verified and inform you of what will be due at the time of service. We encourage you to contact your insurance company regarding your financial responsibility prior to your visit so that there is no delay at check-in. **Please be aware that we do not fall under your global OB/GYN coverage and specialist benefits will apply.**

Children Policy

Due to the nature of our exams and procedures, children are not permitted in the exam rooms or labs. We ask that all children wait in the waiting area. For safety reasons, children under the age of 12 require adult supervision at all times while in the waiting area. If you arrive for your appointment with a small child and do not have a chaperone, you will be asked to reschedule your appointment for a date in which you are able to obtain childcare.

Same Day Add-on Appointments

We understand that emergencies arise in pregnancy and your physician would like for you to be seen today. We will do our best to minimize your wait time, however our patients with appointments will be seen first. There may also be a wait time while we verify your insurance. We will fit you in as soon as we can. We apologize ahead of time for the inconvenience.

Consultation and Office Visits

An ultrasound appointment is **not** a visit with the doctor. An appointment with the doctor must be scheduled in advance. Any routine pregnancy concerns or new medical issues must be communicated to your OBGYN. If you request to speak to a doctor, be aware the visit will likely be subject to additional charges.

The doctors and staff at Pembroke Perinatal Center appreciate your understanding and compliance with these policies. I have read and fully understand these policies as listed above.

_____ _____

Patient Signature Date

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CENTER

Patient Financial Responsisbility Form

To assure us that you have read this document, please initial each line below and sign the bottom of the form.

_____ It is my sole responsibility to know and understand my insurance policy and coverage.

_____ Although PPC staff will make every effort to obtain accurate information from your insurance carrier prior to the time of service, I understand that verification of benefits is **NOT** a guarantee your insurance carrier will pay for all services rendered.

_____ I fully understand that the amount due at the time of service is an **estimate** and I am responsible for the full amount owed regardless of how close it is to the estimation. The insurance company may leave you responsible for more or less than what we collect in office. In the event you have over paid, you will receive a refund.

_____ Refunds will only be issued once all claims have been processed and paid by the insurance. We are unable to issue refunds if a claim is still pending.

_____ It is my responsibility to notify PPC of any insurance changes, preferably prior to your scheduled appointment to obtain proper insurance authorization if needed.

_____ On each visit, there may be multiple services billed to my insurance. I understand that I am financially responsible for any copayments, coinsurance, deductible and services not covered through my insurance plan. I also understand that **all payments are expected at the time of service.**

_____ If I am unable to make a payment in full, I understand that PPC does offer payment arrangements to help me. **A good faith payment is due at the time services are rendered.** This does not apply to copays. Copays are collected in full at each visit.

_____ Not all insurance plans cover all services. In the event that your insurance determines a service to be "not covered" or is determined to be not medically necessary, experimental, investigational, unscientific or excessive, **you will be responsible for the complete charges**.

_____ Insurance plans may have a maximum limit of ultrasounds that will be covered. If you require additional ultrasounds, **you will be responsible for the complete charges**. It is your sole responsibility to know and understand your insurance coverage.

_____ If you opt to be self-pay, the balance must be collected in full on the date of your appointment. Partial payments will not be accepted.

_____ In the event the doctor is unable to complete the exam due to gestational age, fetal lie or asks that you return for a follow up, it is not a continuation of the previous visit. It is considered a new visit and you will be responsible for all applicable copays, deductibles and/or coinsurance.

I, _____, acknowledge that I have read and understand the statements above.

Signature: _____ Date: _____

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Consent for Obstetrical Ultrasound

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 as well as any follow-up ultrasounds that may be recommended. **Upon request, a chaperone may be provided for your comfort and safety.**

What is Ultrasound and what can it show about my pregnancy?

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

Is Ultrasound safe?

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

Types of Exams

A basic ultrasound provides information concerning placental location, fetal position, multiple gestations (e.g. twin pregnancy), gestational age and the possible presence of fetal malformations.

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

A vaginal ultrasound, (in which a special ultrasound instrument about the thickness of a tampon is inserted into the vagina), is occasionally used to provide detailed views of the uterus or portions of the fetus that are low in the pelvis. This may be used to see the heartbeat, the location of a very early pregnancy, to evaluate the placenta or to better visualize the cervix. As with all other ultrasound exams, the vaginal ultrasound is safe and generally of little discomfort.

Does a normal ultrasound prove that my baby will have no abnormalities?

While ultrasound will detect many abnormalities, it is NOT definitive for fetal malformations. Despite a normal interpretation of the test, some babies may be born with abnormalities not identified by the examiner during the study. You should realize that even with an extensive ultrasound, the examiner might still be unable to find fetal abnormalities that are later discovered at a late gestational age or after birth. Although ultrasound is a very helpful diagnostic tool, it should not be considered as absolute proof of the absence of fetal defects.

*****THE USE OF CELL PHONES, CAMERAS AND ANY RECORDING DEVICES ARE STRICTLY PROHIBITED IN THE ULTRASOUND ROOM. PLEASE BE COURTEOUS AND KEEP PHONES ON SILENT AND PUT AWAY.*****

Consent

Should you have any questions concerning ultrasound, do not hesitate to discuss them with your doctor or the sonographer before undergoing the procedure. **I understand that an ultrasound is a medical procedure that involves examination of the pelvic organs and may indicate an exam including but not limited to a pelvic exam.** You are requested to sign this document prior to the performance of your ultrasound examination and to thereby acknowledge that you have read and understood the information contained herein, and have given informed consent to this procedure. The consent will remain active until you withdraw your consent in writing.

Patient Name: _____ **Date**: _____

Patient Signature: _____

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Laboratory Services

To assure us that you have read this document, please initial each line below and sign.

In regards to laboratory services, I _____ acknowledge that I have read and understand that:

_____ It is **my responsibility** to notify PPC if my insurance has restrictions or limitations regarding lab work, **prior** to my blood work being drawn, especially in regards to **genetic testing.**

_____ PPC sends bloodwork/specimens to a variety of different labs (depending on the type of testing required). **PPC cannot guarantee that a participating lab will be In-Network. You will be be notified if a particular lab will be Out-of-Network**.

_____ I understand that **NOT** all specialty labs are In-Network with my insurance and I will be financially responsible for all copayments, coinsurance, deductible, or services that are not covered by my insurance. **Unfortunately, PPC is unable to provide an estimate of costs for any lab services**.

_____ PPC staff does **NOT** have any role or control over the billing details of each particular lab, therefore I understand that if I do receive a bill**, I must contact the lab or my insurance carrier directly regarding any billing questions.**

Signature: _____ Date: _____

The following questions are used for clinical and laboratory purposes only:

What is your race (*please circle*)?

American Indian/Alaska Native Asian Black Native Hawaiian/Pacific Islander White Other

What is your ethnicity (*please circle*)?

Hispanic Non-Hispanic (*please specify*): _____

Pharmacy Information

Name of pharmacy: _____

Address: _____

Phone Number: _____

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY QUESTIONNAIRE / QUESTIONARIO DE HISTORIAL MEDICO

When was the **FIRST** day of your last menstrual period?			¿Cuándo fue el **PRIMER** día de su último período menstrual pasado?		
Are you sure?	Yes	No	¿Está segura?	Sí	No
Are your periods normal?	Yes	No	¿Son sus períodos normales?	Sí	No
How many pregnancies, including this pregnancy?			¿Cuántos embarazos, incluyendo este embarazo?		
How many babies born at term (nine months)?			¿Cuántos bebés llevados en el término (nueve meses)?		
How many babies born premature?			¿Cuántos bebés nacidos prematuros?		
How many living children do you have?			¿Cuántos hijos vivos tienes?		
How many miscarriages?			¿Cuántos espontáneo / natural abortos?		
How many medically induced abortions?			¿Cuántos inducido abortos?		
Is this pregnancy a result of In Vitro Fertilization?	Yes	No	¿Es este embarazo resultado de la fertilización in vitro?	Sí	No
If yes, was there a donor egg used?	Yes	No	¿Se usó un óvulo donante?	Sí	No
What is the age of the egg donor?			¿Cuál es la edad del donador?		
What is the age of the father of the pregnancy?			¿Cuál es la edad del padre del embarazo?		

Past Pregnancy History/Historia Pasada del Embarazo

	Date of birth Dia de parto	Gestational Age /Edad gestacional	Vaginal Delivery or C/S Parto vaginal or cesária	Weight Peso	Gender El Género	Complications or reason for C-section/ Complicaciones o razón de la cesárea
1						
2						
3						
4						
5						

Current Pregnancy Symptoms	Yes/Si	No	Comments/Comentarios
Vaginal bleeding (sangrado vaginal)			
Vaginal discharge or odor (secreción o olor vaginal)			
Vomiting (vomito)			
Problem with pain or urination (dolor al orinar)			
Hypoglycemia (Hipoglucemia)			
Illness with fever (enfermedad con fiebre)			
Nausea or inability to eat (náusea)			
Headache (dolor de cabeza)			
Constipation (estreñimiento)			
Abdominal pain (dolor abdominal)			

What is your occupation? _____

Patient Name: _____ Date of Birth: _____

Do you have a LATEX ALLERGY? ¿Tiene usted una ALERGIA AL LÁTEX? YES/SI NO

Please check Yes or No in regards to your own or family history below:
Por favor marque Sí o No en cuanto a su propia historia o de la familia por debajo:

HISTORY (Historia)	**YES (Si)**	**NO**	**Self or Family**	**COMMENTS** ***Please include dates*** **(Comentarios, por favor incluya fechas)**
Allergic reaction (Reacción alérgica)				
Anemia, including sickle cell (Anemia)				
Asthma (Asma)				
Autoimmune Disorder, including Lupus (Enfermedad de Autoinmune)				
Abnormal Pap Smear (Papanicolaou anormal)				
Blood Transfusion (Transfusión de Sangre)				
Breast disorder (Trastorno de mama)				
Depression (Depresión)				
Psychiatric Disorder (Trastorno psiquiátrica)				
Diabetes				
Heart Disease (Trastorno cardiac)				
Hypertension/High Blood Pressure(Hipertensión)				
Infertility (Esterilidad)				
Liver Disease (Trastorno del hígado)				
Neurologic Disorder (Trastorno neurológico)				
Renal Disorder/Kidney Problems (Trastorno renal)				
(Rh) Disease (Incompatibilidad de Rh)				
Thyroid Disease (Trastorno de tiroides)				
Trauma History (Historia de trauma)				
Uterine Abnormalities (Anomalias Congentias del Utero)				
Varicosities/ DVT (Varices / trombosis)				
Anesthetic Complications (Complicaciones anestésicas)				
Tobacco (tabaco)				(Packs/day)
Alcohol				(drinks/day)
Illicit or Recreational Drug use (drogas Ilícitas o recreativas)				
Other Medical Problems or Family History (Otra historia médica de la familia)				

Surgery/Hospitalization (Cirugía / Hospitalización)	**Year/Ano**	**Comments/ Comentarios**

Are you currently taking any medication/supplements and why? ¿Qué medicamentos estás tomando actualmente y por qué? _____

_____

Patient Name: _____ Date of Birth: _____

Please check Yes or No in regards to your own or family history below:

Por favor marque Sí o No en cuanto a su propia historia o de la familia por debajo:

Genetic Screening	**Yes/Si**	**No**	**Comments/ Comentarios**
Patient Age **>35** at due date (Edad de paciente>(mas) 35)			
Neural Tube Defect (Spina Bifida, Anencephaly) Defecto del tubo neural (espina bífida, anencefalia)			
Trisomy 21 (Trisomía 21)			
Congenital Heart Disease (Enfermedades Congénitas del Corazón)			
Cystic Fibrosis (Fibrosis quística)			
Tay-Sachs (Jewish, Cajun, French Canadian) Enfermedad de Tay-Sachs (judía, Cajun, francés canadiense)			
Thalassemia (Italian, Greek, Mediterranean, Asian) Talasemia (italiana, griega, mediterránea, asiática)			
Canavan Syndrome (Síndrome de Canavan)			
Hemophilia or hematologic Disease Hemofilia o la enfermedad hematológica			
Huntington's Chorea (Corea de Huntington)			
Autism (Autismo)			
If yes, was person tested for Fragile X? En caso afirmativo, se hiso la prueba de X Frágil?			
Mental Retardation (Retraso Mental)			
If yes, was person tested for Fragile X? En caso afirmativo, se hiso la prueba de X Frágil?			
Muscular Dystrophy (Distrofia Muscular)			
Sickle Cell Disease or Trait (African) La enfermedad de células falciformes o rasgo (África)			
Other Inherited Genetic or Chromosomal Disorder Otros trastorno hereditario genético o cromosómico			
Maternal Metabolic Disorder (Type 1 Diabetes, PKU) Trastorno metabólico materno (diabetes tipo 1, PKU)			
Recurrent Pregnancy Loss, or a Stillbirth **Pérdida recurrente del embarazo, o un muerte fetal**			
Other birth defects (Otros defectos de nacimiento)			
Child die after birth (Niño muere después del nacimiento)			
Other Genetic Screening (Otro Cribado Genético)			
Exposure/Infection History La exposición/ Historia de infección			
Partner has history of HIV (Pareja tiene historia de HIV)			
Patient or partner has history of Genital Herpes Paciente o su pareja tiene historia de herpes genital			
Exposure to Tuberculosis (Exposición a la tuberculosis)			
Rash or Viral illness since last menstrual period Enfermedad eruptiva viral o después la última menstruación			
History of sexually transmitted disease Historial de enfermedad de transmisión sexual			
Possible Varicella Suspectibility (Susceptibilidad de Varicella)			
Other exposure history or Infection Historia de exposición o infección			

Please provide most recent Weight (peso) _____ lbs Height (estatura) _____feet/in

Pembroke Perinatal CENTER

Photo Release

For good and valuable consideration, I _____ hereby authorize Pembroke Perinatal Center, LLC permission to use my and/or my child's likeness in a photograph, ultrasound or video in conjunction with educational presentations and media publishing to promote the practice as well as Maternal Fetal Medicine in general. I understand that such likeness will become the property of Pembroke Perinatal Center, LLC and will not be returned.

I understand that all patient identifiers such as name, date of birth and medical record number will be removed from all ultrasound images.

I acknowledge I will not receive any monetary compensation for the above and waive any right to future compensation.

I hereby hold harmless and release and forever Pembroke Perinatal Center, LLC from any and all claims, demands and causes of action which I, my heirs or representatives have, may have or will have as a result of this authorization.

I am at least 18 years of age and am able to provide this authorization. I understand and acknowledge that signing this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

By signing below, I acknowledge that I am giving Pembroke Perinatal Center, LLC permission to use my photograph and or video(s).

_____ _____
Signed Date

_____
Print Name

By signing below, I **do not** give Pembroke Perinatal Center, LLC permission to use my photograph and or video(s).

_____ _____
Signed Date

_____
Print Name