

Arcadia Well Woman

PATIENT REGISTRATION

(PLEASE PRINT CLEARLY)

NAME _____ SOCIAL SECURITY NO. _____
LAST FIRST MI

DATE OF BIRTH _____ GENDER _____ MARITAL STATUS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE NO. _____ CELL PHONE NO. _____

RACE _____ ETHNICITY _____ LANGUAGE _____

EMAIL (required for online patient portal) _____

PREFERRED PHARMACY NAME _____ PHONE NUMBER _____ CROSS STREETS _____

OCCUPATION _____ PLACE OF EMPLOYMENT _____

MAY WE TEXT MESSAGE YOUR CELL PHONE? YES NO PREFERRED METHOD OF CONTACT: Cell Portal Home

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD DURING REGISTRATION

INS CO _____ CLAIMS ADDRESS ON BACK OF CARD _____

GROUP # OR NAME _____ INSURANCE ID NO. _____

POLICY HOLDER/RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDER ADDRESS _____ SSN _____

PLACE OF EMPLOYMENT _____ DAY PHONE NO. _____ EVENING PHONE NO. _____

DO YOU HAVE SECONDARY INSURANCE? YES NO

SECONDARY INS. CO _____ SECONDARY INS. ADDRESS _____

GROUP # OR NAME _____ INSURANCE ID NO. _____

POLICY HOLDER/RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDER ADDRESS _____ SSN _____

PLACE OF EMPLOYMENT _____ DAY PHONE NO. _____ EVENING NO. _____

Emergency Contact

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ BEST CONTACT NUMBER _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICAN AND TO RELEASE/ACQUIRE INFORMATION: I HEREBE AUTHORIZE RELEASE OF MEDICAL INFORMATION AND DIRECT PAYMENT TO ARCADIA WELL WOMAN FOR SERVICES RENDERED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT. I ALSO AUTHORIZE ARCADIA WELL WOMAN TO ACQUIRE INFORMATION RELATED TO MY MEDICAL AND MEDICATION HISTORY.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

Arcadia Well Woman

Obstetric Intake

Date: _____

Name: _____ DOB: _____ Age: _____

Occupation: _____ Marital Status: _____

Spouse/partner Name: _____ Age: _____

Occupation: _____ phone: _____

Support person: _____ phone: _____

Past Medical History:

Y / N Heart problems _____ Y / N Hypertension _____

Y / N Lung problems _____ Y / N Bladder Problems _____

Y / N Kidney disease _____ Y/N Diabetes _____

Y / N Liver disease _____ Y/N Hepatitis _____

Y / N Bowel disease _____ Y / N Neurologic disease _____

Y / N Breast disease _____ Y / N Thyroid disease _____

Y / N Psychiatric _____

GYN History:

Last Menstrual Period: _____ Monthly periods: Yes / No +Preg test date: _____

Y / N Last pap when? _____ Abnormal pap? Y / N Year: _____ Treatment: _____

Y / N Genital Herpes _____ Y / N Genital Herpes in partner _____

Y / N History of Chlamydia, gonorrhea or trichomonas? _____

Y / N Uterine problem _____ Y / N Ovarian disease _____

Past Surgical History:

Date Type

Pregnancy History:

No.	Year	Weeks	Sex	Vag/C-S	Weight	Complications
1						
2						
3						
4						
5						
6						

Smoker Y / No / Not any more Amount _____ For how long _____

Smoker in home Y / No / Not any more

Alcohol Y / No / Not any more

Drugs Y / No / Not any more List: _____

Prenatal vitamins Y / No Calcium Y / N Omega 3 / DHA Y / N

Current Medications:

Name Dose Indication

Medications prior to pregnancy:

Name Dose Indication

Allergies to drugs: _____

Allergies to other substances: _____

Family History: any of these problems in members of Maternal or Paternal family?

Y / N Congenital Heart Defect _____ Y / N Neural Tube Defect / Spina bifida _____

Y / N Sickle Cell disease _____ Y / N Thalassemia _____

Y / N Down's Syndrome _____ Y / N Cystic Fibrosis _____

Y / N Jewish Ancestry _____ Y / N Muscular Dystrophy _____

Y / N Mental Retardation _____ Y / N Autism _____

Y / N Chromosomal problem _____

Y / N Genetic problem _____

Are there any babies in the family with any birth defects? Y / N _____

Have cats in the home? Y / N _____

Are you safe at home? Y / N _____

Live with someone with: Tuberculosis Y / N

Hepatitis Y / N

HIV Y / N

Do you have any concerns at this time?

FETAL TESTING INFORMATION

Please read this important information carefully.

Birth defects affect 3-4% of all pregnancies. Some, but not all, of the possible birth defects can be discovered by blood tests, ultrasound and genetic testing.

The testing that you decide to perform for your pregnancy is an individual choice based on many factors such as your health, your age, your previous pregnancy experiences and your family's health history.

There are two types of testing for your pregnancy: **screening** and **invasive** testing.

Screening tests have ***no risk*** to the fetus or the mother. Screening tests include blood tests and ultrasound. Screening tests can identify a woman who is at higher risk than expected of having a baby with a birth defect, but cannot detect all of these birth defects (such as spinal cord defects or heart problems).

Invasive tests have a ***very small risk*** to the fetus and an extremely rare risk to the mother. Invasive tests include chorionic villous testing and amniocentesis. Invasive tests obtain tissue or fluid for chromosomal testing.

First trimester screening blood test (10 weeks) for the five most common chromosomal abnormalities. Offered to women > 35 or women with a personal or family history of chromosome birth defects.

First trimester (11-13 weeks) screening blood test and ultrasound. This testing can detect **up to 85%** of Down's Syndrome and **up to 98%** of Trisomy13, Trisomy 18 and Turner's syndrome. This test is done with a specialist.

Second trimester (15-21 weeks) screening tests include a **blood test (MSAFP)** done at 15-21 weeks in our office. This test defines fetal risk for spinal cord defects (neural tube defects), Down's syndrome and Trisomy 18

At 18-20 weeks an **ultrasound** will confirm your baby's growth, your due date and can detect 35% of fetal birth defects, but misses 65% of all birth defects.

First trimester invasive testing is called **chorionic villous sampling (CVS)**. A small catheter is passed through the cervix under ultrasound guidance to obtain a small sample of the placenta which contains the baby's chromosomes. Results take 7-10 days. Risk of miscarriage is 1 in 200.

Second trimester invasive testing is called **amniocentesis**. This test is performed by an obstetrician or obstetric radiologist by inserting a needle through the mother's abdomen into the uterine cavity. Fluid withdrawn from the uterus contains the baby's cells and chromosomes. Results take 7-10 days. Risk of miscarriage is 1 in 250.

All testing is optional and is your personal choice.

Specially trained genetic counselors can help you decide if invasive testing is right for you. If you need additional information or referral to any of these counselors or doctors, we can help you

FETAL TESTING PLAN

Patient: _____ Date: _____

First trimester blood test for Downs (done at our office)	10-12 weeks
First trimester screening for Down's (schedule with specialist)	11-13 weeks
Second trimester blood test for spine and Down's (done at our office)	15-18 weeks
Chorionic Villous Sampling (schedule with specialist)	12-13 weeks
Amniocentesis (schedule with specialist)	15-20 weeks
Second trimester ultrasound	18-20 weeks

- | Decline | Accept | <u>My choice for testing is:</u> |
|----------------|---------------|---|
| _____ | _____ | 1. Maternal blood test for fetal chromosomes |
| _____ | _____ | 2. First trimester blood test and ultrasound |
| _____ | _____ | 3. Second trimester blood test (MSAFP) |
| _____ | _____ | 4. Genetic counseling. |
| _____ | _____ | 5. Chorionic villous sampling |
| _____ | _____ | 6. Amniocentesis |
| _____ | _____ | 7. I only want ultrasound |
| _____ | _____ | 8. I am undecided today about what testing is right for me. |

I understand that all testing must be performed during strict time frames and that it is my responsibility to schedule and perform these tests at the correct time. If I miss a test time I understand that the opportunity to test may be lost.

Any test that I have not scheduled and performed I have declined to perform.

Patient: _____ Date: _____

Reviewed by: _____ Date: _____

Cystic Fibrosis

Cystic fibrosis (CF) is an inherited lethal disease of the mucus and sweat glands. It affects the lungs, pancreas, liver, intestines, sinuses, and sex organs. CF causes mucus to be thick and sticky. The mucus clogs vital organs and causes multiple health issues.

The symptoms and severity of CF can vary. Some people have serious problems from birth. Others have a milder version of the disease that doesn't show up until they are teens or young adults. Sometimes individuals will have few symptoms, but later may have more symptoms.

There is no cure for CF, but treatments have improved greatly in recent years. Today, some people who have CF are living into their forties or older.

CF is a genetic disease. Effected individuals have inherited two copies of the CF gene from their parents. Parents can carry one CF gene and not know it because they have no symptoms.

Racial or Ethnic Group	Carrier Frequency
Ashkenazi Jewish	1/24
Non-Hispanic Caucasian	1/25
Hispanic American	1/46
African American	1/65
Asian American	1/94

The risk of having a baby with CF depends on your ethnic background:

Caucasian	1 : 2500
Hispanic	1 : 8500
African American	1 : 17,000
Asian	1 : 35,000

Testing for CF is usually done prior to pregnancy so that parents can be informed and make appropriate reproductive decisions. This test can also be done during pregnancy if desired.

In all 50 states newborns undergo blood screening at birth which includes testing for the CF gene. So your child will automatically be tested shortly after birth.

Testing is optional.

I desire CF testing: _____

I decline CF testing: _____

Witness: _____ Date: _____

Cord Blood Banking

Cord blood is the blood that remains in the umbilical cord and placenta following birth. This blood is usually discarded. However, cord blood banking utilizes facilities to store and preserve a baby's cord blood.

The cord blood of your baby is an abundant source of stem cells that are genetically related to your baby and your family. Stem cells are able to transform into other types of cells in the body to create new growth and development. They are also the building blocks of the immune system. The transformation of these cells provides doctors with a way to treat leukemia and some inherited health disorders. The stem cells from your baby's cord blood may also be effective in treating certain diseases or conditions of a parent or sibling.

Stem cells in a baby's umbilical cord blood can replace damaged cells inside their body. These new cells repair wounds, restore lost brain functions and increase healthy blood count. Medical experts discover new cord blood treatments every year. These valuable stem cells can now be stored in a process called cord blood banking.

At birth your physician can collect the remaining blood in the umbilical cord and placenta into the kit provided by your cord blood bank.

Sometimes, not enough cord blood can be collected. This problem can occur if the baby is premature or if there is more than one baby and they share a placenta. It also can occur for no reason. If an emergency occurs during delivery, it may not be possible to collect cord blood.

Problems with the mother may not allow any cord blood to be collected. If the mother has genital herpes or a uterine infection at the time of delivery, then cord blood may not be safe for storage.

There are some points to think about when making a decision about storing cord blood:

Many diseases cannot be treated with a person's own stem cells.

The chance that cord blood stem cells will be needed to treat your child or a relative is about 1 : 2700. However, research is being done into new uses for stem cells and many more uses for cord blood may be discovered in the future.

Currently, it is not known how long cord blood can successfully be stored.

If you decide to store cord blood, you will need to choose a cord blood bank at least a month prior to delivery.

I have read this material: _____ Date _____



Arcadia Well Woman

Dale Ann Dorsey, MSN WHNP-BC Mary Frazee, MSN WHNP ARDMS

PATIENT OFFICE POLICIES

Thank you for choosing **Arcadia Well Woman** for your Obstetrics and Gynecology care needs. We are committed to providing you with quality and affordable health care. We are pleased that you have placed your trust and confidence in us. In order to help acquaint you with our practice, we would like to make you aware of the following policies.

INSURANCE: We participate in many insurance plans, including some Medicare and Medicaid. We will attempt to bill whichever insurance you have advised us of as a courtesy. Please help us maintain accurate records by filling out forms legibly, and letting us know whenever there are important changes (like your address, telephone number[s], any changes in your name, your medical insurance, etc.). Contracts with insurances are constantly changing. It is the **patient's responsibility** to call the office prior to your appointment to verify that the office is contracted with your insurance.

KNOW YOUR BENEFITS: Each and every insurance company and plan, including Medicare and Medicaid, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Some insurance companies require referrals or authorizations. It is your responsibility to acquire the appropriate referrals and authorizations prior to your appointment. Your insurer can assist you with any questions you have relative to your own benefits with them. **Arcadia Well Woman cannot be held responsible for informing patients whether a particular service is "covered" or not.** However, our staff will make every effort to try to assist you in understanding your health benefits or supply you with other health plan related resources.

PROOF OF INSURANCE/ID: All patients must complete our patient information form. We must also obtain a copy of your driver's license or photo ID, and current, valid insurance card. If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay in full for services in advance.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: All copayments, and patient balance of coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to do so may be considered a breach of your contract with your health plan. We may decline to see patients for non-emergent visits if copayments are not made at the time of the visit.

NONPAYMENT: In the event that your insurance does not pay your claim to us in sixty (60) days, we will transfer the remaining balance to you and will send you a statement. If the account becomes 90 days past due, then the unpaid balance may be turned over to a collection agency. Please be aware that all collection fees and/or legal fees will be owed in addition to the remaining balance.

NON-COVERED SERVICES: Your Arcadia Well Woman provider may provide services that may not be covered as a benefit of your specific plan with your insurer. Patients or Guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan. It is your responsibility to know and understand your specific insurance plan and what benefits are provided.

Arcadia Well Woman

Dale Ann Dorsey, MSN WHNP-BC Mary Frazee, MSN WHNP ARDMS

PRIVATE PAY/SELF PAY: Payment in full is due at the time of visit, without exceptions.

CANCELLATION POLICY: "NO SHOW" POLICY: Any patient that does not show for their scheduled office visit appointment, or fails to cancel prior to 24 hours of their appointment will receive a \$50 charge. Continual missed appointments or rescheduled appointments with less than 24 hours' notice will be a cause for dismissal from the practice.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, Pathology and Lab samples sent outside of our office are billed independently of Arcadia Well Woman. You may receive a bill from the outside lab and will be responsible for payment to that facility.

TESTING/TREATMENT: The provider may send out specimens to the laboratory in order to properly diagnose and treat specific and ongoing issues. You may receive a bill from the outside lab and will be responsible for payment to that facility. Your signature at the bottom of this office policy authorizes our providers to treat you, and to recommend and/or order laboratory tests or other specialized tests as indicated for diagnosis for your medical condition.

RETURNED CHECKS: \$30.00 Fee for returned checks. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

MINOR AGE PATIENTS: In accordance to Arizona state law, a young woman, aged 13 and older can access sexual and reproductive health services (such as STD testing and treatment, birth control and pregnancy testing, etc.) without parental consent. All other health issues do require consent from a parent or legal guardian if the child is under the age of 18. The parent or legal guardian who brings the minor in for medical attention will be held responsible for payment at the time of services that are rendered.

I have read and agree with the above Patient Office Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient Name (print)

Patient or Legal Guardian Signature

Date

I acknowledge that I have received and read a copy of Arcadia Well Woman's Notice of Patients Rights.

Patient Signature

Date

Patient Printed Name

Date

Parent, Guardian,
Responsible Party,
Legal Representative, if any

Patients Date of Birth