Valley Perinatal™

PATIENT INFORMATION

Name _____ Date _____

Address _____ Phone _____

City, State Zip _____ Cell Phone _____

Occupation _____ Work Phone _____

Employer _____ Date of Birth _____

Email _____ Soc. Sec. Num. _____

❑ Married ❑ Single ❑ Domestic Partner ❑ Other: _____

Spouse/Partner _____ Phone _____

Occupation _____ Work Phone _____

Emergency Contact _____ Relation _____

Phone _____

Doctor _____ Phone _____

Type of Doctor: ❑ ObGyn ❑ Family Physician ❑ Other (specify) _____

Insurance Information

Subscriber Name _____ Relation to Patient _____

Subscriber SSN _____ Subscriber Date of Birth _____

Subscriber Employer _____ Employer Phone Number _____

Insurance Company _____ Phone _____

Insurance Billing Address _____

ID/Subscriber Number _____ Group Or Plan # _____

Additional Insurance Information (if applicable)

Subscriber Name _____ Relationship to Patient _____

Subscriber Soc. Sec. Num. _____ Subscriber Date of Birth _____

Employer _____ Employer Phone Number _____

Name of Insurance Company _____ Phone _____

Insurance Billing Address _____

ID/Subscriber Number _____ Group Or Plan # _____

I hereby authorize the release of necessary information to my attending physician. I hereby authorize the release of information necessary to secure the payment of benefits by my insurance company. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

Patient Signature: _____ Date: _____

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PREGNANCY AND FAMILY HISTORY QUESTIONNAIRE

Although most babies are born healthy, there is a baseline risk for birth defects in every pregnancy. A personal medical and family history is taken to determine if there are any additional risk factors in the pregnancy. Your answers will be reviewed by the genetic counselor/physician and discussed with you during your appointment.

Patient Information

Name: _____

Birth date: _____

Father of the Baby's Information

Name: _____

Birth date: _____

CURRENT PREGNANCY HISTORY

Date of last menstrual period: _____ Current maternal weight (if known):_____

Height_____

The expected date of delivery is _____ and is based on (circle one): last menstrual period, date of conception, fertility treatment, early ultrasound.

Did you have fertility treatment? N ☐ Y ☐ If yes, what type? _____

Did you use donor eggs? N ☐ Y ☐ If yes, age of donor? _____

During this Pregnancy, have you had or used any of the following?

Alcohol	N ☐	Y ☐	Bleeding or spotting	N ☐	Y ☐
Cigarettes	N ☐	Y ☐	High Fever (more than 101)	N ☐	Y ☐
Recreational Drugs	N ☐	Y ☐	Infections/Rashes	N ☐	Y ☐
X-rays	N ☐	Y ☐	Other concerns?	N ☐	Y ☐
Seizures	N ☐	Y ☐			

If yes**,** please explain: _____

Please list all medications you have taken since becoming pregnant: _____

What medications do you take now? _____

Are you currently experiencing any complications? _____

Have you had any genetic screening in this pregnancy: First trimester (<14wks) or second trimester (14 wks or more) screen? If so, when was testing performed? _____

During this pregnancy, have you had any ultrasounds prior to today?

_____

What is your understanding of the purpose of today's appointment? _____

PREGNANCY HISTORY

No.	Year	Miscarriage	Abortion	Ectopic	Delivery Mode (if c-section, reason)	Weeks	Sex	Weight

Did you experience any complications in any of your previous pregnancies such as gestational diabetes, high blood pressure, premature labor, incompetent cervix, or birth defects? If yes, please explain: _____

_____

_____

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MEDICAL HISTORY

If yes, please explain:

Do you have diabetes?	☐ N	☐ Y	_____
Are you treated for epilepsy (seizures)?	☐ N	☐ Y	_____
Do you have high blood pressure or heart problems?	☐ N	☐ Y	_____
Do you have thyroid disease?	☐ N	☐ Y	_____
Do you have any allergies to medication, latex or foods?	☐ N	☐ Y	_____
Have you had any surgeries?	☐ N	☐ Y	_____

FAMILY HISTORY

Are you adopted?	☐ N	☐ Y
Is the father of the baby adopted?	☐ N	☐ Y
Are you and the father of the baby related by blood to each other (i.e. cousins)?	☐ N	☐ Y
Does the father of the baby have any health concerns?	☐ N	☐ Y

Is there any personal or family history of the following conditions in your family or the father of the baby's family? (Please consider siblings, nieces, nephews, parents, aunts, uncles, first cousins and grandparents)

	Personal		Family			Personal		Family	
Autism	☐N	☐Y	☐ N	☐Y	Seizures or epilepsy	☐ N	☐Y	☐ N	☐Y
Mental retardation	☐N	☐Y	☐ N	☐Y	Blindness at a young age	☐ N	☐Y	☐ N	☐Y
Fragile X syndrome	☐N	☐Y	☐ N	☐Y	Hearing loss at a young age	☐ N	☐Y	☐ N	☐Y
Down syndrome (Trisomy 21)	☐N	☐Y	☐ N	☐Y	Bleeding/clotting disorders	☐ N	☐Y	☐ N	☐Y
Other chromosome abnormalities	☐N	☐Y	☐ N	☐Y	Hydrocephalus	☐ N	☐Y	☐ N	☐Y
Spina bifida/anencephaly	☐N	☐Y	☐ N	☐Y	Three or more miscarriages	☐ N	☐Y	☐ N	☐Y
Heart defect at birth	☐N	☐Y	☐ N	☐Y	Stillbirth	☐ N	☐Y	☐ N	☐Y
Thalassemia	☐N	☐Y	☐ N	☐Y	Infant/Childhood death	☐ N	☐Y	☐ N	☐Y
Cleft lip or palate	☐N	☐Y	☐ N	☐Y	Kidney disease	☐ N	☐Y	☐ N	☐Y
Cystic Fibrosis	☐N	☐Y	☐ N	☐Y	Heart Disease	☐ N	☐Y	☐ N	☐Y
Sickle cell disease	☐N	☐Y	☐ N	☐Y	Cancer diagnosis < 50 years	☐ N	☐Y	☐ N	☐Y
Tay-Sachs disease	☐N	☐Y	☐ N	☐Y	Diabetes	☐ N	☐Y	☐ N	☐Y
Dwarfism	☐N	☐Y	☐ N	☐Y	Hypertension	☐ N	☐Y	☐ N	☐Y
Muscular dystrophy	☐N	☐Y	☐ N	☐Y	Other	☐ N	☐Y	☐ N	☐Y

If yes, please explain: _____

Do you have any family history of hereditary diseases or genetic conditions other than those above? _____

_____

Other concerns? _____

_____

ANCESTRY

In every population, certain hereditary conditions occur more frequently than in others. In some cases, testing is available to determine if a couple is at an increased risk to have a child with certain conditions. Please indicate your ethnic background below.

Patient Ancestry:

European American (Caucasian)	☐
African American/ Black	☐
Hispanic	☐
French Canadian, Cajun	☐
Jewish	☐
Italian, Greek, Middle Eastern	☐
Asian, Indian, Central Asian	☐
Native American	☐

Other _____

Patient signature: _____

Date: _____

Father of the Baby's Ancestry:

European American (Caucasian)	☐
African American/ Black	☐
Hispanic	☐
French Canadian, Cajun	☐
Jewish	☐
Italian, Greek, Middle Eastern	☐
Asian, Indian, Central Asian	☐
Native American	☐

Other _____

Reviewed By: _____

Date: _____

Valley Perinatal™

TO OUR PATIENTS:

Our primary goal is to provide our patients with the highest quality of care in a reassuring, professional and caring environment. We also need to respectfully collect payment for VPS services to able to continue to provide the same excellent care to each and every patient. In collecting payments due, we strive to inform our patients of any financial obligations and provide available payment options.

The following is an explanation of the Valley Perinatal Service policies regarding payment for services provided to you.

- You are responsible for payment of all services provided by Valley Perinatal Services. An estimate of your charges will be provided prior to your scheduled appointment. However additional services may be provided during your visit that may not be included in your estimate.

- If you do not have insurance coverage for our services, you will be required to pay for your office visits and procedures at the time-of-service.

- If you have an application with AHCCCS pending approval as a courtesy we will defer your billing until a determination of your status has been received. However if coverage is not active within 30 days of your initial appointment all charges will be your responsibility and any future appointments will require payment at time of service.

- If you are insured, there may be an insurance co-pay, deductible or co-insurance due at time – of-service. VPS will submit our services to your insurance company for payment; you are responsible for the balance of the account and any portion not paid by your insurance. Please notify us of any changes in your insurance plan or coverage as soon as possible to help in receiving payments from your insurance provider.

- There are many insurance plans, some with limitations and riders specific to you. It is your responsibility to check with your insurance provider to ensure that our services will be covered. If you are out-of-network different co-pays and deductibles will apply.

- Statement balances are due upon receipt. A $10.00 late fee will be added to your account if the balance is not paid within 30 days. A $50.00 late fee will be added to your account if the balance is not paid within 60 days. In the event your account is sent to an outside collection agency, an additional fee of 35% of the total balance will be added to your account.

- Statement balances over 90 days past due will be sent to an outside collection agency and subject to an additional collection fee and legal action may be pursued. If your account is sent to collections, further services by Valley Perinatal Service will require approval of a VPS Provider.

- In the event an overpayment has been made on the account, a full audit will be completed. A refund will be issued 90 days after all claims have been processed by the payor. If you are a co-managed obstetrical care patient, a refund will be issued after delivery.

- For your convenience, we can keep your credit and/or debit card on file and after insurance processes we can run any outstanding balance on your card.

- If you receive a statement from us and have any questions, please contact a member of our billing team at (480) 467-2175.

Continued…….

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Appointment Information:

- VPS will make best efforts to remind all patients 24-48 hours in advance of their appointment. **If you are unable to keep an appointment you must call our office at least 24hrs in advance during regular office hours to avoid a $100.00 missed appointment fee.** Provider approval to schedule another appointment is required for all patients who miss a scheduled appointment.

Request Medical Records:

- There is a $50.00 charge to provide a personal copy of your medical records. Please allow 14 business days for medical records to be copied. VPS will charge $50.00 to provide a copy of the ultrasound images for copy requests advanced after the date of service.

ACCEPTANCE OF TERMS

I certify that I have read and fully understand the policies of Valley Perinatal Services. I realize that I am responsible for my charges and any additional charges and legal fees assessed to my account resulting from VPS actions to collect on overdue balances.

Signature (patient or legally responsible party) Date

ASSIGNMENT OF BENEFITS

I authorize Valley Perinatal Services to bill my insurance company and to receive payments on my behalf from them. I authorize the physician to release information required for filing the necessary insurance claim forms.

Signature of legally responsible party Date

WAIVER OF ASSIGNMENT OF BENEFITS

I understand by not signing the above assignment of benefits, I will be responsible for 100% of all charges incurred at the time of service.

Signature of legally responsible party Date

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Patient Consent— OB

- Prenatal ultrasound is a powerful method of evaluating the unborn fetus. The vast majority of birth defects occur in patients without a family history or other known risk factors. By undergoing this ultrasound, I understand that it is likely to be reassuring and confirm normal development, but also understand that birth defects may occasionally be detected.

- Certain "marker" ultrasound findings may also be seen in the minority of normal fetuses. While some of these findings may slightly increase the risk of Down syndrome or other birth defects, they are usually not important in which case they may cause needless anxiety.

- VPS has physicians who are international experts in obstetric ultrasound and fetal birth defects. They continue to conduct clinical research to further improve the accuracy of diagnostic methods. I acknowledge my willingness to participate in clinical research as long as all patient information is anonymous (my name will not be given to others).

- For quality control and ongoing clinical research, I agree that I or my physician's office can be contacted at a later date to determine the outcome of this pregnancy.
- Correlation with blood tests or other information may be helpful in interpreting the ultrasound. I give consent to my physician or laboratories to release all information that may assist in interpretation of my ultrasound.

- An obstetric ultrasound often requires ancillary ultrasound methods including, but not limited to, 3D ultrasound, transvaginal scans, and Doppler studies. I understand these ancillary exams will result in additional charges to the insurance company. Blood tests and consulting fees may also apply when indicated.

SIGNATURE _____ DATE _____

Valley Perinatal™

NOTICE OF PRIVACY PRACTICES (NPP)

Effective Date: March 2013
Revised Date: Dec 2014

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Valley Perinatal Services respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations:
For treatment:

- We may use or disclose your PHI to provide you treatment or services, and to manage and coordinate your medical care. For example Information obtained by a technologist, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may your PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.
- If you have paid out of pocket out of pocket in full for your services, you have the right to ask that your PHI with respect to that service not be disclosed to a health plan for purposes of payment or health care operations.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan;
  - accounting, legal, risk management, and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights
The health and billing records we create and store are the property of the practice. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not requires to grant the request, but we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. If your PHI is maintained in an electronic format you may request that an electronic copy of your record be given to you. You may make this request in writing.
- Have us review a denial of access to your health information-except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Be notified upon a breach of any of your unsecured PHI.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released.
- It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- For help with these rights during normal business hours, please contact: Valley Perinatal Services, Privacy Officer, 480-756-6000.

Continued ….

Valley Perinatal™

Our Responsibilities
We are required to:
- Keep your protected health information private
- Give you this notice
- Follow the terms of this notice

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

Questions or Concerns
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Officer at 480-756-6000.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Privacy Officer at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.
We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Notification of Family and Others
- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to assist in disaster relief efforts.
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:
- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **With Medical Researchers**. If the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA**) relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law**:
  - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public
  - to public health or legal authorities
  - to protect public health and safety
  - to prevent or control disease, injury, or disability
  - to report vital statistics such as births or deaths
- **To Report Suspected Abuse or Neglect** to public authorities
- **To Correctional Institutions** if you are in jail or prison, as necessary to your health and the health and safety of others.
- **For Law Enforcement** Purposes such as when we receive a subpoena, court order, or other legal process, or you are a victim of a crime
- **For Health and Safety Oversight Activities**. For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks on a job site.
- **To The Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may share information for national security purposes.
- **Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

Other Uses and Disclosures of Protected Health Information
- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

We have a website that provides information about us at: www.valleyperinatal.com.
By signing, you acknowledge that we have provided you with this form of our privacy practices.

_____ _____

Patient's Name Date

Valley Perinatal™

By signing below, I acknowledge that I have been provided with a copy of the Valley Perinatal Services Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Valley Perinatal Services and how I my obtain access and control this information.

_____ _____

Signature of Patient or Guardian Date

_____

Print Patient name or Guardian

_____

Description of Guardian

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1._____

2._____

3._____

Preferred method of contact for test results:

Home#_____ May we leave a message? ☐ YES ☐ NO

Cell#_____ May we leave a message? ☐ YES ☐ NO

Work#_____ May we leave a message? ☐ YES ☐ NO

Email#_____ May we leave a message? ☐ YES ☐ NO