

## HEALTH INFORMATION FORM

### PATIENT HEALTH HISTORY

Date: \_\_\_\_\_

Name: _____	Date of Birth: _____
First Day of Last Menstrual Cycle: _____	Estimated Due Date: _____
Referring Physician: _____	
Pharmacy Name: _____	Pharmacy #: _____
Height: _____ Weight: _____ Reason for Consultation: _____	

### MEDICATION HISTORY

**Allergies:** (Check All That Apply)

- |                                     |                                  |                                 |                                   |  |
|-------------------------------------|----------------------------------|---------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa  | <input type="checkbox"/> Morphine | <input type="checkbox"/> No Known Drug Allergies |
| <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Insulin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex    | <input type="checkbox"/> Other _____             |

**Medication:** (List any medications taken at any point during this pregnancy)

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			4.		
2.			5.		
3.			6.		

### PREGNANCY HISTORY

Year	Weeks @ Delivery	Birth Weight	Vaginal/Cesarean	Complications
			Yes    No	Yes    No
Will you be 35 years or older at delivery?				Conceived by IVF?
Will the father be 50 years or older at delivery?				Was there Donor Egg or Donor Sperm used?
Fever or Rash during this pregnancy?				Cervical insufficiency? (incompetent cervix)
Radiation Exposure? (X-ray, CT, etc.)				Prior cervical surgeries?

### FAMILY GENETIC HISTORY AND SCREENING (Including Patient, Father, and Other Family Members)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Autism			Cystic Fibrosis			Mental Retardation		
Birth Defects			Down Syndrome			Muscular Dystrophy		
Canavan Disease			Fragile X Syndrome			Neural Tubal Defects		
Chromosomal Abnormalities			Hemophilia			Sickle Cell Trait		
Congenital Heart Defect			Huntington's Chorea			Tay-Sachs		
Other: _____								

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**YOUR PERSONAL MEDICAL HISTORY (Please Check All That Apply TO YOUR SELF)**

	Yes	No		Yes	No		Yes	No
Anemia/Blood Transfusion			Diabetes			Lupus		
Asthma/Lung			Heart Disease			Seizure/Epilepsy		
Arthritis			HIV			Thyroid Disease		
Blood Clots (e.g. DVT)			Hypertension			Trauma		
Cancer			Kidney Infection/Stones			HSV or another STD		
Depression			Liver (e.g. Hepatitis)			Other:		

**SURGICAL HISTORY**

Year	Surgery	Indication

**SOCIAL HISTORY**

	Yes	No	Please Explain
Tobacco			# of packs per day ____ for ____ years
Alcohol			# of drinks per week _____
Illicit/Recreational Drugs			
Exercise			
Do you feel safe at home? (Physical, Verbal, Sexual Abuse)			

**REVIEW OF SYSTEMS:**

	Now	Past		Now	Past		Now	Past
<b>1. Constitutional</b>			<b>5. Respiratory</b>			<b>10. Psychological</b>		
Fevers			Wheezing			Depressed		
Chills			Frequent Cough			Bi-polar Syndrome		
Sleep Difficulties			Shortness of Breath			Anxiety		
<b>2. Eyes</b>			<b>6. Gastrointestinal</b>			<b>11. Endocrine</b>		
Double Vision			Nausea/Vomiting			Excessive Thirst		
Seeing Stars			Abdominal Pain			Heat/Cold Intolerance		
Vision Changes			<b>7. Genitourinary</b>			<b>12. Hematologic</b>		
<b>3. Ear/Nose/Throat</b>			Painful Urination			Clotting Problems		
Hearing Changes			Blood in Urine			Bruising		
Sore Throat			<b>8. Musculoskeletal</b>			<b>13. Neurological</b>		
Sinus Problems			Joint Pain			Numbness/Tingling		
<b>4. Cardiovascular</b>			Muscle Pain			Weakness		
Chest Pain			Bone Pain			Dizziness		
Irregular Heart Rate			<b>9. Integumentary</b>			<b>14. Other:</b>		
Heart Murmur			Rashes/Moles/Lumps					

Completed By: \_\_\_\_ Patient      \_\_\_\_ Office Personnel      \_\_\_\_ Physician

Patient Signature: \_\_\_\_\_ Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT TO TREAT

I, \_\_\_\_\_, hereby give my consent to Dr. Kevin Magee, Dr. Nicole Yost, Dr. Reenu Eapen, Dr. Zach Rubeo, Dr. Timothy Crombleholme, Dr. David Gore, Dr. Maytham Al-Kubaisi, Dr. Holly Dunn, Dr. Danielle Moye', Dr. Margaret Warren, Meghan Christian, FNP-BC, and Madeline Crank, PNP-BC of Fetal Care Consultants, LLC the authorization to provide my medical treatment. I understand that Fetal Care Consultants, LLC will explain my condition, foreseeable risks, and methods of treatment before treatment is provided. I authorize Fetal Care Consultants, LLC to perform any additional or different treatment that is thought necessary if in an emergency situation, or a condition is discovered that was not known previously. I have carefully read and fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the necessary procedure with the care provider.

**Please check:**

I have received and reviewed an explanation of the above checked treatments and associated risks of treatment.

I understand that audio and video recording is prohibited in the office.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Legal Guardian Name (if applicable)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Legal Guardian Signature

\_\_\_\_\_  
Date

***Please initial applicable procedure:***

Amniocentesis

Genetic Counseling  Sonography

Chromosome Analysis

Lab Draw

First Trimester Screen

NIPT

## NEW PATIENT REGISTRATION FORM

### PATIENT'S INFORMATION:

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Age: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
Social Security: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Spouse Occupation: \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  Widowed  Other

### REFERRAL INFORMATION:

Referring Physician's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
Address: \_\_\_\_\_

### INSURANCE INFORMATION:

Primary Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Patient's Relationship To Insured: \_\_\_\_\_ Policy Holder's Name (If Other Than Patient): \_\_\_\_\_  
Subscriber's Social Security #: \_\_\_\_\_ Gender:  Male  Female Date Of Birth: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Patient's Relationship To Insured: \_\_\_\_\_ Policy Holder's Name (If Other Than Patient): \_\_\_\_\_  
Subscriber's Social Security #: \_\_\_\_\_ Gender:  Male  Female Date Of Birth: \_\_\_\_\_

### EMERGENCY CONTACT:

Name: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

### ASSIGNMENT AND RELEASE:

Please read the following and sign below:

#### ASSIGNMENT OF BENEFITS, BILLING POLICY, AND RELEASE OF MEDICAL INFORMATION:

I hereby authorize my insurance benefits to be paid directly to Fetal Care Consultants of Texas, LLC or any of its wholly owned subsidiaries. I understand that I am financially responsible for all payments not made by my insurance company, including (i) patient responsibility amounts such as co-pays and deductibles, (ii) non-covered services, (iii) payments not made because of failure to follow payers' administrative requirements (except as otherwise agreed), (iv) if plans benefits are exceeded, or otherwise. I am also responsible if my insurance company does not pay in accordance with the Texas Prompt Payment Regulations.

I authorize release of all protected health information to my insurance company to obtain payment for services.

#### MEDICARE PATIENTS:

I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for any Medicare claim. I assign payment of Medicare benefits to my billing provider.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## COMMUNICATION WITH PATIENT

### Designation for Release

*It is the physician responsibility to ensure that the physician-patient relationship remains confidential. The privacy statement of our practice is the basis for how we treat your protected health information (PHI). HIPAA allows physicians to use professional judgment on disclosing certain PHI to family, friends or legal representative without authorization. This form is an aid to our physicians in making determination regarding disclosure of such information. Our providers realize that there may be times when the patient may not want another person to be informed about your medical condition and medical needs. The physicians want you to, if you so desire, to name the person whom you wish the office staff speak about your medical condition.*

- Only one person can be designated in this role
- The designation is valid unless you cancel it in writing
- If you designate no one, we may not release information to any family or friend.

I, \_\_\_\_\_ designate the following person be allowed to speak with a physician, nurse or staff at Fetal Care Consultants, LLC should it be necessary on my behalf. I hereby give permission to release to my designee any information about my medical condition or medical needs or status of my account and I release Fetal Care Consultants, LLC, its physicians and staff, from any claim of confidentiality in connection with the release of this information.

Name of Designated Person: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Patient Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

**[ ] I decline to designate another person to speak with my physician or staff.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

Is it okay to leave a message regarding my care at Fetal Care Consultants, LLC on the contact number you have provided us?

[ ] YES [ ] NO

## Consent to Communicate Medical Information

### **Voicemail Communication**

Welcome to Fetal Care Consultants! Many times, during the course of your care our providers will want to provide information to you about laboratory results or other medical issues. Sometimes it is difficult to connect with patients by phone which delays our ability to relay information. Some patients prefer that we leave messages on their voicemails as a way to eliminate delays. Because we are bound to protect patient privacy, we cannot use this method of communication unless we have permission to do so. Please indicate your preference as to how we can communicate information to you during your care as a patient here:

Yes, you may leave a message on my  Home # ( ) \_\_\_\_\_

Cell # ( ) \_\_\_\_\_

No, do not leave any medical information on my voicemail.

### **Communication with Family Members or Significant Others**

Some patients would like us to discuss their medical care with a spouse, family member or other trusted associate. To assure privacy, we require patient permission to do so. Please list below any other persons with whom we may share your medical information.

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

### **Request for email Communication**

Some patients prefer to communicate with our clinical and administrative support staff by email. However, as email communications is not encrypted, there is no assurance of confidentiality of information when communicated this way. Nevertheless, we will communicate with you via email if that is more convenient for you. To do so, please provide us with your email information below:

Yes, I authorize email communication

No, I do not authorize email communication

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
email Address

## FINANCIAL AGREEMENT

We would like to welcome you to our office and are happy you have chosen us for your medical care. Our goal is to provide you with the best care available. In order to meet this goal, we need your assistance and understanding of our patient policies. Our financial policy is an essential part of assuring the resources needed to maintain this vital healthcare facility are met for our patients.

We are here to help answer any questions you may have regarding your insurance coverage and payments. However, your insurance is a contract between you and your employer and the insurance company. It is your responsibility to understand the provisions, limits, and requirements of your individual benefit plan. We will file you claims directly to your company if we participate in your insurance. If we do not participate in your insurance, we will supply you an extra copy of your superbill to submit to your insurance company. We will also file secondary insurance if you have coverage. Any uncovered portion of your visit will be your personal financial responsibility. This includes any and all co-pays, co-insurance, deductibles and uncovered services. After your insurance has processed and insurance pays their portion of the bill, any remaining balance is your responsibility and due in full upon receipt. Furthermore, if "clean claims" submitted to an insurance carrier are not paid within the 30-day limit established by the Texas Prompt Payment Regulations, FCC reserves the right to bill you directly for our services.

Full payment is due at the time services are rendered. We accept cash, check, Master and Visa credit/debit cards. Your copayment, deductible and coinsurance will be collected at the time of your visit, in addition to any previous balance on account. If you need an estimate of costs prior to your visit, please call our office and we will do our best to provide a rough estimate however this estimate is only a rough guidance. At the time of your visit the physician may deem additional services necessary depending upon your healthcare needs.

Patients will be billed for amounts due and have a financial responsibility to pay these amounts. If prompt payment is not received on any unpaid balances on your account after 3 statements, your account will be reported to a collection agency for delinquent status. Patients will be responsible for any collection, interest or legal expenses associated with the collection efforts.

There is a flat fee of \$25 for copies of medical records. If a patient presents an insufficient funded personal check (NSF check) for payment on their account they will be charged \$35, as well as be required to pay for all future visits with cash, a money order, cashier's check or credit card.

There may be an instance that your insurance may not cover Doppler velocimetry, 76820, for your diagnosis. In the event our physicians feel it is medically necessary for your care we will provide this service but it will be at a cost to you. To assist you financially we will honor the contracted rate rather than the full charge. Please let us know if you have any questions.

Thank you for choosing us for your healthcare needs. We believe it is important our patients fully understand our financial policy and be well informed. It is your responsibility to notify us in writing of any changes in account status including phone, address, and insurance information. Our business office is open during office hours and we are more than happy to answer any questions you may have regarding our financial policy.

Please sign below to indicate that you have read this notice, understand the information it contains and that any questions you might have about the information presented herein have been answered to your satisfaction.

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Patient Name

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Signature

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Date

## MEDICAID AGREEMENT

I understand that in the opinion of Fetal Care Consultants, LLC the services or items that I have requested to be provided to me on \_\_\_\_\_ may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Health or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Comprendo que segun la opinion del Fetal Care Consultants, LLC es posible que Medicaid no cubra los servicios o las provisiones que solicite \_\_\_\_\_ por no considerarlos razonables ni medicamente necesarios para mi salud. Comprendo que el Departamento de salud de Texas o su agente de seguros de salud determina la necesidad medica de los servicios o de las provisiones que el cliente solicite o reciba. Tambien comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicite y que reciba si despues se determina que esos servicios y provisiones no son razonables ni medicamente necesarios para mi salud.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **For Children/Minors:**

Parent or Legal Guardian Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_



## NO SHOW POLICY

When you make an appointment with us, we reserve a significant amount of time specifically for your consultation. Unfortunately, when a patient doesn't show up for their scheduled appointment, another patient loses an opportunity to be seen. For this reason, it is the policy of Fetal Care Consultants, LLC to call to reschedule or cancel a clinic appointment. Any patient that does not arrive for their scheduled appointment within a 15-minute window and does not call to cancel prior appointment is considered a no-show. Patients that do not follow this protocol will be assessed a \$25 no show fee.

*The only exceptions to this requirement are a medical emergency, inpatient hospitalization or a crisis. For those patients utilizing Medicaid transportation, if your transportation is a no show, you must obtain a letter from Medicaid stating such in order to waive the no show fee for our office.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date