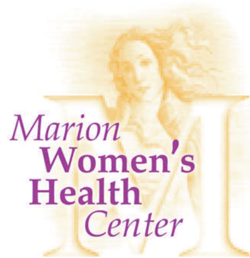

Congratulations on your pregnancy and
Welcome to Marion Women's Health Center.

At your initial visit, you will have a complete physical examination, including a pelvic exam. A detailed personal and family medical history will also be taken at that time. Completing the enclosed papers prior to your visit will help our staff gather all of the necessary information.

Please check in with the receptionist 20 minutes before your scheduled appointment to allow time to fill out any additional paperwork that may be necessary and for your paperwork to be placed in your chart. If you are unable to keep your scheduled appointment, please call to cancel with at least 24 hours notice. If you miss an appointment and do not call to cancel in advance, we will call you to reschedule. After three missed appointments, you will not be allowed to make any future appointments.

At your first visit, you will need to present your insurance card. If you do not have insurance or we do not have a contract with your insurance company, a $550 deposit is required. If we have a contract with your insurance company, any Co-payment designated on your insurance card will be collected at your first visit. **If you are under the age of 21, you must bring valid insurance cards for both of your parents, even if you have your own insurance.**

After your first visit, our billing department will calculate a payment plan based upon the estimated amount that will be owed for your prenatal care and delivery. You will receive a letter with the estimated amount that you will owe (if any) and a payments will be set up on a monthly or per visit basis.

At each visit, including your initial one, we request that you bring your First Morning urine specimen. Please keep it refrigerated until your appointment.

Our office hours are Monday and Thursday 8:30 am to 7:30 pm, Tuesday 8:30 am to 4:30 pm and Wednesday and Friday 8:30 am to 11:45 am.

If you have any problems or concerns prior to your scheduled appointment, please call the office. There is a physician and/or certified nurse midwife on call 24 hours a day. Please reserve calls after 10 pm to emergencies only.

We look forward to seeing you in the near future.

PATIENT INFORMATION FORM

NAME Last: ______________________________ First: ______________________ MI:______

DOB: _________Age ____Married____Single___ Divorced____Separated____Widowed____

Address __________________________________City ______________ ST _____ Zip _______

Home phone: ________________Cell Phone: ______________SSN:______________________

Employer: ____Work Ph: __________________

Pharmacy: ______________________ Location ___________________ Phone: ____________

Spouse: _______________________DOB: _______________ SSN: ______________________

Emergency Contact: __________________Relationship: _____________ Phone:____________

Primary Care Physician: _____________________________Phone: ________________________

Allergies:

Previous Medical/Surgical History:

Advanced Directives
Do you have an Advanced Directive (DNR)? Y N

FOR OFFICE USE ONLY

Date	Problems	Date	Surgeries/Deliveries

MARION WOMEN'S HEALTH CENTER
INSURANCE INFORMATION AND PAYMENT AUTHORIZATION

Patient Name:____

Primary Coverage Insurance Company:___________________________________

Policy ID#_________________________ Group # ________________________

Effective Date: ________________ Copay amount* $ ____________________

Subscriber Name ____

Subscriber SSN: ___________________ Subscriber Date of Birth:______________

Subscriber Address(if different from patient)________________________________

Subscriber relationship to patient ______________________________________

Subscriber Employer ____

Secondary Coverage Insurance Company (if applicable): ______________________

Policy ID# _________________________ Group # ______________________

Effective Date: ________________ Copay amount* $ ____________________

Subscriber Name ____

Subscriber SSN: ___________________ Subscriber Date of Birth: ______________

Subscriber Address (if different from patient)_______________________________

Subscriber relationship to patient_______________________________________

Subscriber Employer ____

PAYMENT AUTHORIZATION

I, ________________________________, hereby authorize Marion Women's Health Center to furnish information concerning my care. I direct the insurer to pay, without equivocation directly to the physician, all benefits due to him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of authorization will be as valid as the original.

Signature of Patient or Guardian: ______________________________ Date: __________

*If your insurance requires a Co-payment, this Co-pay must be paid at each visit for which they are required. If you are unable to make your Co-payment at the time of service, your visit will be rescheduled.

Smoking and Pregnancy

Statement of Understanding

Maternal smoking affects the outcome of both the pregnancy and the child. I have been informed that smoking during pregnancy increases the risk of:

1. Abruption of the placenta (Early separation of the placenta from the uterus).
2. Bleeding during pregnancy.
3. Lower birth weight, which may have cause my child to have long term physical and intellectual deficits.
4. Miscarriage.
5. Placenta previa.
6. Premature repture of membranes (bag of water breaks before contractions begin).
7. Premature labor and delivery.
8. SIDS (Sudden Infant Death Syndrome).
9. Stillbirth

I understand the adverse effects of smoking. I have been advised to stop smoking and/or not to start.

Signature____ Date____________

At your initial visit, a family medical history will be completed. To aid this process, please answer the following questions. Include immediate family only – yourself, baby's father, parents, siblings and grandparents.

Illness	**Yes**	**No**	**If yes, explain**
Heart disease			
High Blood Pressure			
Cancer			
Lung Disease (TB, Asthma)			
Kidney Disease			
Neurological Disease (Epilepsy)			
Metabolic/Endocrine (Thyroid)			
Anemia/Blood Disorders			
Psychiatric Illness (Depression)			
Diabetes			
Have you ever had:			
Rheumatic Fever			
Stomach problems (ulcers)			
Kidney Infection (bladder)			
Infertility			
Surgeries			
Accidents (major)			
Blood Transfusion			
Allergies to medications			

How old were you when you had your first menstrual period? ____________ years

Within the last year, how often were your periods? ___________ How long did they last?______

Have you had any of the following since your last menstrual period: (circle)

spotting or vaginal bleeding   abdominal cramping   headaches   nausea or vomiting   fever

OBSTETRICAL ULTRASOUND

I, ___________________________________, hereby request the performance of **Obstetrical Ultrasound.** This procedure will be performed by Sharon Hostetler RDMS.

Recent recommendations from the American College of Obstetricians and Gynecologists (ACOG) suggest that specific fetal structures be examined during your ultrasound examination. While every effort will be made to identify birth defects of the brain, chest, heart, abdomen, kidneys and extremities, not all birth defects will necessarily be detected.

This ultrasound test is not a treatment for any condition but is done for diagnostic purposes. The information obtained may be used to confirm the presence of a fetal heart beat, evaluate the baby's growth, estimate the size of the baby, detect the presence of multiple fetuses and to detect **some but not all birth defects. I**t is possible that fetal birth defects may not be seen on the ultrasound or that normal anatomy could falsely appear abnormal. Therefore, neither a normal ultrasound nor the results of any other prenatal test guarantee a normal, healthy baby.

__________ I agree to the ultrasound examination and do not wish to be referred to a specialist for a more detailed evaluation

__________ I prefer to be referred to a specialist who may have a higher detection rate for serious birth defects.

Currently, there are no known health risks to the mother or fetus during an ultrasound examination. I understand that alternatives to this examination may be available to me.

I acknowledge that I have had an opportunity to discuss with Dr. Moodley/Brenda Gatchel CNM/CRNP (provider) and they have explained to my satisfaction the purpose and nature of this obstetrical ultrasound, as well as reasonable risks. I understand that medicine is not an exact science, that it may involve the making of medical judgments based upon the facts known to the physician at the time, and that it is not reasonable to expect the physician to be able to anticipate nor explain all possible risks and complications, and further, that an undesirable result does not necessarily indicate an error in judgment. I understand no guarantee as to the results has been made to me. I expressly wish the physician to exercise his/her best judgment during the course of the procedure and to inform me of the findings of the obstetrical ultrasound.

I understand that this obstetrical ultrasound may or may not be paid for by my insurance company. Many insurance companies will not pay for an ultrasound unless medical indications are present. I understand and agree that if the procedure is not paid for by my insurance, I will be responsible for the payment.

All of my questions have been answered and I do hereby consent to the performance of obstetrical ultrasound.

____________________________________	____________________________________
Patient Signature	Patient Name (printed)
____________________________________	____________________________________
Physician/Provider	Date

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of Marion Women's Health Center's Notice of Privacy Practices, but decline to take a copy.

____ ____________________

Patient of Personal Representative Signature Date

I acknowledge that I have received a copy of Marion Women's Health Center's Notice of Privacy Practices.

____ ____________________

Patient of Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:____

To ensure confidentiality and comply with HIPAA regulations, it is the policy of our office to release information regarding our patients only to the patient. By signing this, you are giving our office staff permission to release information to your referring physician, insurance companies and any necessary treating physicians, therapists or hospitals.

If you wish for others to receive information regarding your care, please list their name, telephone number and relationship to you below. If you are a minor, parents/guardians are not automatically authorized to be given information. You must list each parent/guardian you give permission for our staff to speak to.

I give my permission to Dr. Moodley, Brenda Gatchel and their staff to speak to the following people regarding my care in addition to those listed in the first paragraph above:

Name	**Telephone Number**	**Relationship.**
______________________	______________	__________
______________________	______________	__________
______________________	______________	__________
______________________	______________	__________

ALL REQUESTED MEDICAL RECORDS require a release filled out and signed by the patient.

When calling our office, our staff will need to speak with you directly.
When we are trying to reach you by telephone, do we have your permission to leave a message on your answering machine or voice mail?

YES NO (Circle One)

____

Patient Name (please print)

____

Patient Signature

____

Date