



Maternal-Fetal Diagnosis & Therapy
 BANNIE L. TABOR, M.D., F.A.C.O.G.
 Corporate Medical Director
 THOMAS E. HOWARD, MD., F.A.C.O.G.
 ROYLAND P. ROBINSON, M.D.
 BRAD D. THIGPEN, D.O.

Genetic Counselors.
 MELANIE M. McNAUGHTON, M.S., C.G.C.
 YVONNE L. HULSEBOS, M.S., C.G.C.

We would like to take this opportunity to welcome you as a patient to Obstetrix Medical Group of Texas. As a practice specializing in the field of Maternal-Fetal Medicine (the care of women with an increased risk for complications during pregnancy and/or childbirth), we are dedicated to providing the best possible care available for you and your baby. As a patient-focused practice, our specialists will evaluate your medical condition and provide you and your doctor with prompt, personal attention, coupled with the benefits of our advanced training and experience in the field of Maternal-Fetal Medicine. To access our services, your obstetrician must refer you. We do not provide primary care maternity services unless your obstetrician has specifically transferred your care to us. It is understood that all consultations and second opinions will be discussed with your obstetrician.

If you are scheduled to see a genetic counselor, your physician's appointment will follow your counseling session. We will try to see you as soon as time permits following your counseling appointment. Often the counseling appointment will be 45-60 minutes in length. **In many maternal-fetal medicine offices emergencies do arise and abnormalities are detected when a patient is examined. This can alter the amount of time the physician or counselor spends with you. We feel certain if you were the person that had a problem you would want the physician and/or counselor to spend more time with you. We ask that you be understanding of those ahead of you. We will do our best to see you on time.** We encourage you to bring reading material, sewing or something to help pass the time you spend with us.

If you are being referred to our practice because of an abnormal laboratory test, please ensure that your referring physician's office has sent us all appropriate laboratory data prior to your appointment. This includes a copy of your blood type, CBC, triple screen, or sonogram reports, and a copy of your prenatal records. We will not be able to see you without this information.

We have enclosed several forms that you need to complete before you can be seen by one of our physicians or genetic counselors. **You will need to bring these completed forms, and your insurance card with you on the day of your appointment.** If your Medicaid is pending, please bring verification from the Medicaid office that you have applied for Medicaid.

If you are a member of an insurance plan that requires a referral, you will need to bring your referral form with you at the time of your appointment. If you are unsure if a referral is required, please check with your insurance company prior to your appointment. Our physicians are considered "sub-specialists", not OB-Gyn physicians; therefore you should let your insurance company know this information as they may require a special referral to a sub-specialist. Most insurance companies will not permit you to "self-refer" to a sub-specialist.

You will be asked to pay your co-payment at the time of your appointment. If you have any questions about your insurance coverage, please contact your insurance representative or your referring physician. **You should check with your insurance company to verify that our physicians and/or the hospital are providers for your insurance plan.** Your insurance company should be able to estimate your out of network benefits if we are not providers, or if the hospital is not a provider and you are being seen in an outpatient hospital setting. **It is your responsibility to be sure that you are covered by your insurance plan where ever you are being seen and that your referral/authorization is in place if required.** We also have staff members available to help answer any insurance questions. Insurance verification is not a guarantee of payment by your insurance company.

If your insurance is an 80/20 policy with a deductible, you will be asked to pay your deductible and 20% of your charges at the time of service. Although you may have paid your obstetrician money towards your deductible, our charges will be filed first with your insurance company and your deductible will be met through our office. If this is the case, you will be asked to pay your deductible at the time our service is provided.

If you do not have any medical insurance coverage, you will be asked to pay your bill in full at the time of service. Our office accepts cash, check, money orders, MasterCard, VISA, Discover and American Express.

The Antenatal Assessment Center at Harris Methodist Fort Worth Hospital is billed as "outpatient hospital" and therefore your co-pay and deductible may be different than a routine doctor's office visit. This facility will bill your insurance and/or you for services. This charge will be your responsibility. Be sure your insurance company allows you to be seen at this facility.

over



PATIENT REGISTRATION FORM

Account # _____

GENERAL INFORMATION

PATIENT INFORMATION

How well do you speak English? ___ Very Well ___ Well ___ Not Well ___ Not At All

Name (First, M.I., Last): _____ DOB: ____/____/____

Mailing Address: _____ Apt #: _____ Cell #: () _____

City, State, Zip Code: _____ Phone #: () _____

Social Security # ____/____/____ Marital Status: (Please circle) Single Married Divorced Widowed

Patient's Employer: _____ Work #: () _____

SPOUSE/GUARDIAN INFORMATION

Name: _____ DOB: ____/____/____

Social Security # ____/____/____ Relationship to Patient: _____

Employer: _____ Work #: () _____

Nearest relative NOT at your address: _____

Street Address, City, State, Zip: _____

Phone #: () _____ Relationship to patient: _____

REFERRING PHYSICIAN INFORMATION

Dr.'s Name:(First) _____ (Last) _____ Specialty:(i.e. OBGYN/PCP) _____

Street Address, City, State, Zip: _____

Phone #: () _____ Fax #: () _____

INSURANCE INFORMATION

Primary Insurance Information

Name of Company: _____ HMO___ PPO___ POS___ EPO___ OTHER___

Insurance Company Telephone Number: () _____ Effective date: _____

Insured: _____ DOB: _____ Relationship to Patient: _____

Insured ID #: _____ Group #: _____

Insured Place of Employment: _____

Insured Business Telephone Number: () _____

Secondary Insurance Information

Name of Company: _____ HMO___ PPO___ POS___ EPO___ OTHER___

Insurance Company Telephone Number: () _____ Effective date: _____

Insured: _____ Relationship to Patient: _____

Insured ID #: _____ Group #: _____

Insured Place of Employment: _____

Insured Business Telephone Number: () _____

PATIENT RESPONSIBILITY

I authorize the release of any medical records or other information necessary to process my insurance claims on my behalf. I authorize Obstetrix Medical Group of Texas to appeal all insurance claims as appropriate on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services whether or not covered by insurance.

SIGNATURE: _____ DATE: _____

LABORATORY CHARGES ARE BILLED SEPARATELY BY THE LAB. It is your responsibility to ensure that the lab has all necessary information for billing. We will provide the lab with your initial insurance information and verify which laboratory your insurance company is contracted with for processing laboratory specimens. If your insurance changes, it is your responsibility to notify us immediately of any change so that our records reflect the correct insurance information for processing your bills and ensuring that your laboratory specimens are sent to the correct laboratory.

At Obstetrix Medical Group of Texas we all love children and have devoted our careers to building healthy families beginning in the early stages of pregnancy. We are committed to providing the finest medical care in a warm and supportive environment. Many of our patients are in the midst of a complicated pregnancy, including some with life-threatening conditions. These women and their families have a justifiably high level of concern and anxiety. Our waiting area is designed for the patients we serve. It is not set up with resources for children. Your sonogram involves detailed high-level medical imaging. It requires concentration and meticulous attention to detail by both the sonographer and the doctor. In many cases, the ultrasound exam can require a lengthy amount of time. The ultrasound is shown in black and white images and frankly, for children, this is a boring experience that rarely maintains their attention. Therefore, we ask that you take these factors into account when considering bringing children with you to your appointment. If you chose to bring your child(ren) please be sure there is another adult, not a sibling, to watch your child(ren) during your screening. We do not have the staff to provide babysitters. Also please be sure your child(ren) do not have any contagious childhood diseases (measles, mumps, parvo virus, TB, etc.). Many childhood diseases can be extremely dangerous to pregnant women. We also ask that you turn your cell phone and pager off during counseling and in the exam rooms, as these can be very disruptive.

On occasion, with today's busy modern telephone technology, our telephones may become disconnected from our answering service. We have policies in place to try to prevent this from happening. If you call our office after hours due to an emergency, and do not reach our answering service, please go to Harris Methodist Fort Worth Hospital.

Brief directions are listed below to the Harris Office, Suite 600, Antenatal Assessment, and Harris Southwest Office. Due to the construction in different areas of Fort Worth and especially the Hospital District area, these directions may not always be accurate.

The **Fort Worth Office** is located in the Harris Center across the street from Harris Methodist Fort Worth Hospital at 1325 Pennsylvania Avenue, Suite 600. If you are traveling west on I-30, exit Summit/8th Avenue and turn left on Summit/8th. Turn left on Pennsylvania Avenue. Right on 6th Avenue, left on Pruitt. The parking garage is on the left side of the street next to the loading dock. Our office is connected to the parking garage. Take the elevator to the ground level (G), walk through the lobby and get on the elevators (Professional Building elevators). Take the elevators to the 6th floor. Our office is located in **Suite 600**.

If you are traveling east on I-30, exit Summit/8th Avenue and turn right on 8th Avenue (Summit), left on Pennsylvania Avenue, right on 6th Avenue and left on Pruitt. The parking garage is on the left side of the street next to the loading dock. Our office is connected to the parking garage. Take the elevator to the ground level (G), walk through the lobby around and get on the elevators (Professional Building elevators). Take the elevators to the 6th floor. Our office is located in **Suite 600**.

The Harris Southwest Office is located in the Harris Plaza at the north end of Harris Methodist Southwest Hospital, 6100 Harris Parkway, Suite 295. From 820/I-20 exit Bryant Irvin Road, turn south on Bryant Irvin Rd, turn left on Oakmont Blvd (east), turn right on Harris Parkway (south). Take the first right and follow the signs to Harris Plaza North. Our office is located on the 2nd floor of Harris Plaza, Suite 295.

From I-35 South take I-20 west towards Abilene and follow the directions above.

Antenatal Assessment Center (AAC), Harris Methodist Fort Worth Hospital is located directly across the street from the Fort Worth Office in Bloxom Tower, 1301 Pennsylvania Avenue. Follow the directions above to the Harris Office. Once you have parked in the garage, walk directly across the street and into the main hospital, next to valet parking. Follow the signs to **Bloxom Tower**. Entrance to Bloxom Tower is across from the gift shop. The AAC is on the 1st floor (not the ground level). **You DO NOT need to go to admitting. However, the hospital will bill a facility fee for their services. Services will be billed as "outpatient hospital". Deductibles/co-pays may be different.**

If you need to reschedule your appointment or you have any additional questions, please do not hesitate to contact our office. We will be happy to help you in anyway possible. We look forward to seeing you and making your visit with us a pleasant one.

Sincerely,

The Physicians and Staff of Obstetrix Medical Group of Texas

Bannie L. Tabor, M.D., Corporate Medical Director

Thomas E. Howard, Jr., M.D.

Royland P. Robinson, M.D.

Brad Thigpen, D.O.

Alaine McAfee, RNC, MS

Kim McMillen, BGS, Practice Manager



Our Notice of Privacy Practices (“Notice”) provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulation requires that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to privacy_officer@pediatrix.com or a letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

Signature of Patient or Authorized Representative

Date

Print Name of Patient

Print Name of Authorized Representative

**NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM**

Obstetrix Medical Group of Texas

Obstetrix Medical Group of Texas



OUR FINANCIAL POLICY: Our physicians and staff are very concerned about the cost of your health care and want to address some issues related to the cost of medical services in our office. Considerable care has been taken in setting our fees. We want to assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

HMO and PPO MEMBERS: If you are a member of an HMO or PPO in which we participate, your deductible or co-payment is required at the time of service. Sonograms may have a different co-payment than routine visits. You are responsible to see that we have a current referral on file if your insurance carrier requires one. If we do not have this referral at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to see your Primary Care Physician prior to being treated to obtain a current referral.

If you are not sure that our physicians are providers for your PPO, call your insurance carrier for clarification.

NEW INSURANCE / CHANGE OF INSURANCE: Should your insurance change at anytime during your pregnancy it is your responsibility to notify us in writing within 10 working days of this change. We have to have this information in order to file your claim with the correct carrier before the insurance company's filing deadline.

FEE FOR SERVICE: Our policy requires payment of your deductible and/or coinsurance at the time of service.

Our agreement is with you, not your insurance company. Although we will assist you in submitting your claim to your insurance carrier, you are ultimately responsible for the service you receive. Payment to our office is neither contingent nor dependent upon your insurance carrier.

We are pleased to accept MasterCard, Visa, Discover, American Express, checks, cash, money orders or traveler's checks.

MEDICARE: We are participating providers for Medicare. Please present your Medicare card at your visit. Patients are responsible for 20% of the amount that Medicare allows. If you have a supplemental insurance, we will submit a claim for you.

MEDICAID: We are Medicaid providers. Please present your Medicaid letter of eligibility at each of your visits.

FULL CARE OBSTETRICAL PATIENTS: It is our policy that the coinsurance or co-payment for which you are responsible as a full care obstetrical patient be paid in full by your 28th week (7th month) of pregnancy. A billing person will discuss the amount owed with you either in writing or in person.

AMNIOCENTESIS, CHORIOINIC VILLUS SAMPLING AND OTHER SPECIALIZED TESTING: Our office will charge you for the services we provide. You will receive a separate bill from the laboratory that processes the test. Our office will be happy to provide you with an approximation of the laboratory charges.

If you have any questions regarding our financial policy or your insurance reimbursement, please feel free to discuss them with our billing office or the office manager.

I have read and understand my financial responsibilities under this policy of Obstetrix Medical Group of Texas.

Signature of Patient

Date



Patient Name: _____ DOB: _____

Social Security Number: _____ Today's Date: _____

Obstetric History Questionnaire

Are you currently pregnant? Yes No

What was the first day of your last menstrual period: _____

What is your due date: _____ What is your blood type? _____

Are there any problems with your current pregnancy:

Prior Pregnancies:

- _____ Number of total pregnancies
- _____ Number of pregnancies carried to full term (40 weeks)
- _____ Number of pregnancies delivered prematurely
- _____ Number of pregnancies continued past 4 ½ months (20 weeks)
- _____ Number of miscarriages (spontaneous)
- _____ Number of tubal pregnancies (ectopic pregnancies)
- _____ Number of voluntary abortions
- _____ Number of multiple births
- _____ Number of living children

Fill information in table below for each pregnancy (living or deceased) start with your first one:

Year	Weeks (Full term = 40 wks.)	Labor Length	Birth Wt LB. / OZ.	Sex	Type Of Delivery (Vaginal or Cesarean Section)	Anesthesia	Place

Comments: _____

Have you had a sonogram / ultrasound during the current pregnancy? Yes No

Do you wish to know the sex of the baby? Yes No

Genetic / Family History Questionnaire

How would you describe your ancestry (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Caucasian (White) | <input type="checkbox"/> French Canadian | <input type="checkbox"/> Asian |
| <input type="checkbox"/> African (Black) | <input type="checkbox"/> Native American | <input type="checkbox"/> Asian-East Indian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Other Southeast Asian |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Unknown Race |
| <input type="checkbox"/> Cajun | | <input type="checkbox"/> Other |

Are you and the father of this baby blood relatives (example: cousins)? Yes No

What is your occupation? _____

What is the name of the father of this baby? _____

What is the occupation of the father of this baby? _____

What is the age of the father of this baby? _____

How would you describe the ancestry of the father of this baby (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Caucasian (White) | <input type="checkbox"/> French Canadian | <input type="checkbox"/> Asian |
| <input type="checkbox"/> African (Black) | <input type="checkbox"/> Native American | <input type="checkbox"/> Asian-East Indian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Other Southeast Asian |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Unknown Race |
| <input type="checkbox"/> Cajun | | <input type="checkbox"/> Other |

Is the father of this baby your partner? Yes No

Comments: _____

Do you, the father of this baby, or any close relatives have:

If yes, please specify which relative.....

- | | | |
|--|------------------------------|-----------------------------|
| 1. Thalassemia MCV < 80 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Neural Tube Defect (Spina Bifida, or Anencephaly) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Congenital Heart Defect | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Down Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

5. Tay-Sachs Yes No
6. Sickle Cell Disease or Trait Yes No
7. Hemophilia or Bleeding Problems (Type: _____) Yes No
8. Muscular Dystrophy (Type: _____) Yes No
9. Cystic Fibrosis Yes No
10. Canavan Disease Yes No
11. Mental Retardation / Autism / Learning Disorder Yes No
- If Yes: Tested for Fragile X Yes No
12. Huntington Chorea Yes No
13. Other Inherited Genetic or Chromosomal Disorder (Type: _____) Yes No
14. Maternal Metabolic Disorder (i.e. Insulin-Dependent Diabetes, PKU)
(Type: _____) Yes No
15. Patient or Baby's Father Had a Child With Birth Defects Not Listed Above
(Type: _____) Yes No
16. Recurrent Pregnancy Loss, or Stillbirth Yes No
17. Blindness or Deafness Yes No
18. Bone or Skeletal Disorder (Dwarfism) (Type: _____) Yes No
19. Breast, Ovarian or Colon Cancer Yes No
20. Kidney Disorder (Type: _____) Yes No
21. Diabetes Yes No
22. Blood Clots or Stroke Yes No
23. Have you taken any medications other than PN vitamins since becoming pregnant Yes No
- If Yes, what type: _____
24. Have you used any street drugs since becoming pregnant Yes No
- If Yes, what type: _____
25. Have you consumed any alcoholic beverages since becoming pregnant Yes No
- If Yes, how much and how often: _____
26. Any Other Illnesses: (Type: _____) Yes No
27. Anything else that seems to run in the family (Type: _____) Yes No

Comments:

Have you had exposure to:

- Sauna Yes No Cat Litter Yes No X-rays Yes No
- Hot tub Yes No Chemicals Yes No Fever / Infections / Rashes Yes No
- Electric blanket Yes No Do you smoke? Yes No

Review Of Systems Questionnaire

Do you or have you taken any medication in the last year:

Medications Taken	Date Taken

Do you have any known allergies:

Are you allergic to any drugs / medications? Specify

Do you have or have you had any of the following conditions:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Fever
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Vision Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Hearing Loss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Ear Infections (Other Than Childhood)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Sinus Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Repeated Nosebleeds
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Long Term Sore Throat
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Pneumonia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Asthma
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Close Contact With Person(s) With Tuberculosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Tuberculosis Vaccine (BCC)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Positive Tuberculosis Skin Test
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Cough
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Shortness Of Breath
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Other Lung Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Heart Murmur
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Mitral Valve Prolapse
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Other Heart Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	High Blood Pressure in Pregnancy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	High Blood Pressure, Other
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Raynaud's Disease, Raynaud's Phenomenon
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Poor Blood Circulation
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Severe Nausea And Vomiting In Pregnancy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Severe Nausea And Vomiting Before Pregnancy

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Intestinal Problems (Irritable Colon, Crohn's Disease, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Recurring Diarrhea
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Constipation Problem
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Heartburn, Reflux
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Hepatitis, Yellow Jaundice
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Liver Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Bladder or Kidney Infections
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Kidney Stones
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Problems With Urine
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Menstrual Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Infertility, Difficulty Getting Pregnant
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Vaginal Infections
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Herpes Or A Partner With Herpes
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Sexually Transmitted Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Pelvic Inflammatory Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Gonorrhea
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Chlamydia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Syphilis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Genital Warts
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	HIV Infection, AIDS Or A Partner With HIV / AIDS
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Abnormal Pap Smears
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Diabetes (High Blood Sugar)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Thyroid Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Other Hormone Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Epilepsy, Seizure Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Drowsiness
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Migraine / Cluster Headaches
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Other Recurring Headaches
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Depression
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Panic Attack Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Mood Disorder / Psychiatric / Emotional Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Skin Problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Unexplained Hair Loss
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Arthritis / Joint Pains
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Lupus
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Rheumatic Fever
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Blood Transfusions
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Bleeding Tendency
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Blood Clots, Thrombophlebitis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Rh Sensitized

Reviewed By: _____
Provider Name



Authorization for Verbal Release of Protected Health Information

STANDARD DISCLOSURE

I authorize Obstetrix Medical Group of Texas to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse, as well as, confirmation of any appointments for me to be seen in the office, hospital or at another physicians office.

- Spouse** _____
- Children** _____
- Parent(s)** _____
- Other** _____

NO INFORMATION

I do not authorize release of any information concerning my treatment. I understand that this includes confirmation of appointment dates, times and location.

This authorization will expire at the end of my treatment with Obstetrix Medical Group of Texas unless I revoke the consent prior to that time.

Signature of Patient

Date

Witness
2/21/2005

Date



IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION

What is Ultrasound?

Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta and baby, making echoes which a computer converts into detailed images. In essence, an ultrasound exam is a series of pictures of the baby and organs in the mother’s pelvis.

Is Ultrasound safe?

There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either the mother or the baby when ordinary power and frequency is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

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

Ultrasound examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the baby and the baby’s organs but does not give complete information about the function of the baby’s organs or tell us that the baby is completely “healthy.” Abnormalities of brain function such as mental retardation cannot be detected by ultrasound. Additionally, there are many conditions that evolve over time, appearing normal at the time of the ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities or those abnormalities that can appear later in the pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal.

Can Ultrasound determine if there are chromosomal abnormalities?

Findings on an ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently, the only way to assess the baby’s chromosomes with certainty is to actually obtain a sample of the baby’s cells by amniocentesis, chorionic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities, either because of the mother’s age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby’s chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasound, please do not hesitate to ask the ultrasound technologist, perinatologist or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

Patient/Guardian signature

Date

Printed Name

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IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION

What is Ultrasound?

Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta and baby, making echoes which a computer converts into detailed images. In essence, an ultrasound exam is a series of pictures of the baby and organs in the mother's pelvis.

Is Ultrasound safe?

There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either the mother or the baby when ordinary power and frequency is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

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

Ultrasound examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the baby and the baby's organs but does not give complete information about the function of the baby's organs or tell us that the baby is completely "healthy." Abnormalities of brain function such as mental retardation cannot be detected by ultrasound. Additionally, there are many conditions that evolve over time, appearing normal at the time of the ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities or those abnormalities that can appear later in the pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal.

Can Ultrasound determine if there are chromosomal abnormalities?

Findings on an ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently, the only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cells by amniocentesis, chorionic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities, either because of the mother's age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby's chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasound, please do not hesitate to ask the ultrasound technologist, perinatologist or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

Patient/Guardian signature

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