Austin Perinatal Associates
6500 N MoPac Epwy. Building 1, Ste 1205, Austin, TX 78731
Phone: (512)206-0101 Fax: (512) 206-0212

PATIENTS NAME: ______________________________
LAST FIRST M

ADDRESS: ______________________ E-MAIL: ______________________

CITY: ______________ STATE: ______________ ZIP: __________

HOME PHONE: ____________ WORK PHONE: ____________ CELL: ____________

SOCIAL SECURITY #: ______________ DATE OF BIRTH: ____/____/____

EMPLOYER: ______________ DRIVER'S LICENSE #: ______________

SPOUSE'S NAME: ______________ SPOUSE'S EMPLOYER: ______________

SPOUSE'S DATE OF BIRTH: ____/____/____ CONTACT #: ______________

PRIMARY INSURANCE ***IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, YOU MUST COMPLETE EACH BLANK

INSURANCE COMPANY: ______________ PHONE #: ______________

CLAIMS MAILING ADDRESS: ______________

POLICY #: ______________ GROUP #: ______________

SELF PAY

POLICY HOLDER'S NAME: ______________ DATE OF BIRTH: ______________

POLICY HOLDER'S EMPLOYER: ______________ PHONE #: ______________

POLICY HOLDER'S SS#: ______________ RELATIONSHIP TO PATIENT: ______________

REFERRING PHYSICIAN: ______________ REASON FOR APPOINTMENT: ______________

ANY OTHER CONDITIONS/COMPLICATIONS/CONCERNS: ______________

LIST ALL DRUG ALLERGIES: ______________

DATE OF LMP: ____/____/____

EXPECTED DUE DATE: ____/____/____

I authorize David L. Berry, M.D. and/or qualified staff to perform upon me, ultrasound and/or any other medical care including treatment necessary for the well-being of me and/or my unborn child. I acknowledge that the practice of medicine and/or ultrasound is not an exact science and that no guarantees can be made to me regarding the outcome of treatment and/or my pregnancy.

PATIENT SIGNATURE: ______________ DATE: __________

I understand the under the Health Insurance Portability and Accountability Act of 1996 I have certain rights to privacy in regards to my private health information. I have read, received a copy (if requested) and understand the Notice of Privacy Practices presented by *Austin Perinatal Associates*. I acknowledge this practice reserves the right to modify this policy as governed by law and I can request a copy of the policy at any time.

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 *Austin Perinatal Associates.*

PATIENT SIGNATURE: ______________ DATE: __________

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SELF INSURED PAYMENT AGREEMENT

You have represented to *Austin Perinatal Associates (hereinafter "Austin Perinatal")* that you are self-insured (i.e. do not have health insurance that covers obstetrics & gynecology). By representing yourself as a self insured patient, you:

(1) are asking that Austin Perinatal not file any documents with an insurance company;
(2) will pay at the time of service;
(3) will receive a "prompt pay" discount off of the regular price; and
(4) are waiving any medical insurance benefits that you might have (understanding that if you do have health insurance, your insurance company might refuse to cover your services based on this wavier).

Austin Perinatal is only requiring you to make payment at the time of service based on your representation. Further, Austin Perinatal is only extending the "prompt pay" discount based on your representation. If your representation is false, you will be liable to Austin Perinatal for any and all losses, expenses and/or damages incurred by Austin Perinatal.

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

Responsible Party Signature (Must be 18 or over) _______________

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FINANCIAL POLICY

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, Care Credit, MasterCard, 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 ________

- As a courtesy to you, we will file primary participating insurance for you with proper assignment. Any additional insurance policies will be yours to file with receipt from our office. Please bring your primary insurance card with you to <u>every</u> 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 ________

- We confirm appointments 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 *Austin Perinatal Associates* 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)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect August 1, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our policy practice we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for an additional copy of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations.
For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, licensing or credentialing activities.

Your Authorization: In addition to our use of your healthcare information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. Your requests must be in writing and may also revoke it (in writing) at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree in writing that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, sonogram reports or other medical forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, postage and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes of treatment, payment, healthcare operations and certain other activities for the last six years but not before August 1, 2003. If you request this accounting information more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but will abide by your requests with the only exception being in an emergency.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS & COMPLAINTS

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means, you may use the contact information below. We are required to abide by the terms of our *Notice of Privacy Practice* currently in effect. We reserve the right to make revisions or changes to this Notice.

We support your right to privacy of your health information. We will provide you with the address to file a federal complaint to the U.S. Department of Health and Human Services upon request.

Contact Officer: Vanessa Armstrong, Operations Officer   Telephone: (512) 206-0101

Patient Signature: ______________________________ Date: ______________

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PATIENT HISTORY

Date:	Referring Doctor/Midwife:
Name:	Age: HT: WT: BMI:
Martial Status:	Partner's Name:

Reason for referral (Your or Your Doctor's Concerns):

Signs and/or symptoms experiencing:

Total # of Pregnancies (Including this one):

# of term deliveries: Preterm deliveries: Miscarriages/Abortions: Living children:

PREGNANCY HISTORY:

Month/Year of Delivery	C-section or vaginal delivery/birthweight	Comments (Premature, abnormality, stillbirth, complication, injury or disease while pregnant):

Please Indicate if you have or have had:	Yes	No	If Yes, brief Description:
Breast Disease			
Ovarian Cyst			
Blood Clots			
Infection of uterus, tubes or ovaries			
Tumor of uterus			
Jaundice			
Cancer			
Seizures			
Pneumonia			
Diabetes			
High Cholesterol			
Migraines			
Kidney Disease			
Heart Disease			
Bleeding Tendencies			
High Blood Pressure			
Congenital Heart Disease			
Lupus			
Hepatitis			
Thyroid Disfunctions			
Positive HIV or AIDS test			

SURGERY (Please list what type and year performed):

Have you ever had a vaginal infection or sexually transmitted disease? ______________ Describe:

Please list all medications you are currently taking (include all prescription and over the counter):

____
____
____
____

Please list all medications you have taken during this pregnancy (include all prescription or non-Rx):

PLEASE LIST ALL MEDICATIONS TO WHICH YOU ARE ALLERGIC:

____

Do you drink alcohol?	If yes, how frequently/much?
Do you smoke?	If yes, how frequently/much?
Do you take recreational drugs?	If yes, which drugs?
How frequently?	How recent?

Do you or the father have any family history of birth defects? ______ List relationship and description:
Cystic Fibrosis
Thalassemia
Sickle Cell Anemia
Neural Tube Defect
Heart Defects
Unexplained mental retardation/Neruromuscular
Chromosomal abnormalities (Down Syndrome, etc.)
Any Other History (please list):

REVIEW OF SYSTEMS (check all that apply):

Fever______
Body Aches______
Headaches______
Dizzy spells______
Weight change______
Visual/Eyes______
Ear/Nose/Throat______
Palpitations/chest pain______
Lung infection/wheezing______
Nausea/vomiting______

Constipation/diarrhea______
Abdominal pain______
Trouble urinating/UTI______
Recent vaginal bleeding______
Vaginal discharge______
Muscle pain/weakness______
Bone pain or fractures______
Skin rashes or itching______
Numbness/tingling______
Weakness______

Depression______
Difficulty concentrating______
Hallucinations______
Too hot/cold______
Blood sugar issues______
Swollen lymph nodes______
Anemia______
Seasonal Allergies______
Frequent illnesses______
Poor immune system______

Maternal - Fetal Medicine and Genetic Services

Patient Name: ______________________________
(Print)

Date of Birth: ____________________

Expected Due Date: _______________

I give the parties listed below, permission to discuss and receive any medical and financial information for this current pregnancy, with all employees of Austin Perinatal Associates, David L. Berry, M.D.

____

Patient signature

Parties involved with current pregnancy:

______________________________	_________________________
Name (print)	Patient Signature
______________________________	_________________________
Name (print)	Patient Signature
______________________________	_________________________
Name (print)	Patient Signature

LATE ARRIVAL POLICY

If a patient is <u>more than 15 minutes</u> late for an appointment, <u>the appointment will need to be rescheduled</u>.

This policy is to ensure the best possible experience for all patients by eliminating unnecessary wait times to see Dr. Berry or his clinical staff. Schedule permitting, you will be given the option to wait for another appointment time the same day.

New patients are encouraged to print off new patient paperwork from our website, <u>AustinPerinatal.com</u>, and fill it out prior to coming in.

Otherwise, new patients need to arrive at our office **<u>20 minutes prior to the scheduled appointment</u>** to complete their paperwork. If paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time, or possibly reschedule the appointment.

The Austin Perinatal Team appreciates your compliance and understanding with this policy so that we can provide excellent medical care and an unparalleled customer experience to everyone.

Initials: __________