Perinatal Associates of San Antonio, PA
502 Madison Oak, Ste 210, San Antonio, TX 78258
Office(210) 481-3000 Fax (210) 496-0042

PATIENT'S NAME: ____
LAST FIRST M

ADDRESS ____

CITY: ____________________STATE ______________ZIP________

PRIMARY PHONE: ________________CELL/HOME WORK:____________ OTHER __________

SOCIAL SECURITY #: ______________________ DATE OF BIRTH _____________

EMPLOYER: __________________________DRIVER'S LICENSE #: ________________

FATHER OF BABY: __________________________ PHONE #: ________________

EMERGENCY CONTACT: ________________________ PHONE #: ________________

EMAIL ADDRESS: ________________________

PRIMARY INSURANCE: Must be completed if you want us to bill your insurance

INSURANCE COMPANY: ________________________ PHONE # ________________

CLAIMS MAILING ADDRESS: ______________________________________

POLICY #:__________________________ GROUP #: ________________

POLICY HOLDER'S NAME: ______________________ DATE OF BIRTH: ____________

POLICY HOLDER'S EMPLOYER: ____________________PHONE #: ________________

POLICY HOLDERS SS#: ________________________RELATIONSHIP TO PATIENT:__________

SECONDARY INSURANCE: Must be completed if you want us to bill your insurance

INSURANCE COMPANY: ________________________ PHONE # ________________

CLAIMS MAILING ADDRESS: ______________________________________

POLICY #:__________________________ GROUP #: ________________

POLICY HOLDER'S NAME: ______________________ DATE OF BIRTH: ____________

POLICY HOLDER'S EMPLOYER: ____________________PHONE #: ________________

POLICY HOLDERS SS#: ________________________RELATIONSHIP TO PATIENT:__________

REFERRING PHYSICIAN: ________________________ PHONE #: ________________

PHARMACY: ______________________________ PHONE #: ________________

I authorize qualified staff to perform upon me, rehabilitation, therapy and/or any other medical care including treatment necessary to improve my well being. I acknowledge that no guarantees can be made to me as to the outcome of treatment.

PATIENT SIGNATURE: ______________________________ DATE: ____________

I authorize my insurance benefits to be paid directly to *Perinatal Associates of San Antonio, PA*, realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

PATIENT SIGNATURE: ______________________________ DATE: ____________

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to *Perinatal Associates of San Antonio, PA.*

PATIENT SIGNATURE: ______________________________ DATE: ____________

PATIENT CONSENT FORM
For Release of Protected Health Information (PHI)

General Information

As a patient of Perinatal Associates of San Antonio (PASA,) when you seek medical advice or receive medical care information (past, present, and future) and personal information such as your name, address and social security number. This information will be used for the treatment of your medical condition (s), obtaining payment from your insurance company and for Healthcare Operations within PASA.

Notice of Privacy Practices

For a description of how your Protected Health Information (PHI) may be used and disclosed, please review PASA's "Notice of Privacy Practices" prior to signing this consent. A copy of the notice is available at the reception desk and at check-out. You may keep a copy for your records. PASA reserves the right to change the notice and will notify all patients of such changes prior to the effective date.

Patient Rights

You have the right to restrict the uses and disclosures of your PHI for the purpose of your treatment, payment for your services and the healthcare operations of PASA, however we are not required to agree to requested restrictions but we are bound by any restrictions agreed upon.

Permission to release Your Protected health Care Information to Family Members or Others

Please mark whether or not you choose to authorize us to release medical and/or insurance information to family or others: __ No __ Yes (If yes, please indicate the individual name(s) below.)

Name	Relationship	Date of Birth
______________________________	______________________	_______________
______________________________	______________________	_______________
______________________________	______________________	_______________

****

PASA has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Your signature below acknowledges:

- You have read and understand this consent.
- You agree to authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician seeing you.
- You agree to have the PHI used and disclosed by PASA for the purpose of your treatment, to secure payment for your treatment and for PASA healthcare operations.
- Prior to signing this consent, you were given the opportunity to review PASA's "Notice of Privacy Practices."
- You are permitting the release of your PHI to the persons noted above.
- You are aware that you may now or at any time request restrictions to the use and disclosure of your PHI.

____ _____________________

Printed Patient Name Date of Birth

____ _____________________

Signature of Patient or Patient's Representative Date Signed

(If Representative signs include legal document and print name below)

FINANCIAL POLICY

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, Care Credit, MasterCard, Discover, American Express and Visa. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due ***prior*** to these services being provided. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau(s).* Initials ________

- **Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays at 100%. It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. This includes lab designation and payment. Any disputes about payment must be resolved between you and your insurer. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. You are also responsible for payment if your claim denies for lack of referral/authorization. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. Initial ________

- We will file primary and secondary participating insurance for you with proper assignment. You must bring all insurance cards with you to every visit. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. Initial ________

- This office is not party to legal disputes. The financial responsibility rests with the patient or parent/guardian for patients under 18 years of age. Initial ________

- A $35.00 fee will be assessed for all returned checks. Initial ________

- As a courtesy, we confirm appointments 24-48 hours in advance. Please notify our office within 24 hours before scheduled appointment to avoid a $25.00 cancellation fee. Initial ________

- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds over $50 will be provided within 30 days from the date all outstanding claims are satisfied. Credit balances less than $50 will be available and processed upon request of the patient. Initial ________

ASSIGNMENT OF BENEFITS

I request payment of the medical benefits, otherwise payable to me, directly to *Perinatal Associates of San Antonio* for services provided by them.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

____ ____________________
Responsible Party Printed Name (Must be 18 or over) Date

____ ____________________
Responsible Party Signature (Must be 18 or over) Date

Welcome to Perinatal Associates of San Antonio. The following information is provided to ensure that our patients understand our office policies and their financial responsibilities when receiving treatment at Perinatal & Fertility Specialists of San Antonio, PA. We want to make your care as comfortable and affordable as possible, and we look forward to working with you. After reading, please initial each item below, then sign your name and date the bottom of the form. A copy will be given to you. If you have any questions, please ask for our office manager who will be glad to answer your questions.

1. Out of respect for all our patients and our staff, cell phones must be turned off once you check in and may be turned back on once you check out. ______ *(Initial)*

2. There will be a $25 service fee applied to your account each time you cancel or no show for your appointment without 24 hours notice. This fee will not be billed to your insurance or any other third party administrator. This will be your personal responsibility and is subject to the same collections policy. _______ *(Initial)*

3. Use of personal recording devices (ie; video cameras, cell phones) is not allowed at any time while in the office or exam rooms. ______ (*Initial)*

4. For our records and billing purposes, please let the front desk know if you have changed your address, phone numbers or insurance. If you receive Medicaid, we need a copy of your new card each month. _______ *(Initial)*

5. We do not allow children in our waiting area. You will need to make the appropriate childcare arrangements prior to your appointments or call to reschedule your appointment for the next available date and time. _______ *(Initial)*

6. We respectfully ask your cooperation in <u>not</u> directing financial questions to our physicians and nursing staff. Our Billing Staff and/or Office Manager are glad to help you with questions on costs or financial issues. _______ *(Initial)*

7. You may bring one adult guest with you to your appointments, except for diabetic class which is for the patient only. ______ *(Initial)*

We thank you for choosing Perinatal Associates of San Antonio and we look forward to working with you.

____________________________________ ____________________

Patient's signature Date

PERINATAL ASSOCIATES
OF SAN ANTONIO

PATIENT GENETIC SCREENING FORM

Referring Obstetrician _______________ Date of Appointment _______________

1. Last Name of Patient ____ First ____ Maiden ____ Home Phone ____ Work Phone ____

Birth-date ____ Age of Mother at Due Date ____ Allergies ____ Blood type ____

Any Chronic Medical Illnesses/Birth Defects? Specify: _______________

2. Last Name of Father of this Pregnancy ____ First ____ Home Phone ____ Work Phone ____

Birth-date ____ Age of Father at Due Date ____

Any Chronic Illnesses/Birth Defects? Specify: _______________

3. Are you related to the father of this pregnancy (i.e. first cousin)? Yes: ________ No: ________

4. ____ # pregnancies ____ # term ____ # pre-term ____ # terminations ____ # miscarriages ____ # live-births

5. List any children (living and deceased) of both parents (include previous partners). If any of these children have medical illnesses, mental or developmental delays, specify in the column to the right.

Name of child	Age	Sex	Father's Name	Specify

6. List any difficulty you may have had in conceiving: _______________

7. List any complications you may have had in past pregnancies: _______________

8. What is your ethnicity (i.e. countries your ancestors are from)? ________ Your partner ________

If your ethnicity is included in the list below, you may be at risk for certain genetic diseases more commonly found in these groups. None of these diseases are routinely tested for with amniocentesis or CVS. Testing can be performed on the amniotic fluid or CVS samples if both parents are known to be carriers for these conditions. Based on your ethnicity, do you or your partner desire carrier testing for any of the following conditions? Please circle one.

Caucasian? (Cystic fibrosis) Yes Decline testing Mom previously tested, Result: ______
Dad previously tested, Result: ______

Ashkenazi Jewish? (Tay-Sachs/Canavan) Yes Decline testing Mom previously tested, Result: ______
Dad previously tested, Result: ______

Please turn over

Cajun/French Canadian? (Tay-Sachs)	Yes	Decline testing	Mom previously tested, Result: ______ Dad previously tested, Result: ______
Black/East Indian? (Sickle Cell disease)	Yes	Decline testing	Mom previously tested, Result: ______ Dad previously tested, Result: ______
Mediterranean/Greek? (B-thalassemia) Italian	Yes	Decline testing	Mom previously tested, Result: ______ Dad previously tested, Result: ______
Southeast Asian/ Phillipino (a-thalassemia)	Yes	Decline testing	Mom previously tested, Result: ______ Dad previously tested, Result: ______

9. Check below if any of the following occurred in either the mother the father of this pregnancy's families - - grandparents, parents, children, sisters, brothers, and descendents (living or deceased).

DESCRIPTION	SPECIFY TYPE AND/OR CAUSE, IF KNOWN
1. ______ Birth defects	______
2. ______ Infant or childhood deaths	______
3. ______ Multiple miscarriages (2 or more)	______
4. ______ Mental retardation	______
5. ______ Muscular dystrophy	______
6. ______ Early onset blindness	______
7. ______ Early onset deafness	______
8. ______ Dwarfism	______
9. ______ Hemophilia or bleeding disorder	______

10. ______ Down syndrome (mongolism)
11. ______ Other chromosome abnormalities
12. ______ Spina Bifida
13. ______ Hydrocephalus (water on the brain)
14. ______ Cleft lip or palate
15. ______ Heart defect at birth
16. ______ Early onset Cancer (under 35)
17. ______ Early onset Emphysema (under 35)
18. ______ Phenylketonuria (PKU)
19. ______ Cystic fibrosis or carrier
20. ______ Tay-Sachs disease or carrier
21. ______ Thalassemia disease or carrier
22. ______ Fragile X Mental Retardation or carrier
23. ______ Polycystic Kidney Disease (PKD)
24. ______ Any other inherited or genetic conditions not listed: ______

If you have checked ANY of the above, indicate which one(s) and the relationship of this individual.

______

______

______

______

In this pregnancy, have you had exposure to:

8. Medications or recreational drugs (include non-prescription drugs)? Yes: ______ No: ______
If yes, give names of medication/drug, amount, and which weeks taken during the pregnancy: ______

______

9. Alcohol? Yes: ______ No: ______ If yes, how much? ______
10. Tobacco? Yes: ______ No: ______ If yes, how much? ______
11. Infections, high fever, or other illnesses? Yes: ______ No: ______ If yes, indicate type, duration, and which weeks during the pregnancy: ______
12. Chemical/Pesticide/X-rays/Cat litter box? Yes: ______ No: ______
(Routine house extermination, lawn fertilization, or dental X-rays are generally not a problem). If yes, indicate type, duration, and which weeks during the pregnancy: ______

______

Do you wish to know the sex of this fetus? Yes: ______ No: ______

Signature of Patient ______ Date: ______