Medical Screening Form

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

Date: _____

Patient Name: _____ Patient DOB: _____ Occupation: _____

Patient Height: _____ Patient Pre-Pregnancy Weight: _____

Partner Name: _____ Partner DOB: _____ Occupation: _____

We obtain this information to provide the best care for you and your developing fetus. It is important for us to review this information with you and assess if any of the above information would have a pertinent effect on your pregnancy.

Please note this information will be reviewed by our clinical staff (sonographer, medical assistants, genetic counselor, and/or nurses) as well as our physician. If you do not wish any of this history to be discussed in front of your family members or any guests in the room, please note that below or notify any of our staff at your earliest convenience.

_____

_____

Medical History

▸ Do you currently have?	Diabetes	Y N	Are you on Medications for this?	Y N
Do you currently have?	Hypertension	Y N	Are you on Medications for this?	Y N
Do you currently have?	Thyroid issues	Y N	Are you on Medications for this?	Y N
▸ Do you currently have?	Seizures	Y N	Are you on Medications for this?	Y N
Do you currently have?	Crohns/UC	Y N	Are you on Medications for this?	Y N
Do you currently have?	Lupus	Y N	Are you on Medications for this?	Y N
Do you currently have?	Asthma	Y N	Are you on Medications for this?	Y N
▸ Do you currently have?	Clotting disorder	Y N	Are you on Medications for this?	Y N
▸ Do you have a history of?	A blood clot/stroke	Y N	Are you on Medications for this?	Y N
▸ Do you have a history of?	Heart problems	Y N	Are you on Medications for this?	Y N

Please specify

Do you have any other medical condition we should be aware of? (please list) _____

_____

What are your current medications? (please include dosage of medication if available)

▸ Medication	Dosage	▸ Medication	Dosage	▸ Medication	Dosage

Pregnancy History

What is your due date for this pregnancy?			
Have you had an ultrasound already in this pregnancy?	Y N	If yes, date:	
How many times have you been pregnant including this pregnancy?			
How many living children do you have?			
Have you had any miscarriages?	Y N	If yes, how many:	▸ (If 3 or more)
Have you had any terminations/discontinuation of pregnancy?	Y N	If yes, how many:	
▸ Were any of the terminations due to fetal abnormality or genetic condition?	Y N		
How many vaginal deliveries have you had?			
How many c-sections have you had?			
Have you ever had twins or triplets?	Y N		
Have you had any children pass away?	Y N		
Did any of your children have to go the Neonatal Intensive Care Unit?	Y N		
In any of your pregnancies did you have problems with high blood pressure or preeclampsia?	Y N		
In any of your pregnancies did you have problems with gestational diabetes?	Y N		

▸ *Genetic counseling indication*

Please continue on reverse

In any of your pregnancies did you have problems with your baby measuring too small?	**Y**	**N**
In any of your pregnancies did you have problems with your amniotic fluid being too low or too high?	**Y**	**N**
In any of your pregnancies did you have preterm labor?	**Y**	**N**
Were you hospitalized in any of your pregnancies?	**Y**	**N**
Did you deliver any of your children preterm (before 37 weeks or more than 3 weeks before your due date)?	**Y**	**N**
Do you have a history of cervical incompetence or problems with your cervix?	**Y**	**N**
Have you ever had surgery on your cervix (cerclage, LEEP, cone biopsy)?	**Y**	**N**
Are you aware of any problems with your uterus (abnormal shape, fibroids, uterine surgery)?	**Y**	**N**
Are you aware of any problems with your ovaries (PCOS, cysts, masses, tumors)?	**Y**	**N**

Pregnancy Exposure History (Any time during the pregnancy, including prior to knowledge of the pregnancy)

▸ Have you been exposed to any radiation since you knew you were pregnant?	**Y**	**N**
▸ Have you been exposed to any alcohol during this pregnancy ?	**Y**	**N**
▸ Have you used any tobacco (cigarettes, e-cigarettes, chew tobacco)?	**Y**	**N**
▸ Have you used any marijuana?	**Y**	**N**
▸ Have you used any other recreational drugs (Heroin, Cocaine, Methamphetamines)?	**Y**	**N**
▸ Are there any medications you stopped once you found out you were pregnant?	**Y**	**N**
Are you taking, or have you taken any herbal medications or supplements?	**Y**	**N**

Pregnancy Exposure History

▸ Will you be 31 or older at delivery if you are carrying twins, triplets, etc.	**Y**	**N**
▸ Will you be 35 or older at the time of delivery?	**Y**	**N**
▸ Was your partner 45 or older at the time of conception?	**Y**	**N**
▸ Were either you or your partner born with a birth defect or physical difference?	**Y**	**N**
▸ Were any of your children born with a birth defect or physical difference?	**Y**	**N**
▸ Are you or your partner related to each other by blood (i.e cousins)	**Y**	**N**
What is your ethnic background? _____ ▸ Any Ashkenazi Jewish ancestry?	**Y**	**N**
What is your partner's ethnic background? _____ ▸ Any Ashkenazi Jewish ancestry?	**Y**	**N**
▸ Have you had carrier testing?	**Y**	**N**

Are you or your partner a carrier for any of the following?

▸ Cystic Fibrosis	**Y**	**N**	**Not Tested**	▸ Spinal Muscular Atrophy	**Y**	**N**	**Not Tested**
▸ Sickle Cell Disease	**Y**	**N**	**Not Tested**	▸ Alpha Thalassemia	**Y**	**N**	**Not Tested**
▸ Beta Thalassemia	**Y**	**N**	**Not Tested**	▸ Fragile X Syndrome	**Y**	**N**	**Not Tested**
▸ Tay Sach's Disease	**Y**	**N**	**Not Tested**	▸ Any other genetic conditions?	**Y**	**N**	**Not Tested**

Were you or your partner, either your children or your partner's children, or any other family members on either side (parents, siblings, nieces, nephews, grandparents, aunts, uncles, cousins) born or diagnosed with any of the following? (If yes, specify who was affected)

Condition			Relationship	Condition			Relationship
▸ Down Syndrome	**Y**	**N**		▸ Missing/Extra Chromosome	**Y**	**N**	
▸ Intellectual Disabilities	**Y**	**N**		▸ Fragile X syndrome	**Y**	**N**	
▸ Autism/ASD	**Y**	**N**		▸ Blindness	**Y**	**N**	
▸ Hearing Loss	**Y**	**N**		▸ Cystic Fibrosis	**Y**	**N**	
▸ Spinal Muscular Atrophy	**Y**	**N**		▸ Sickle Cell Anemia	**Y**	**N**	
▸ Alpha/Beta Thalassemia	**Y**	**N**		▸ Tay Sach's Disease	**Y**	**N**	
▸ Muscular Dystrophy	**Y**	**N**		▸ Hungtington's Disease	**Y**	**N**	
▸ Blood Clotting Disorder	**Y**	**N**		▸ Bleeding Disorder	**Y**	**N**	
▸ Neurofibromatosis	**Y**	**N**		▸ Spina Bifida/Anencephaly	**Y**	**N**	
▸ Hydrocephaly	**Y**	**N**		▸ Heart Defect	**Y**	**N**	
▸ Kidney Defect	**Y**	**N**		▸ Polycystic Kidney Disease	**Y**	**N**	
▸ Genital Anomalies	**Y**	**N**		▸ Cleft Lip/Palate	**Y**	**N**	
▸ Diaphragmatic Hernia	**Y**	**N**		▸ Abdominal Wall Defect	**Y**	**N**	
▸ Limb/Hand/Foot/Finger/Toe Abnormality	**Y**	**N**		▸ Other Birth Defect	**Y**	**N**	
				▸ Other Genetic Condition	**Y**	**N**	

If you answered yes to any question, please explain:

_____

_____

▸ *Genetic counseling indication*

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 and your unborn child by your physician. There are many reasons that this diagnostic test may have been ordered. Some of these include: evaluation of your baby for birth defects, growth patterns, amniotic fluid level, Doppler flow indices, abnormal blood test results, or as adjuncts to diagnostic/therapeutic testing or procedures. The quality of ultrasound examinations are extremely dependent on the equipment utilized, the sonographer doing the ultrasound, the position of your baby within your womb, your body habitus, previous abdominal surgery and the physician who interprets your exam.

Ultrasound examinations have never been shown to damage you or your baby. 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 about your baby, such as birth defects and growth abnormalities. Ultrasound is also used to see where the baby is in relation to the needle when certain invasive procedures are done, such as amniocentesis.

Failure to have this ultrasound done may make it difficult, if not impossible, to care for you and your pregnancy in the best way possible. There may be abnormalities of your reproductive system that may benefit from diagnosis and treatment. You may not be able to take advantage of many options afforded to you by law. The birth of your baby may be compromised by not being able to have the appropriate specialists present during your pregnancy and at the time of your delivery that your baby may need. Without ultrasound, therapeutic measures would also not be possible, and this may result in a damaged baby or even the loss of the life of your baby.

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

I understand that ultrasound cannot see all things in me or my unborn child, but that it may be very helpful tool to help manage my pregnancy and plan the delivery. 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

☐ VISA ☐ MasterCard ☐ DISCOVER NETWORK

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 8:00 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 sent to you electronically 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 every visit. Patients must promptly notify the practice 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 preferred 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 future services being performed. 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.

Cost of Services

Our cost of services 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 pricing 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 option 2 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. 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, results of procedures and any financial information. 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 those designated below, 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. The purpose of this consent is to leave messages with members of your household or on your answering machine. This consent will remain in force until revoked.

I authorize the **Delaware Center for Maternal and Fetal Medicine of Christiana Care** to release information and leave messages on voicemail/answering machine 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 #:_____

DCMFMCC may leave messages on my home phone number_____ or cell

phone number _____voice messaging system.

Patient: asfdfsa _____ 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: _____