OBSTETRIX MEDICAL GROUP

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

13. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

14. Law Enforcement. We may release your PHI if asked to do so by a law-enforcement official:

a. In response to a court order, subpoena, warrant, summons or similar process;
b. To identify or locate a suspect, fugitive, material witness, or missing person;
c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
d. About a death we believe may be the result of criminal conduct;
e. About criminal conduct at the hospital or in our offices; or
f. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

15. Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

16. National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

17. Protective Services for the President and Others. We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

18. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release may be necessary for a number of reasons, such as:

a. For the institution to provide you with health care;
b. To protect your health and safety or the health and safety of others; or
c. For the safety and security of the correctional institution.

D. All Other Uses and Disclosures Require Your Prior Written Authorization.

In any situation not described in sections III.A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (but only to the extent that we haven't already taken any action relying on the authorization).

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Receive a Copy of this Notice. You have a right to obtain a copy of this Notice in paper form, even if you have received a copy electronically.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or permitted to make without your authorization (which are generally described in sections III.C(4) through (18) above. However, unless the purpose of the disclosure relates to your treatment, when you pay out-of-pocket in full for a treatment and request a restriction in writing, we must comply with your request that we not disclose your PHI to a health plan. To request restrictions, you must make your request in writing to the person listed in Section VI below.

C. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (e.g., your work address rather than your home address) or by alternate means, such as electronic mail ("e-mail") instead of regular mail. Your request must be in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

D. The Right to Review and Get A Copy of Your PHI. In most cases, you have the right to review and get a copy (or electronic version if available) of your PHI that we have, but you must make the request in writing. If we don't have your PHI, but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request, unless we need additional time (up to 30 days more) to respond. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

E. The Right to Get a List of the Disclosures We Have Made.

1. You have the right to get from us or our business associates a list of certain instances in which we or our business associates have disclosed your PHI. If the services were provided by our business associates, we may identify the business associate and the business associate will provide the disclosures for you. The list will not include uses or disclosures to carry out treatment, payment, or health care operations or disclosures directly to or authorized by you. The list also won't include uses and disclosures that are incidental to a permitted use or disclosure, that are part of the limited data set we maintain for research and quality improvement purposes, that are made for national security purposes, to corrections or law enforcement personnel, or that were made before April 14, 2003.

2. We or our business associates will respond within 60 days of receiving your written request, unless we need additional time (up to 30 days more) to respond. The list we give you will include disclosures made during the time period you specify, provided, however, that the time period may not be longer than six (6) years and may not include dates before April 14, 2003. The list will indicate the date of the disclosure, to who PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same twelve (12) month period, we may charge you for the costs of providing the additional list(s). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

F. The Right to Correct or Update Your PHI.

1. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing.

2. We will respond to you within 60 days of receiving your request, unless we need additional time (up to 30 days more) to respond. We may deny your request in writing if the PHI:

a. Is accurate and complete;
b. Was not created by us;
c. Is information that we are not required to provide access to;
or
d. Is not part of our records.

3. Any written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

G. The Right to Receive Notice of a Breach of Unsecured PHI.

1. In certain circumstances you have a right to receive notice of a breach of unsecured PHI.

2. In the case of a breach of unsecured PHI, as defined under HIPAA, we shall notify you in no later than 60 days of our discovering the breach (or of being notified of the breach by our business associate). The determination that such notifications are required, and the manner in which they are made, shall be in accordance with HIPAA and under the direction of our Privacy Officer.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, you may contact our Privacy Officer: by e-mail at privacy_officer@mednax.com; or by phone at (954) 384-0175; or by writing to: Privacy Officer, MEDNAX Services, Inc., 1301 Concord Terrace, Sunrise, FL 33323.

VII. EFFECTIVE DATE OF THIS NOTICE

The effective date of this notice is February 17, 2010.

OBSTETRIX® MEDICAL GROUP

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 Date of Birth

OBSTETRIX MEDICAL GROUP

Authorization for Verbal Release of Protected Health Information

☐ **STANDARD DISCLOSURE**

I authorize Obstetrix Medical Group of Texas to discuss my medical history, diagnosis, treatment, prognosis, and financial, insurance and billing information 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 appointment for me to be seen in the office, hospital or another physicians office.

☐ Spouse_____

☐ Children_____

☐ Parent(s)_____

☐ Other_____

☐ **NO INFORMATION**

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

I consent and authorize the release of any test results to be left on my voice mail at my

☐ home ☐ cell ☐ work number Phone Number_____

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

_____ _____
Signature of Patient Date

_____ _____
Witness Date

5/13/2010

OBSTETRIX MEDICAL GROUP

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):

☐ Caucasian (White)	☐ French Canadian	☐ Asian
☐ African (Black)	☐ Native American	☐ Asian-East Indian
☐ Hispanic	☐ Mediterranean	☐ Other Southeast Asian
☐ Ashkenazi Jewish	☐ Middle Eastern	☐ Unknown Race
☐ Cajun		☐ 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):

☐ Caucasian (White)	☐ French Canadian	☐ Asian
☐ African (Black)	☐ Native American	☐ Asian-East Indian
☐ Hispanic	☐ Mediterranean	☐ Other Southeast Asian
☐ Ashkenazi Jewish	☐ Middle Eastern	☐ Unknown Race
☐ Cajun		☐ 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	☐ Yes	☐ No
2. Neural Tube Defect (Spina Bifida, or Anencephaly)	☐ Yes	☐ No
3. Congenital Heart Defect	☐ Yes	☐ No
4. Down Syndrome	☐ Yes	☐ 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:

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

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

Reviewed By: _____

Provider Name

Obstetrix Medical Group of Texas

OBSTETRIX®
MEDICAL GROUP

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, CHOROINIC 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

OBSTETRIX
MEDICAL GROUP

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

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 1-30, 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

OBSTETRIX MEDICAL GROUP

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___

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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

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SIGNATURE: _____ DATE: _____

OBSTETRIX
MEDICAL GROUP

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

OBSTETRIX®
MEDICAL GROUP

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, CHOROINIC 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

OBSTETRIX MEDICAL GROUP

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):

☐ Caucasian (White)	☐ French Canadian	☐ Asian
☐ African (Black)	☐ Native American	☐ Asian-East Indian
☐ Hispanic	☐ Mediterranean	☐ Other Southeast Asian
☐ Ashkenazi Jewish	☐ Middle Eastern	☐ Unknown Race
☐ Cajun		☐ 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):

☐ Caucasian (White)	☐ French Canadian	☐ Asian
☐ African (Black)	☐ Native American	☐ Asian-East Indian
☐ Hispanic	☐ Mediterranean	☐ Other Southeast Asian
☐ Ashkenazi Jewish	☐ Middle Eastern	☐ Unknown Race
☐ Cajun		☐ 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	☐ Yes	☐ No
2. Neural Tube Defect (Spina Bifida, or Anencephaly)	☐ Yes	☐ No
3. Congenital Heart Defect	☐ Yes	☐ No
4. Down Syndrome	☐ Yes	☐ 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:

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

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

Reviewed By: _____

Provider Name

OBSTETRIX MEDICAL GROUP

Authorization for Verbal Release of Protected Health Information

☐ **STANDARD DISCLOSURE**

I authorize Obstetrix Medical Group of Texas to discuss my medical history, diagnosis, treatment, prognosis, and financial, insurance and billing information 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 appointment for me to be seen in the office, hospital or another physicians office.

☐ Spouse_____

☐ Children_____

☐ Parent(s)_____

☐ Other_____

☐ **NO INFORMATION**

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

I consent and authorize the release of any test results to be left on my voice mail at my

☐ home ☐ cell ☐ work number Phone Number_____

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

_____ _____
Signature of Patient Date

_____ _____
Witness Date

5/13/2010

OBSTETRIX® MEDICAL GROUP

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 Date of Birth

PEDIATRIX MEDICAL GROUP

PEDIATRIX CARDIOLOGY

OBSTETRIX MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES
Pediatrix Medical Group/Obstetrix Medical Group
and their affiliated entities

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW OUR PATIENTS OR THEIR LEGAL REPRESENTATIVE(S) CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. [The use of the words "you" and "your" in the remainder of this document refer to you and/or your child(ren) under the care of any of our physicians, and your legal representatives.]

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short, and it includes information that can be used to identify you, that we have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy practices at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in our offices. You can also request a copy of this notice from the contact person listed in Section VI below at any time and can view a copy of the notice on our Web Site located at: www.mednax.com /noticeofprivacypractices. When required, we will redistribute the notice.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization, and for others, we do not. The following categories describe different ways that we may use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use and disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose PHI will fall into one of the categories.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

We may use and disclose your PHI for the following reasons:

1. For treatment. We may disclose your PHI to provide you with medical treatment or services. Therefore, we may disclose PHI about you to physicians, nurses, technicians, medical students, and other health care personnel who provide you with health care services or who are involved in your care, such as pharmacists, dieticians, genetic counselors, etc.

2. For payment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and to your health plan to get paid for the health care services we provide to you. We may tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims. However, we may not provide your PHI to your health plan or our billing companies if you self-pay and request a restriction in writing.

3. For health care operations. We may disclose your PHI for our health care operations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care service to you. In order to decide whether or not new treatments are effective, we may combine health information about many patients. We may disclose your PHI to medical students and other health care providers for review and teaching purposes. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

B. Uses and Disclosures for Patient Directories and to Persons Assisting in Your Care.

Generally, we will obtain your verbal agreement before using or disclosing PHI in the following ways. However, in certain circumstances, such as an emergency, we may use and disclose your PHI for these purposes without your agreement.

1. Patient directories. We may include your name, location, general condition, and religious affiliation in a patient directory for use by clergy and visitors who ask for you by name.

2. Disclosures to family, friends or others. We may provide your PHI, including your condition and status, to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that a family member or other person responsible for your care can be notified about your condition, status and location.

C. Certain Other Uses and Disclosures that Do Not Require Your Authorization.

We may use and disclose your PHI without your consent or authorization for the following reasons:

1. Appointment Reminders. We may use and disclose PHI to contact you as a reminder that you have an appointment for tests or treatment.

2. Treatment Alternatives. We may use and disclose PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

3. Health-Related Benefits and Services. We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

4. Research. Under certain circumstances, we may use and disclose your PHI for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. In some cases, research will be conducted through a limited database of PHI that we maintain for research and quality improvement purposes that excludes patient names and other identifying information. All other research projects involving the use of PHI are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with the patients' need for privacy of their PHI. Before we use or disclose PHI for research without your consent, the project will have been approved through this research approval process. We may, however, disclose your PHI to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave our control.

5. As Required By Law. We will disclose your PHI when required to do so by federal, state or local law.

6. To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any such disclosure, however, would be to someone able to help prevent the threat.

7. Organ and Tissue Donation. If you are an organ donor, we may release PHI about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

8. Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

9. Workers' Compensation. We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

10. Public Health Risks. We may disclose PHI about you for public health activities. These activities generally include the following:

a. Preventing or controlling disease, injury or disability;
b. Reporting births and deaths;
c. Reporting child abuse or neglect;
d. Reporting reactions to medications or problems with products;
e. Notifying people of recalls of products they may be using;
f. Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

11. Victims of Abuse, Neglect or Domestic Violence. We may notify the appropriate government authorities if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make such disclosures if you agree or when required or authorized by law.

12. Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

13. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

14. Law Enforcement. We may release your PHI if asked to do so by a law-enforcement official:

a. In response to a court order, subpoena, warrant, summons or similar process;
b. To identify or locate a suspect, fugitive, material witness, or missing person;
c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
d. About a death we believe may be the result of criminal conduct;
e. About criminal conduct at the hospital or in our offices; or
f. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

15. Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

16. National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

17. Protective Services for the President and Others. We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

18. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release may be necessary for a number of reasons, such as:

a. For the institution to provide you with health care;
b. To protect your health and safety or the health and safety of others; or
c. For the safety and security of the correctional institution.

D. All Other Uses and Disclosures Require Your Prior Written Authorization.

In any situation not described in sections III.A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (but only to the extent that we haven't already taken any action relying on the authorization).

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Receive a Copy of this Notice. You have a right to obtain a copy of this Notice in paper form, even if you have received a copy electronically.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or permitted to make without your authorization (which are generally described in sections III.C(4) through (18) above. However, unless the purpose of the disclosure relates to your treatment, when you pay out-of-pocket in full for a treatment and request a restriction in writing, we must comply with your request that we not disclose your PHI to a health plan. To request restrictions, you must make your request in writing to the person listed in Section VI below.

C. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (e.g., your work address rather than your home address) or by alternate means, such as electronic mail ("e-mail") instead of regular mail. Your request must be in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

D. The Right to Review and Get A Copy of Your PHI. In most cases, you have the right to review and get a copy (or electronic version if available) of your PHI that we have, but you must make the request in writing. If we don't have your PHI, but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request, unless we need additional time (up to 30 days more) to respond. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

E. The Right to Get a List of the Disclosures We Have Made.

1. You have the right to get from us or our business associates a list of certain instances in which we or our business associates have disclosed your PHI. If the services were provided by our business associates, we may identify the business associate and the business associate will provide the disclosures for you. The list will not include uses or disclosures to carry out treatment, payment, or health care operations or disclosures directly to or authorized by you. The list also won't include uses and disclosures that are incidental to a permitted use or disclosure, that are part of the limited data set we maintain for research and quality improvement purposes, that are made for national security purposes, to corrections or law enforcement personnel, or that were made before April 14, 2003.

2. We or our business associates will respond within 60 days of receiving your written request, unless we need additional time (up to 30 days more) to respond. The list we give you will include disclosures made during the time period you specify, provided, however, that the time period may not be longer than six (6) years and may not include dates before April 14, 2003. The list will indicate the date of the disclosure, to who PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same twelve (12) month period, we may charge you for the costs of providing the additional list(s). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

F. The Right to Correct or Update Your PHI.

1. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing.

2. We will respond to you within 60 days of receiving your request, unless we need additional time (up to 30 days more) to respond. We may deny your request in writing if the PHI:

a. Is accurate and complete;
b. Was not created by us;
c. Is information that we are not required to provide access to;
or
d. Is not part of our records.

3. Any written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

G. The Right to Receive Notice of a Breach of Unsecured PHI.

1. In certain circumstances you have a right to receive notice of a breach of unsecured PHI.

2. In the case of a breach of unsecured PHI, as defined under HIPAA, we shall notify you in no later than 60 days of our discovering the breach (or of being notified of the breach by our business associate). The determination that such notifications are required, and the manner in which they are made, shall be in accordance with HIPAA and under the direction of our Privacy Officer.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, you may contact our Privacy Officer: by e-mail at privacy_officer@mednax.com; or by phone at (954) 384-0175; or by writing to: Privacy Officer, MEDNAX Services, Inc., 1301 Concord Terrace, Sunrise, FL 33323.

VII. EFFECTIVE DATE OF THIS NOTICE

The effective date of this notice is February 17, 2010.