CACHE VALLEY Women's Center

1325 North 600 East, Suite 102 · Logan, Utah 84341 · Phone 435-753-9999 · Fax 435-753-2301

Congratulations on your pregnancy! Our experience with insurance companies is that there will be a portion of the global fee that will be your responsibility along with any deductibles or co-pays if they apply. Please check with your insurance company to determine your benefits, and what your portion will be. Below is an approximate amount for each scenario.

Please circle one option below:

Normal Delivery: $3480.00 10% $348.00

$3480.00 20% $696.00

$3480.00 30% $1044.00

Insurance _____

Deductible _____

Co-pays _____

The global fee does not include any lab work, ultrasounds, non-stress tests or extra medical procedures or care due to complications or increased risk factors during pregnancy. The amount will increase by approximately 40% if there are any increased risk factors, complications or if the delivery is a Cesarean section.

It is our policy that you pay your portion in full before delivery. Please fill out the information below and return it to our office on your first OB appointment. If you have questions regarding the above information please contact our billing department.

FOR OFFICE USE ONLY

_____ I will make a payment of $ _____ each month.

_____ I have dual insurance coverage, copies of cards are attached.

_____ My insurance states that pregnancy is covered 100%.

Note: if you have Medicaid you will be required to bring your current card with you each month or else you will need to pay $300.00 at the time of your visit. If you do not have insurance, you will be required to pay $300.00 at your initial ob visit.

Patient Signature Date Office Signature

Patient Printed Name Estimated Delivery Date

Patient Date of Birth Today's Date

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

Today's Date _____

Patient Name _____
Last First Middle

Address _____ P.O. Box _____

City _____ State _____ Zip _____ Email _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell ( ) _____

Date of Birth _____ Age _____ Sex: M / F SS# _____

Race _____ Ethnicity _____ Primary Language _____

Employer Name _____ Address _____ Phone _____

Employment Status: Full Time / Part Time Marital Status: Single / Married / Divorced / Other Driver's License# _____

Spouse's Name _____ DOB _____ SS# _____

Spouse's Employer _____ Address _____ Phone _____

INSURANCE INFORMATION

(Primary) Insurance Company _____ Employer _____

Subscriber Name _____ Relationship to Subscriber _____

Policy # _____ Group # _____ Policy start date _____

Policy Holder DOB _____ Policy Holder SS# _____

Secondary Insurance Company _____ Employer _____

Subscriber Name _____ Relationship to Subscriber _____

Policy # _____ Group # _____ Policy start date _____

Policy Holder DOB _____ Policy Holder SS# _____

EMERGENCY INFORMATION

_____
Emergency Contact Name Address Phone # Cell #

_____
Emergency Contact Name Address Phone # Cell #

***Do we have permission to leave appointment information on your answering machine or with family members? Yes / No**
***Do we have permission to leave test results on your answering machine or with family members? Yes / No**

*I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by me or my insurance company at any given time in writing. I also authorize payment to be made directly to the doctor from my insurance company.

Signature _____ Date _____

* We have updated our HIPAA Notice of Privacy Practices. Please visit our website, at cvwomenscenter.com and click on the "forms" tab. Please read the updated notice and initial and date here once it has been read. Initial_____Date_____ If you are unable to read this online, or would like a copy of this notice, please contact our office at 435-753-9999

Office Financial Policy

Cache Valley Women's Center provides their services to you, not your insurance company. Because of this fact you are responsible for payment of any bill incurred in this office. We cannot provide services assuming that the insurance company will come through with payment. As a courtesy to you we will bill your primary insurance company. However, within 60 days we will expect you to pay the balance in full. It will then be your responsibility to collect from the insurance company. We will also be happy to send a bill to your secondary insurance as well. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, that is your responsibility. Please contact your insurance company to inquire if we are a provider for your insurance.

All Co-payments and/or percentages that your insurance required you to pay must be made at the time of visit. We accept cash, personal checks, and most major cards.

Often our patients find themselves without any insurance coverage. It is our policy that payment is to be made in full at the time of service unless prior arrangements have been made.

Any account that has been left unpaid after 30 days will be charged an interest rate of 2% monthly (24% annually). In the event that an account is left unpaid the undersigned agrees to pay costs charged by our collection agency (50% of the unpaid balance) and all limited reasonable attorney's fees.

Thank you for taking the time to read our financial policy. If you have any further questions or concerns, please call the office.

I agree to and understand the above financial policy.

Signature _____ Date _____

Amended

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Gary K. Fowers, MD
Barry A. Noorda, MD
David A. Kirkman, MD
Anne S. Blackett, DO

The comfort of home, the care of professionals

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Amy Billings, PAC
Anna Lara, PAC
D'Anne Moon, CNM
Kenneth A. Wade, PAC

CONSENT FOR OBSTETRICAL TREATMENT

The goal of obstetrics is that every pregnancy be wanted and culminate in a healthy mother and a healthy baby. Advances in medicine have reduced some of the risk of injury and death, but especially in obstetrics because there is no guarantee of successful outcome. Your baby may suffer serious problems at birth because of natural processes and complications that are beyond your control, the control of your physician, and the control of the hospital where you plan your delivery.

During your pregnancy, your doctor may recommend limitations on your activities, referral to other physicians, hospitalization or other medical treatment. Unexpected complications can occur during your pregnancy or labor which may require prompt delivery of your baby. Drugs are available to stimulate labor, instruments called forceps may be used, and delivery by cesarean section may be recommended. Each of these procedures involves substantial and significant risks.

> DISCUSS ANY PROPOSED TREATMENT AND ANY OTHER ALTERNATIVES AVAILABLE TO YOU WITH YOUR DOCTOR. MAKE SURE YOUR QUESTIONS ARE ANSWERED. IT IS YOUR RESPONSIBILITY TO SHARE ALL DECISIONS ABOUT THE CARE YOU WILL RECEIVE.

Should an emergency arise, the availability of hospital anesthesia and surgery personnel may affect how quickly your baby can be delivered. In the hospital where your delivery is planned, anesthesia and surgery personnel are not present but are available on an "on call" basis, 24 hours a day. Past experience has shown that in most cases emergency delivery CAN be accomplished within 30 minutes of notification of personnel.

By signing this document, you acknowledge that there are substantial and significant risks to both mother and child in the childbirth process and that there can be no guarantees of a successful outcome.

Name (please print) _____ Date _____

Signature _____ Witness _____

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OB/GYN Intake History

Name: _____ DOB _____ Date _____

Name of spouse or partner _____ Number in household _____

ALLERGIES _____ Referred By _____

REVIEW OF SYMPTOMS:

Please check ☐ if the following are a significant problem for you NOW.

- ☐ Abdominal pain
- ☐ Abnormal periods
- ☐ Anxiety
- ☐ Asthma
- ☐ Bloating
- ☐ Blood in urine
- ☐ Bloody stool
- ☐ Bruising easily or often
- ☐ Chest pain
- ☐ Constipation
- ☐ Coughing blood
- ☐ Crying often
- ☐ Depression
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Dry skin or rashes
- ☐ Ear aches or ringing
- ☐ Enlarged lymph nodes
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Headaches, type _____
- ☐ Hot flashes
- ☐ Incomplete emptying
- ☐ Incontinence
- ☐ Joint pain or stiffness
- ☐ Nausea
- ☐ Night sweats
- ☐ Pain with urination
- ☐ Painful intercourse
- ☐ Painful periods
- ☐ Palpitations or "heart racing"
- ☐ Premenstrual syndrome
- ☐ Reflux or heartburn
- ☐ Seizures
- ☐ Sexual concerns or questions
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Sleeping problems
- ☐ Sore throat
- ☐ Sore(s) that won't heal
- ☐ Urgency
- ☐ Urinary frequency
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Vaginal irritation
- ☐ Vision changes
- ☐ Vomiting
- ☐ Weight gain
- ☐ Weight loss
- ☐ _____

Personal PAST History

- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Clot
- ☐ Blood transfusion
- ☐ Bowel trouble
- ☐ Bulimia
- ☐ Cancer, type _____
- ☐ Celiac disease
- ☐ Depression
- ☐ Fracture (which broken bone) _____
- ☐ Graves Disease
- ☐ Hashimoto's
- ☐ Heart trouble
- ☐ Hepatitis A, B, or C (circle one)
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV
- ☐ HPV
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Insomnia
- ☐ Jaundice
- ☐ Joint pain
- ☐ Kidney infections
- ☐ Kidney stones
- ☐ Migraines
- ☐ Murmur
- ☐ Osteoarthritis
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Seizures/epilepsy
- ☐ Staph infection
- ☐ Stroke
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Ulcers
- ☐ _____

Name: _____

Medications and dosing: _____

_____

SURGERIES:

Surgery/Reason	Date	Surgery/Reason	Date

OB/GYN HISTORY

Number of pregnancies _____ Number of children _____ Abortion _____

Miscarriage _____ Full term deliveries _____ Birth Control type _____

Last Menstrual Period _____ Menses lasts approximately _____

Are menses regular/irregular? (Circle one)

FAMILY HISTORY Please list maternal or paternal grandparents

ILLNESS	YES	WHO?	AGE DIAGNOSED	Family Member ILLNESS	YES	WHO?
Breast Cancer				Diabetes, Type I		
Colon Cancer				Diabetes, Type II		
Other Cancer				Stroke		
Ovarian Cancer				Blood Clots		
Depression				Heart Disease		
Anxiety				High Blood Pressure		
Drinking Problem				High Cholesterol		
Drug Problem				Thyroid Problems		

SOCIAL HISTORY

	Yes	No	Never	
Tobacco				Packs per day How many years
Tobacco in the last five years				If yes, when did you quit?
Alcohol				Drinks per day Drinks per week
Social Drugs				Name of Drug(s)
Regular Exercise				Hours per day Hours per week
Caffeine				Ounces per day Name of drinks
Sexually Active				

Has anyone ever touched you inappropriately? _____

Do you feel safe at home? _____

PERSONAL PROFILE

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Significant other

School completed: ☐ High School ☐ College ☐ Graduate degree ☐ Other

Current Job (if any) _____ ☐ Full time ☐ Part time

This form completed by: **Patient** **RN/MA** **MD/PA**

Patient Signature _____ **Date** _____

Prenatal Genetics Screening

Name _____ Age _____ DOB _____

Maternal Age

1. Will you be 35 years or older when the baby is due? Yes / No

Genetic Diseases Common to Certain Ethnic Groups

1. Are you or the baby's father of African descent? Yes / No

   If YES, have either of you been screened for sickle cell trait? Yes / No

2. Are you or the baby's father of Eastern European Jewish descent (Ashkenazi)? Yes / No

3. Do you or your partner have any close relatives from Italy, Greece, or other Mediterranean countries? Yes / No

4. Do you or your partner have any close relatives from the Philippines or Southeast Asia? Yes / No

Personal and Family Genetic History

1. Have you, the baby's father, or any member of your respective families ever had any of the following disorders:

   A. Congenital heart defect (blue baby, hole in the heart)? Yes / No

   B. Hemophilia (bleeding disorder in which the blood clots slowly)? Yes / No

   C. Downs Syndrome (Trisomy 21) Yes / No

   D. Other Chromosomal abnormalities? Yes / No

   E. Muscular Dystrophy (disease causing muscle weakness)? Yes / No

   F. Cystic Fibrosis (disease involving the lungs)? Yes / No

   G. Spina Bifida (open spine), Hydrocephaly (water on the brain) or Anencephaly (absent brain)? Yes / No

   H. Tay Sachs Yes / No

   I. Thalassemia Yes / No

   J. Huntington chorea Yes / No

   K. A genetic disorder or birth defect not listed above? Yes / No

   If YES, please list: _____

If YES, to any of the above, please indicate relationship _____

_____

Name _____ DOB _____

2. Do you or the baby's father have a birth defect? Yes / No

   If YES, please describe _____

3. Have you had a previous stillbirth with a birth defect? Yes / No

4. Have you had three or more first trimester (first 12 weeks) losses? Yes / No

5. Do you or the baby's father have any relatives with an intellectual disability? Yes / No

6. Excluding and iron supplement or other vitamins, have you taken any medications or recreational drugs (alcohol, cocaine, methamphetamines, LSD, marijuana, etc.) during the pregnancy? Yes / No

   If YES, please list: _____

7. Have you ever been vaccinated for, or do you have a history of chicken pox (varicella)? Yes / No

Pre-term Labor Questionnaire

Do you have a history of:

1. Miscarriage before 3 months? Yes / No
   1 2 3 +
2. Miscarriage after 3 months? Yes / No
   1 2 3 +
3. Previous pre-term labor? (20 - 37 weeks) Yes / No
4. Previous pre-term delivery? (20 - 37 weeks) Yes / No
   Reason for pre-term delivery:
   A. Pre-term labor
   B. Premature rupture of membranes
   C. Medically indicated induction
5. Cone biopsy, cervical LEEP procedure, or other cervical procedure? Yes / No
6. Uterine anomaly Yes / No
7. Cervical cerclage or incompetent cervix? Yes / No
8. Positive B-strep from vaginal culture? Yes / No
9. Are you a daughter of DES exposure Yes / No
10. Do you have a history of sexually transmitted infections? Yes / No
    If YES, please list, including dates if known: _____

Name _____ DOB _____

With <u>this pregnancy only</u> have you experienced any of the following?

1. Vaginal bleeding? Yes / No
2. Illness with a fever? Yes / No
3. Kidney infection? Yes / No
4. Bladder infection? Yes / No
5. Cigarette smoking? Yes / No

   Packs per day? _____
6. Alcohol use? Yes / No
7. Drug use? Yes / No

Gestational Diabetes Screening

Do any of the following apply to you?

1. I have delivered a baby weight 9 lbs or more at birth Yes / No
2. I have a family member with diabetes Yes / No
3. I have had diabetes in a previous pregnancy Yes / No
4. I am a diabetic now Yes / No
5. I have delivered a stillborn child Yes / No
6. I have delivered a child with a physical abnormality Yes / No
7. I have had 3 or more consecutive miscarriages Yes / No

In the area provided below, please list the details of your previous deliveries, use additional paper is more space is needed.

Date of delivery	Place of birth	Sex	Weight	Gest. age	Anesthesia type	Delivery type	Labor length	Maternal problems	Newborn problems

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Cache Valley Women's Center's physicians and providers do not affiliate with, or back up any planned home deliveries. If you are planning on a home delivery with a midwife or doula, please be aware that this will sever our patient/physician relationship, which will result in your dismissal from our practice.

Patient Signature _____ Date _____

Printed Name _____

Witness Signature _____ Date _____

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