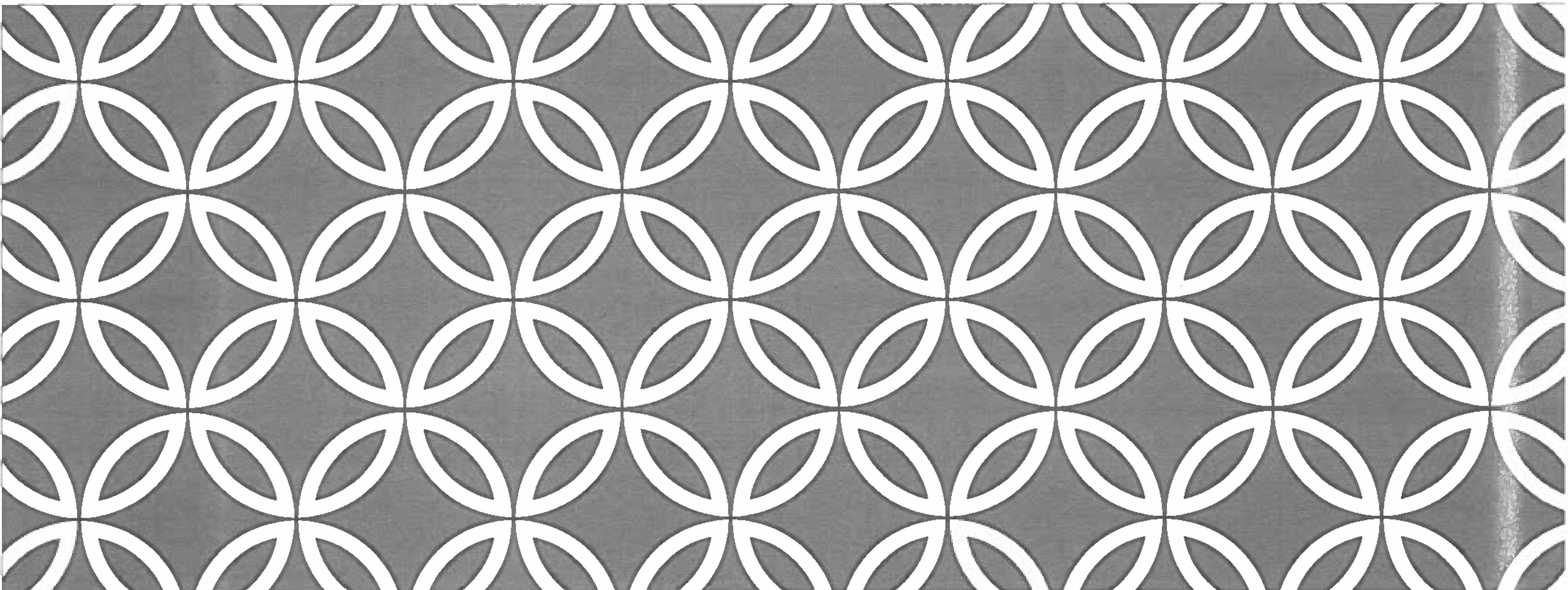

ASSOCIATES IN CENTRAL OHIO OBSTETRICS & GYNECOLOGY

575 Westar Crossing, Suite 102
Westerville, OH 43082
Phone: (614) 839-5555
Fax: (614) 839-5100

6482 East Main St, Suite B
Reynoldsburg, OH 43068
Phone: (614) 856-0327
Fax: (614)856-3300

NEW PREGNANCY PACKET

Appointment Date:
Arrival Time:
Physician:

IMPORTANT INFORMATION ABOUT OUR PRACTICE

OUR PRACTICE

Our practice consists of both male and female physicians. The physicians rotate taking call which means your care may be rendered by both. We also have multiple female nurse practitioners you might see for a visit when your physician is unavailable in the office. We have a male ultrasonographer who may scan you throughout your pregnancy. Our physicians deliver at the following hospitals ONLY: St. Ann's Hospital and Riverside Methodist Hospital

INITIAL OB OFFICE VISIT

Because of the physical exam, please do not douche or have intercourse 24 hours prior to your appointment. The visit will consist of an interview, physical examination, blood work and an ultrasound. The blood work at your initial visit will include determining your blood type, blood count, screening for prior vaccinations, and screening for viral infections including HIV, hepatitis B and hepatitis C as well as any other tests deemed medically necessary. Please allow 1.5 hours for your initial visit, even if you have been see at our practice previously for a pregnancy. All paperwork must be filled out completely. Bring insurance card. Arrive 30 min prior to your appointment time. We require 24 hour notice if you need to cancel or reschedule. Failure to do so will result in a no show charge of $52

INSURANCE

If your insurance carrier requires a referral from your primary care physician, it is your responsibility to obtain this referral prior to the date of your office visit. It is advisable for you to call our office prior to your visit to verify that we received your referral. If you do not have the proper referral by the time of your appointment, you will be asked to reschedule your appointment. Your insurance company will be contacted by the practice for verification of your maternity benefits. Our office DOES require payment of any deductible, copayments, or uninsured portions of services in full by your seventh month of pregnancy. Once this information is obtained from your insurance carrier, you will be set up on a monthly payment schedule for your payment responsibilities. We accept cash, check, or credit card (Visa, MasterCard, or Discover). For billing questions please call: 614-923-0153

INFORMATION REQUIRED PRIOR TO BEING SEEN

We require that you present your insurance card at every visit. If you had an insurance change and have not yet received your card from your insurance carrier, we ask that you contact our office prior to your appointment so that we may advise you of the information required to be seen. If you do not have insurance to cover your pregnancy, you are required to pay for your initial visit in full. A payment plan is possible for remaining costs of care and delivery.

HELPFUL TIPS FOR NAUSEA/VOMITING IN PREGNANCY

- Eat a piece of bread or a few crackers before you get out of bed in the morning or when you feel nauseated.

- Get out of bed slowly. Avoid sudden movements.

- Eat several small meals throughout the day.

- Eat high protein foods such as eggs, cheese, nuts, meat, as well as fruits. These foods help prevent low levels of sugar in your blood, which can contribute to nausea.

- Drink spearmint, peppermint, raspberry leaf, ginger root, ginger tea, or ginger ale.

- Take deep breaths. Get fresh air by taking a walk or opening a window.

- Try safe over the counter medications such as Vitamin B6 & Unisom. See details on "Safe Medications in Pregnancy" chart.

IMPORTANT INFORMATION ON GENETIC TESTING

- Screening tests can give information about a pregnant woman's risk of having a baby with certain birth defects or genetic conditions. These tests also can help your doctor detect possible problems during your pregnancy. Some pregnant women may have other tests, depending on their medical histories, previous pregnancies, family or ethnic background, or exam results.

- It is important to realize these are SCREENING tests, NOT DIAGNOSTIC tests. These tests ONLY provide information about whether your baby is at a higher or lower risk for certain conditions. A positive result DOES NOT necessarily mean your baby has the condition tested for. It will only direct us toward the need for additional, more definitive testing.

- **Trisomy 21,** or Down Syndrome, is a genetic condition that causes intellectual disability and other birth defects. On average this occurs in 1/700 births but risk increases with the age of the mother.

- **Trisomy 18,** or Edward's Syndrome, is a genetic condition that causes severe intellectual and physical disabilities . Most babies born with this condition will either die before birth or within the first year of life. It occurs in approximately 1/4,000 live births.

- **Trisomy 13,** or Patau Syndrome, causes severe intellectual and physical disabilities and most babies born with this will not live past the first week of life.

- **Neural tube defects** are birth defects that impact the brain and spinal cord. Most common defect is Spina Bifida which can cause issues with walking and bowel and bladder control. The risk of neural tube defects is 1/1,500.

- **Cystic Fibrosis (CF)** is one of the most common inherited diseases in the Caucasian population. It causes breathing problems and lung infections, as well as digestive problems and infertility. CF does not cause mental retardation or birth defects. People with CF might have a shortened life span, however many will live into their 40's or longer.

- **Spinal Muscular Atrophy** is a condition that affects the nervous system that controls voluntary muscle movement. It does not affect intelligence. It can be severe and significantly shorten a child's lifespan. Affects 1/9,000 people.

GENETIC TESTING OPTIONS

TEST	DESCRIPTION	TIMING	ADVANTAGES	DISADVANTAGES	MAX COST ESTIMATE
First Trimester Screen	- Assesses risk for Down Syndrome & Trisomy 13/18 - Blood test & ultrasound to measure fat pad on back of baby's neck	11-13 weeks	- Noninvasive - Detection rate of 95%	- 5% false positive rate	Bloodwork: $75-240 Ultrasound: $255 Total: $330-495
AFP	- Assesses risk for neural tube defects, such as spina bifida	15-19 weeks	- Noninvasive - Detects 80% of babies w neural tube defects	- Risk of false negative or false positive results	$99
AFP QUAD (If you did not have prior screening for Down Syndrome)	- Assesses risk for Down Syndrome - Assesses risk for neural tube defects, such as spina bifida	15-19 weeks	- Noninvasive - Does not require an ultrasound - Can be done in 2nd trimester	- Detection rate up to 81% - 6% false positive rate	$419

* These cost estimates are only approximate and are estimates through LabCorp. If your insurance requires you to have testing through a different lab, it is possible that costs may vary.

TEST	DESCRIPTION	TIMING	ADVANTAGES	DISADVANTAGES	MAX COST ESTIMATE
NIPT (Noninvasive prenatal testing)	- Blood test that looks for baby's chromosomes in your blood - Tests for Trisomy 21, 18, & 13 - Also reports gender - Only covered by insurance if >35 years old or have family history of chromosomal problems	After 10 weeks	- Noninvasive - Detection rate of 97-99%	- 5% false positive rate - May not be covered by insurance	$1,100
Cystic Fibrosis (CF) Carrier Screen	- Tests for 23 most common genetic mutations that cause C.F. - Most common autosomal recessive condition in Caucasian population - Screening recommended if patient or partner has personal or family history of C.F.	Anytime	- Noninvasive - Confirmatory diagnostics available - Can get specialists involved	- Risk of false negative result - May not be covered by insurance	$800
Spinal Muscular Atrophy (SMA) Carrier Screen	- Loss of nerve cells that control muscle movement - Can be very serious and cause early death - Recommended in patients with a family history	Anytime	- Noninvasive - Confirmatory diagnostics available - Can get specialists involved	- Risk of false negative result - May not be covered by insurance	$400-600

* These cost estimates are only approximate and are estimates through LabCorp. If your insurance requires you to have testing through a different lab, it is possible that costs may vary.

Associates in Central Ohio OB/GYN, Inc. (ACOOG)

575 Westar Crossing, Suite 102, Westerville, OH 43082 (614) 839-5555
6482 East Main Street, Suite B, Reynoldsburg, OH 43068 (614) 856-0327

☐ New patient ☐ Established patient

Patient Information

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Marital Status

Preferred method for appointment reminders (Check one): Call ☐ E-mail ☐ Text ☐ Primary Care Physician: ______________

Social Security Number: _____ - _____ - _______ Date of Birth: _____ / _____ / _______

Emergency Contact

May we release protected health information to this individual? ☐ YES ☐ NO

Last Name First Name MI

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Relationship

Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ Other

Other (Please Specify): ______________________________ Effective Date: _____ / _____ / _______

/

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_______) _______ - __________
Social Security Number of Policy Holder: ______ - ______ - ________ Policy Holder Date of Birth: ________/__________/__________
Insurance Identification Number: ______________________ Group Identification Number: ______________________

Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: ______________________

Name of Employer (Company Name) Occupation

Phone Number: (_____) _____ - __________

Address

City State Zip Code

New Pregnancy Questionnaire

Dating Information

What was the date of your last menstrual period?

About

Height * ft in

Pre-pregnancy Weight lb

What is your occupation?

Is English your native language? No Yes

What is the name of your partner/spouse?

What is the phone number of your partner/spouse?

Is the father or sperm donor of the baby 40 or older?* No Yes

Sensitive

Has your current partner ever threatened you, or made you feel afraid?* No Yes

Have you ever been in an abusive relationship?* No Yes

Do you feel unsafe in the neighborhood where you live?* No Yes

Pregnancy History

Is this your first pregnancy?* No Yes

Have you ever had a C-Section? No Yes

Do you feel like you had a really stressful experience with any labor and delivery from any previous pregnancy? No Yes

Did you have a forceps assisted delivery in any previous pregnancy? No Yes

Did you ever have Vacuum Extraction delivery assistance on a previous pregnancy? No Yes

Question		
Did you deliver a larger than normal infant (baby greater 8lbs,13oz) on a previous pregnancy?	No	Yes
Have you ever lost a pregnancy after 14 weeks gestation?	No	Yes
Have you ever had your uterus rupture during pregnancy, labor, or delivery?	No	Yes
Have you ever had a placental abruption or placental separation?	No	Yes
Have any of your babies been infected with Group B Strep?	No	Yes
Have you ever had a baby who was too small or growth restricted?	No	Yes
Have you had Gestational Diabetes with a previous pregnancy?	No	Yes
Have you been diagnosed with high blood pressure/preeclampsia gestational hypertension or HELLP syndrome in your previous pregnancies?	No	Yes
Were you ever admitted with pre-term contractions or diagnosed with pre-term labor in a previous pregnancy?	No	Yes
Have you had a preterm delivery at less than 37 weeks?	No	Yes
Have you ever been diagnosed with a shortened cervix in a previous pregnancy?	No	Yes
During a previous delivery, did the baby's shoulder get stuck on the way out?	No	Yes
Have you ever had a hemorrhage after delivery with a previous pregnancy?	No	Yes
Have you had postpartum depression?	No	Yes
Were you ever re-admitted to the hospital after a delivery?	No	Yes
Did you have complications during a previous pregnancy or postpartum other than those listed above?	No	Yes

Endocrine History

Question		
Do you have an overactive thyroid, or Graves disease?	No	Yes
Do you have an underactive thyroid, or Hashimoto's thyroiditis?	No	Yes
Do you have insulin-dependent or juvenile (Type 1) diabetes?*	No	Yes
Do you have adult-onset (Type 2) diabetes?*	No	Yes

Do you have Polycystic Ovarian Syndrome (PCOS)	No	Yes

Cardiovascular History

Do you have high blood pressure?*	No	Yes
Do you have ITP, history of low platelet count, or a platelet disorder?*	No	Yes
Have you ever had a blood clot in the leg (DVT) or lung (Pulmonary Embolism) or a disorder that makes your blood clot more than usual?*	No	Yes
Do you have any cardiovascular problems (heart/heart valve disease, previous heart surgery, heart defects, aortic aneurysm, arrhythmia, rapid or irregular heartbeat, or postpartum heart failure)	No	Yes

Neurological History

Do you have any type of seizure disorder?	No	Yes
Have you ever been diagnosed with a stroke (CVA, TIA)?	No	Yes
Have you ever been diagnosed with migraines?	No	Yes

Psychiatric History

Do you have problems with anxiety?*	No	Yes
Have you had a problem with depression?*	No	Yes
Have you ever been diagnosed with PTSD?	No	Yes
Have you ever been diagnosed with OCD?	No	Yes
Have you been diagnosed with a bipolar (manic-depressive) disorder?	No	Yes
Do you have schizophrenia?	No	Yes
Have you ever attempted suicide?	No	Yes
Have you ever been diagnosed with ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)?	No	Yes

Respiratory History

Question			
Do you currently have asthma?*	In Past	No	Yes
Do you have any pulmonary disease or lung problems other than asthma?		No	Yes

Surgical History

Question		
Have you ever had any complications with anesthesia?	No	Yes
Have you ever had postoperative complications?	No	Yes
Have you had weight loss/bariatric surgery?*	No	Yes
Have you ever had a blood transfusion?*	No	Yes
Have you ever had back surgery?	No	Yes
Have you ever had abdominal surgery (other than a C-section)?*	No	Yes
Have you ever had cosmetic surgery (including breast augmentation, tummy tuck)?	No	Yes
Have you ever had transplant surgery	No	Yes

Gastroenterological History

Question		
Do you have Ulcerative Colitis?	No	Yes
Do you have Crohn's disease?	No	Yes
Do you have any history of gastrointestinal or digestive disorders other than the conditions noted above?	No	Yes

Urologic History

Question		
Have you ever had any urinary tract/urologic surgery?	No	Yes
Do you have any type of kidney/renal disease (including history of kidney stones or kidney infection)?*	No	Yes

General Medical History

Do you have antiphospholipid syndrome (APS) / thrombophilia / hypercoagulability?	No	Yes
Do you have lupus?	No	Yes
Do you have rheumatoid arthritis?	No	Yes
Do you have Sjogrens Syndrome?	No	Yes
Have you ever been diagnosed with or undergone treatment for a Blood Disorder?	No	Yes
Do you have a connective tissue disorder (Ehlers-Danlos or Marfan Syndrome)?	No	Yes
Have you ever been diagnosed with or undergone treatment for Cancer?	No	Yes

Gynecological History

Have you had 3 or more miscarriages?	No	Yes
Have you ever needed IVF or other treatment to get pregnant?	No	Yes
Have you ever had any surgery or procedures on your cervix?*	No	Yes
In a previous pregnancy, have you ever had your cervix sewn or taped closed due to a weak or incompetent cervix?*	No	Yes
Have you ever had a cold knife cone biopsy (conization) to remove tissue from your cervix?*	No	Yes
Have you ever had a LEEP (Loop Electrosurgical Excision Procedure) performed to remove abnormal cells from your cervix?*	No	Yes
Have you ever had cervix cryosurgery to freeze and destroy abnormal tissue in your cervix?*	No	Yes
Have you ever been diagnosed with a uterine anomaly such as a bicorunate, unicorunate, arcuate, or septate uterus?	No	Yes
Do you have (or have you had) uterine fibroids (myomas)?	No	Yes
Have you ever had an operation to remove a fibroid or myoma from your uterus?	No	Yes

Family History

Do you or your partner have an ethnic background of Cajun/French Canadian?	No	Yes

Do you or your partner have an ethnic background of Greek/Mediterranean/Italian?	**No**	**Yes**
Do you or your partner have an Ashkenazi/Eastern European Jewish background?	**No**	**Yes**
Has anyone in your or your partner's family had a baby with anencephaly?	**No**	**Yes**
Has anyone in either your or your partner's family had Canavan Disease?	**No**	**Yes**
Have you, your partner or either your or your partner's family had a chromosomal defect?	**No**	**Yes**
Has anyone in either your or your partner's family had familial dysautonomia (FD)?	**No**	**Yes**
Have you, your partner or either your or your partner's family had a heart defect?	**No**	**Yes**
Do you, your partner or either your or your partner's family have sickle cell anemia?	**No**	**Yes**
Has anyone in your or your partner's family had sickle cell trait (SCT)?	**No**	**Yes**
Has anyone in your or your partner's family had a child with Down syndrome?	**No**	**Yes**
Has anyone in your or your partner's family had hemophilia?	**No**	**Yes**
Has anyone in your or your partner's family had Muscular Dystrophy?	**No**	**Yes**
Do you, your partner or either your or your partner's family have cystic fibrosis?	**No**	**Yes**
Has anyone in your or your partner's family had Huntington's Chorea?	**No**	**Yes**
Has anyone in your or your partner's family had Fragile X?	**No**	**Yes**
Has anyone in your or your partner's family had spinal muscular atrophy (SMA)?	**No**	**Yes**
Have you, your partner or anyone in your or your partner's family had von Willebrand Disease?	**No**	**Yes**
Do you, your partner or anyone in either family have any birth defects?*	**No**	**Yes**
Does anyone in either your or your partner's family have an intellectual disability?	**No**	**Yes**
Do you, your partner or either your or your partner's family have any children with special needs?	**No**	**Yes**

Has anyone in the family had pre-eclampsia?	No	Yes
Do your or your partner's family have any close relatives (parent, child, sibling) with diabetes?	No	Yes

Infection History

Have you been exposed to tuberculosis?	No	Yes
Have you had a rash or viral illness since your last menstrual period?	No	Yes
Have you ever been diagnosed with MRSA?	No	Yes
Have you ever been diagnosed with Hepatitis B?	No	Yes
Have you ever been diagnosed with Hepatitis C?*	No	Yes
Are you HIV positive?	No	Yes
Have you ever been diagnosed with any sexually transmitted disease (STD) - (Gonorrhea, Chlamydia, Trichomonas, HIV, HPV, or Syphilis?	No	Yes
Have you ever had a genital herpes?	No	Yes
Does your partner have a history of genital herpes?	No	Yes
Have you ever had cold sores?	No	Yes

Vaccination History

Have you ever had chickenpox or been vaccinated against it?	No	Yes

Social History

Do you have any objections to blood transfusions?	No	Yes
Do you have a cat?	No	Yes
Do you have exposure to chemicals or radiation?	No	Yes

Question	Options
When was the last time you drank any alcohol?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
When was the last time you smoked, vaped, or used any tobacco/nicotine products?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
Do you vape or use e-cigarettes?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
When was the last time you smoked a cigarette?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
When was the last time you used marijuana, cocaine, meth, benzos, and/or opioids?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
When was the last time you used any marijuana?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
When was the last time you used any cocaine?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
When was the last time you used any methamphetamines?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
When was the last time you used any benzos (such as Valium, Xanax, or Ativan)?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
When was the last time you used any opioids?	Never / Years Ago / Weeks Ago / Not Since Pregnant / Current
Are you exposed to second-hand tobacco smoke?	No / Current

Options Counseling

Question	Options
Do you have questions about your options regarding this pregnancy?*	No / Yes

Preferred Name: Pronouns:

DOB: Age:

Medication	Dose	Frequency	Prescriber

Allergy (medication, food, latex, etc.)	Reaction

____ No Known Allergies

Total Number of Pregnancies: Total Living Children:

Total Number of Miscarriages or Abortions: Total Ectopic Pregnancies:

Date	Weeks	Weight	Sex	Vaginal, Cesarean	Pregnancy Complications

Date	Surgery	Location Performed

OBSTETRICAL ULTRASOUND

I, ______________________________, hereby request the performance of an **Obstetrical Ultrasound**. This procedure will be preformed by ______________________________________.

Ultrasound is a technique used to view the baby in the uterus (womb) with the use of sound waves. During an abdominal ultrasound examination, a gel is spread over your abdomen and a scanning device moves lightly over the area. As sound waves pass through the layers of the abdomen and uterus, they are reflected to show the developing baby, placenta, uterus, and nearby structures. These images are then converted into sound echoes, which can be seen on a monitor. In the case of vaginal ultrasound, performed in early pregnancy or in certain other situations, the scanning device is a small probe, which is placed inside the vagina. This is similar to having a pelvic examination and may be mildly uncomfortable.

This ultrasound test is not a treatment for any condition but is done for diagnostic purposes. The information obtained may be used to confirm the presence of fetal heart beat, evaluate the baby's growth, estimate the size of the baby, detect the presence of multiple fetuses, **and to detect some but not all birth defects**. It is possible that fetal birth detects may not be seen on the ultrasound examination performed today, or that anatomy could falsely appear abnormal. Therefore, neither a normal ultrasound nor the results of any prenatal test guarantee a normal, healthy baby.

Currently, there are no known health risks to the mother or fetus during an ultrasound examination.

There may be alternatives to this examination available to you. However, alternative methods of prenatal diagnosis have their own risks.

I acknowledge that I have had an opportunity to discuss with and have had explained to my satisfaction the purpose and nature of this obstetrical ultrasound, as well as reasonable risks. I understand that medicine is not an exact science, that it may involve the making of medical judgments based upon the facts known to the physician at the time, and that it is not reasonable to expect the physician to be able to anticipate or explain all possible risks and complications, and further, that an undesirable result does not necessarily indicate an error in judgment. I understand that no guarantee as to the results have been made to me. I expressly wish the physician to exercise his/her best judgment during the course of the procedure, and to inform me of the findings of the obstetrical ultrasound.

I DO or DO NOT wish to know the estimated gender of my baby. (Please circle one)

I understand that there is not 100% certainty when determining gender through ultrasound.

I understand that this obstetrical ultrasound may or may not be paid for by my insurance company. Many insurance companies will not pay for an ultrasound unless medical indications are present. I understand and agree that if the procedure is not paid for by my insurance, I will be responsible for the payment.

All my questions have been answered, and I do herby consent to the performance of an obstetrical ultrasound.

______________________________ ______________________________

(Patient Signature) (Printed Patient Name)

______________________________ ______________________________

(Physician/Provider Signature) (Date)

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: **Email:** ____________________

Signature: ______________________________ **Date:** ____________________

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, If not Patient:______________________________

***Note: If you do not want to participate in Health Information Exchange (HIE), it is <u>your</u> responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

Privia Financial Policy & Notice of Privacy Practices Effective February 2022

PRIVIA HEALTH

Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: **Date of Birth:**

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**____________________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Cell Phone:**__________________________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:**____________________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Written Communication:**__________________________________

- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

____

____

☐ **Other:**______________________________________

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below**Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

•**Name:**__________________________________**Telephone:**__________________________**Relationship:**_______________________
Email::__________________________________

•**Name:**__________________________________**Telephone:**__________________________**Relationship:**_______________________
Email::__________________________________

•**Name:**__________________________________**Telephone:**__________________________**Relationship:**_______________________
Email::__________________________________

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons**not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: ____ **Date:** ___________________________
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Associates in Central Ohio OB/GYN, Inc.

The doctor and patient are desirous of entering into and/or maintaining a positive physician/patient relationship that focuses on quality patient care and open lines of communication. The parties to this agreement shall agree to pursue a good faith effort to resolve any problems that may arise between them. As a part of entering into the physician/patient relationship, the patient agrees to submit in writing to Associates in Central Ohio OB/GYN, Inc., any dispute, controversy or disagreement arising out of or relating to the physician/patient relationship and the agreement to provide medical services.

1. After the matter has been presented in writing to Associates in Central Ohio OB/GYN, Inc., the parties shall use negotiation in an attempt to reach a voluntary resolution of their differences.

2. If the dispute, controversy or disagreement is not resolved in a reasonable time, then the matter shall be submitted to mediation in accordance with the Associates in Central Ohio OB/GYN, Inc. Rules of procedure.

   Mediation is a process in which a neutral third party helps the doctor and the patient discuss the issues that have arisen between them with the ultimate goal of resolving any problems. Either party is entitled to seek legal representation at any time, but Associates in Central Ohio OB/GYN, Inc. wishes to provide the patient with this opportunity to settle any problems that may have arisen without the need to incur additional cost and fees.

   These Mediation Rules of Procedure provide in part that:

   - The patient is not required to reach a resolution in mediation.
   - The mediator (or co-mediators) will be a neutral third party who is trained in mediation.
   - All mediation sessions are considered confidential as defined in Ohio Revised Code 2317.123.
   - The costs of mediation will be paid by Associates in Central Ohio OB/GYN, Inc.
   - The date, time and place of any mediation session shall be scheduled by the mediator in consultation with the parties.
   - The use of mediation does not preclude either party from pursuing any other remedies that may be available to them.
   - Any agreements reached by the parties shall be in writing and signed by both parties.
   - Parties considering mediation should remember by signing this agreement they agree to make a good faith effort at mediation prior to pursuing litigation. Any decisions may affect their legal rights. Mediation is not a substitute for legal advice. Parties should consult with their legal counsel for any questions regarding legal rights.

It is the goal of Associates in Central Ohio OB/GYN, Inc. that all physicians and patients engage in a cooperative approach to ensure quality healthcare and that any conflicts that may arise between them will be resolved in the same cooperative style through mediation.

______________________________ ______________________________

Patient Date Doctor Date

PRIVIA HEALTH

FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our *Authorization and Consent To Treatment Form* before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out. You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

You are responsible for understanding the limitations of your insurance policy, including:

- If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).
- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Any co-payment, coinsurance or deductible that may apply

NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES

If you do not have insurance or are not using insurance to pay for your care, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the NO SURPRISES ACT, health care providers must give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item.
- You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-888-774-8428.

CARD-ON-FILE PROCESS

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork

and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

YOUR RESPONSIBILITIES

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed appointment, a $75.00 fee for a missed pediatric appointment, a $100.00 fee for a missed physical, or a $200 fee for a missed procedure or surgery. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

Interpreter and Translation Services. If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least forty-eight (48) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

Additional information about our financial policies is available on our website at priviahealth.com.

Thank you for choosing us as your healthcare provider!