



GYN Patient History

Name: _____ Date of Birth: _____

First day of last period: _____

Length of cycle from first day to first day each month: _____

Average length of bleeding: _____ regular irregular

Type of bleeding: normal light heavy passing clots

Postmenopausal: yes no Last period was _____ years ago

Are you currently pregnant: yes no Type of Birth Control: _____

Height: _____ Weight: _____

How many times have you been pregnant: _____

Number of children: _____ Number of miscarriages: _____

Type of delivery: vaginal _____ cesarean _____

Please indicate if you currently have or have a history of any of the following:

<u>Current</u>	<u>History of</u>	<u>Current</u>	<u>History of</u>
_____	_____ pelvic pain	_____	_____ abnormal bleeding
_____	_____ endometriosis	_____	_____ pelvic adhesions
_____	_____ ovarian cyst	_____	_____ Tamoxifen
_____	_____ fibroids	_____	_____ hormone replacement therapy

Previous diagnosis of Cancer: Uterine Cervical Ovarian Breast

Most recent pelvic ultrasound: When: _____ Where: _____

Previous GYN surgeries (i.e., ablation, D&C, tubal ligation, hysterectomy, etc.):

Why did your physician order today's exam (i.e., pain, abnormal bleeding, ovarian cyst, IUD localization, family history of ovarian, uterine or cervical cancer):

GYN pelvic ultrasounds are performed transvaginally on all patients that have been sexually active. If you have never been sexually active your exam will be performed transabdominally.

Sexually active: yes no

Patient Signature: _____

Date: _____

Marital Status: (circle one) S M D W

Name: _____ DOB: _____

Preferred Language: _____ English _____ Spanish _____ Am Sign Language Other: _____

Race: SELECT ONLY ONE

- _____ American Indian or Alaskan Native
- _____ Asian
- _____ Native Hawaiian or Other Pacific Islander
- _____ Black or African American
- _____ White
- _____ Hispanic
- _____ Other Race
- _____ Other Pacific Islander
- _____ Unreported/Refused to report

Ethnicity: SELECT ONLY ONE

- _____ Hispanic/Latino
- _____ Non-Hispanic/Latino
- _____ Unreported/Refused to report

Sexual History:

Have you had sex in the past 12 months: Yes No Last Menstrual Period: _____

Patient Signature: _____

Delaware Center for Maternal and Fetal Medicine of Christiana Care, Inc.

Ultrasound Consent Form

An ultrasound has been ordered on you by your physician. There are many reasons that this diagnostic test may have been ordered. An evaluation of your pelvis that may include uterus, ovaries and adnexa will be performed. The quality of ultrasound examinations are extremely dependent on the equipment utilized, the sonographer doing the ultrasound, your body habitus, previous abdominal/pelvic surgeries and the physician who interprets your exam.

Ultrasound examinations have never been shown to be harmful. This is not an x-ray. Ultrasound uses sound waves. The ultrasound produces a small burst of high frequency sound and then listens for the “echo” of the sound in your body. A computer then integrates this information to make the picture that you see on the screen. Many things can be seen pertaining to your pelvic organs.

Failure to have this ultrasound exam may make it difficult for your physician to make a diagnosis and care for you in the best possible way. There may be abnormalities in your pelvis that may benefit from diagnosis and treatment.

The utmost care and concern is given to you. Even so, ultrasound is not a perfect science and things can be missed or not seen depending on the position of your organs and your body composition. There are some abnormalities that are never seen with ultrasound.

I understand that ultrasound cannot see all things, but that it may be a very helpful tool to help manage my care. I have read this consent, fully understand the above information, and have had all my questions answered to my satisfaction.

_____ I ***elect*** to have an ultrasound performed on me.

_____ I ***decline*** to have an ultrasound performed on me.

Patient Signature _____

Date _____

Witness _____

Date _____

Delaware Center for Maternal and Fetal Medicine of Christiana Care, Inc.

Change of Information Policy

All patients will be held responsible for providing our office with any changes including but not limited to:

- Change of insurance (s) primary, secondary and tertiary
- Name changes
- Change of address
- Change of phone number (s)

Failure to do so at the time of service may result in the denial of your claim with your insurance company which will result in the patient being responsible for payment in full.

We have thirty (30) days to file a clean claim with insurance companies and after thirty (30) days claims may be denied for “timely filing”.

I have read the policy and understand I will be charged in full for failure to comply with the above policy:

Patient Printed Name

DOB

Date

Patient Signature

Delaware Center
for Maternal



Fetal Medicine
of CHRISTIANA CARE, INC.

Credit Card Authorization Release Form

I hereby authorize, Delaware Center for Maternal and Fetal Medicine of Christiana Care, Inc., to charge my credit card account in the event that I fail to **pay the balance on my account or set up a payment arrangement within 7 business days** of my first statement.

Date: _____

Patient Name: _____ Patient DOB: _____

Credit Card Billing Information (please print):

First Name _____

Last Name _____

Address _____

City _____

State _____ ZIP _____

Phone Day _____ Evening _____

Payment Information



Account # _____ - _____ - _____ - _____

Exp. Date _____

Cardholder's Name (please print): _____

Cardholder's Signature _____

Delaware Center for Maternal and Fetal Medicine of Christiana Care, Inc.

Important Information for Our Patients

Regular Office Hours

Our regular office hours are 8:30 am to 4:30 pm Monday through Friday. We are available by phone 7:30 am to 5:00 pm Monday through Friday.

Urgent Care After-Hours

Urgent care is defined as an issue that cannot wait until regular office hours. Calls received after hours or on days when the office is closed will be forwarded to our answering service for the physician on call. All urgent issues should be directed to your obstetrician. Please note that there is a \$50.00 charge for patients paging the on call physician for non-medical issues.

Emergency Care

For a serious emergency call 9-1-1 immediately.

Photography and Videotaping

Recording devices are not permitted in the examination room. This includes, but is not limited to, the following: Digital cameras, video cameras, cell phone cameras, laptop cameras, etc. Images from your ultrasound will be provided to you at the end of your exam.

Patient Information and Identification

Patients are required to present a valid photo ID and all current insurance cards at each and every visit. Patients must promptly notify the practice in writing of any changes to their demographic and/or insurance information. Patients are also required to respond promptly to any requests for information from their insurance companies. Failure to comply with any of these provisions may result in a patient responsibility of our full fee for services rendered.

Appointment Confirmations

We will make every effort to place a reminder call to your primary telephone number prior to your scheduled appointment. We will leave a message on your voicemail if you do not answer.

Appointment Cancellations

If you need to cancel or reschedule your appointment we require notification at least one business day in advance. If you arrive late for your appointment you may need to be rescheduled. Failure to notify us in a timely manner may result in a \$50 Missed Appointment Fee billed directly to you, not your insurance company. Missed appointment fees must be paid prior to or at time of service. Multiple missed appointments may result in dismissal from the practice.

Patient Balance Notification

You may also receive a courtesy telephone call prior to your appointment to notify you of any balances that will be due at your next visit.

Fee Schedules

Our fee schedule has been calculated to include a reduction for Self-Pay Patients and CHAPS Program Members. An additional discount will not be offered. A copy of our fee schedule is available upon request.

Insurance Companies (Participating)

We participate with some, but not all, insurance companies. A list of the companies with whom we participate is available upon request. If you are a member of an insurance company with whom we participate, we will submit claims directly to your plan on your behalf and accept their maximum allowable charge as payment in full. You are responsible for paying the appropriate deductible, coinsurance or copay amount as determined by your insurance company. This payment is due at the time of service prior to your appointment. Any additional patient responsibility identified by your insurance company on their explanation of benefits (EOB) will be due immediately.

Please note that a quotation of benefits by your insurance company may vary from the final determination of benefits during claims processing. Your insurance policy is a contract between you and your insurance company. If you have any questions about how benefits were determined you need to contact your insurance company directly.

Insurance Companies (Non-Participating)

If you are covered by a non-participating insurance company, payment in full will be required upon check in. As a courtesy we will submit a HCFA 1500 claim form to your insurance company.

Referral Authorization/Pre-Certification

Many insurance companies require referral authorization and/or pre-certification for specialty services. Please familiarize yourself with your insurance company's requirements. If the appropriate referral authorization has not been received in our office prior to your visit, your appointment may be rescheduled. If your insurance company denies a service for lack of referral it is your responsibility to pay the bill in full. It is important for you to remember to contact your PCP or Ob/Gyn before seeking services from a specialist.

Payment Options

Payment is due at the time services are rendered. Please come prepared to pay the appropriate amount due at each appointment. We accept cash, checks, money orders, MasterCard, Visa, Discover and Care Credit.

Cash

We accept cash payments and will provide a printed receipt for all cash transactions.

Checks

We do not accept post-dated checks. You will be charged a \$30 Returned Check Fee for any check returned to us for insufficient funds. Future payments must be cash, money order or credit card.

Credit Cards

We accept MasterCard, Visa, Discover and Care Credit for patients who are interested in financing their healthcare expenses over time. Credit card payments may be made over the phone at 302-319-5680 ext 141 or on our website at www.dcmfm.com. You will be charged a \$30 fee for each declined transaction.

Exception: Care Credit payment can only be made at time of service or on the Care Credit website at www.carecredit.com.

Collections

Patient accounts which are past due will be referred to a collection agency. A 25% Phase 1 Collection Administration Fee may be added to the account at the time of referral. Accounts in collections beyond 90 days may be assessed an additional 25% Collection Administration Fee. Accounts referred to a collection agency may also be reported to the credit bureaus (Equifax, Experian, and TransUnion). This may affect your credit rating. Failure to pay your financial responsibilities after insurance may also be viewed as a breach of contract by your insurance company.

Dismissal from the Practice

Patients may be dismissed from the practice. Reasons for dismissal may include, but are not limited to: non-payment, excessive missed appointments, failure to follow agreed upon treatment plan or the refusal of a patient to maintain acceptable behavior.

Medical Record

All requests for copies of medical records must be submitted in writing. A medical records fee must be received in our office prior to release of the record. Fees available upon request.

By my signature, I certify that I understand and agree to the above.

Patient Name (Printed): _____

DOB: _____ Date: _____

Patient Signature: _____

DCMFM Representative (Printed): _____

HIPAA

Patient Privacy Data Release & Consent Form

Many of our patients allow family members such as their spouse, parents or others to call and request information including appointment days and times, results of tests and results of procedures. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your protected health information released to family members you must review, fill-in, and sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent will remain in force until revoked or requested in writing by you our patient.

I authorize the **Delaware Center for Maternal and Fetal Medicine of Christiana Care** to release information about my care including appointment days/times and results of tests and procedures and billing information to the following individuals:

1. Name: _____ Relationship to Patient: _____
Phone #: _____

2. Name: _____ Relationship to Patient: _____
Phone #: _____

Patient: _____ Date: _____

Signature of Patient/Guardian: _____

Preferred Method of Communication

Please select your primary and secondary means of communication that you prefer for all personal healthcare communications with DCMFMCC. Please circle below:

Primary: Home Number Cell Number Work Number

Secondary: Home Number Cell Number Work Number

Note e-mails will not contain PHI or ePHI in clear-text within transmitted e-mails from DCMFMCC.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of the **Delaware Center for Maternal and Fetal Medicine of Christiana Care** to leave telephone messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab, pathology or procedure results, or to ask a patient to call our office regarding an issue or concern.

At no time will a representative of the **Delaware Center for Maternal and Fetal Medicine of Christiana Care** discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent will remain in force until revoked.

DCMFMCC may leave messages on my home phone number _____ or cell phone number _____ voice messaging system.

DCMFMCC may leave the message with a family member listed on this form: Yes or No

Patient: _____ Date: _____

Signature of Patient/Guardian: _____

Receipt & Acknowledgment of DCMFMCC's Patient Privacy Data Release & Consent Form

By signing and dating here, you acknowledge receipt of the DCMFMCC Notice of Privacy Practices and have reviewed these practices and procedures and fully understand them. It is your right to request a hardcopy from DCMFMCC or you may download a copy of this document here www.dcmfm.com/forms/.

Patient: _____ Date: _____

Signature of Patient/Guardian: _____