FETAL CARE CENTER

HEALTH INFORMATION FORM

PATIENT HEALTH HISTORY

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____
First Day of Last Menstrual Cycle: _____Estimated Due Date: _____
Referring Physician: _____
Pharmacy Name: _____ Pharmacy #: _____
Height: _____feet _____inches Pre-pregnancy Weight:_____ Current Weight:_____
Reason for Consultation: _____
How many weeks at first ultrasound? _____
How many weeks at first ultrasound? _____

MEDICATION HISTORY

Allergies: (Check All That Apply) ☐ **No Known Drug Allergies**
☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Morphine
☐ Aspirin ☐ Insulin ☐ Iodine ☐ Latex ☐ Other _____

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

Medication Name	Dose	Frequency
1.		
2.		
3.		

Medication Name	Dose	Frequency
4.		
5.		
6.		

PREGNANCY HISTORY (Please use back for more information)

Year	Weeks @ Delivery	Birth Weight	Vaginal/ Cesarean	Gender	Country & Hospital of Delivery	Pregnancy and Delivery 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? (Xray, 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:								

Fetal Care Consultants, LLC. 7777 Forest Lane, Suite D1190
Phone: (972) 566-5600; Fax: (972) 566-5680

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HEALTH INFORMATION FORM

Patient Name: _____Today's Date: _____

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 other STD's		
Depression			Liver (e.g. Hepatitis)			Other:		

SURGICAL HISTORY (Please use back for more information)

Year	Surgery	Indication

SOCIAL HISTORY

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

REVIEW OF SYSTEMS: (If not applicable, leave blank)

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

Completed By: _____Patient _____Office Personnel _____Physician

Patient/Legal Guardian Signature:_____ Date:_____

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FETAL CARE CENTER
DALLAS

NEW PATIENT REGISTRATION INFORMATION

Patient Information

Last Name: _____ **First:**_____ **Initial:** _____
Date of Birth: _____ Age: _____ Social Security Number: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone (Home/Cell): _____ Email: _____
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other

Referring Physician Information

Referring Physician: _____Phone: _____ Fax: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Group #_____
Phone: _____ Fax: _____
Subscriber Name: _____ Date of Birth: _____□ M □ F
Relationship to Insured: _____Social Security #:_____
Secondary Insurance: _____ Policy #: _____ Group #_____
Phone: _____ Fax: _____
Subscriber Name: _____ Date of Birth: _____□ M □ F
Relationship to Insured: _____Social Security #:_____

Emergency Contact

Name: _____ Phone: _____
Relationship to Patient: _____

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: _____

FETAL CARE
CENTER

CONSENT TO TREAT

I hereby give my consent to Fetal Care Consultants, LLC and authorize 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 (if applicable)
Date	

FETAL CARE CENTER

CONSENT TO COMMUNCIATE MEDICAL INFORMATION

Voicemail Communication

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. 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

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 communicating in 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

email Address _____

☐ No, I do not authorize email communication

_____ _____

Patient Name Date

_____

Patient/Legal Guardian Signature

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FETAL CARE CENTER

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. We 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.

- 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 agree to designate the following person(s) 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: _____

Name of Designated Person: _____ Date: _____

Relationship: _____ Phone Number: _____

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

_____ _____

Patient Name Date

_____

Patient/Legal Guardian Signature

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FETAL CARE CENTER

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 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.

If a patient presents an insufficient funded personal check (NSF check) for payment on their account they will be charged a $35, as well as be required to pay for all future visits with cash, a money order, cashiers check or credit card.

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.

_____ _____

Patient Name Patient/Guardian Signature

_____

Date

FETAL CARE
CENTER

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 Name: _____

Patient Signature: _____

Date: _____

For Children/Minors:

Legal Guardian Name: _____

Legal Guardian Signature: _____

Date:_____

Relationship to patient: _____

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