Maternal-Fetal Medicine Associates of Maryland, LLC

Important Information for Our Patients

Office Hours

The office is open from 8:00 am to 4:30 pm, Monday through Friday.

Patient Information and Identification

Patients are required to present a valid photo ID and current insurance card at their initial visit. Patient must promptly notify the practice of any changes to their demographic and/or insurance information. Failure to notify MFMofMD of any changes may result in a patient being responsible for full fees of services rendered.

Appointment Confirmations/ Cancellations

An automated reminder will be sent to you three business days prior to your scheduled appointment per your preference (call or text). If you need to cancel or change an appointment, we require a minimum of 24 hours advance notice. Failure to give 24 hours notice will result in a $75 Missed Appointment Fee billed directly to you, not your insurance company. Missed appointment fees must be paid prior to any rescheduling of appointments. Multiple missed appointments may result in dismissal from the practice.

Visitors

Your spouse, support person, or friend is welcome to accompany you to your appointment. However, please be mindful that our exam rooms and waiting areas have limited spaces. At this time, we can only accommodate one adult guest with each patient, no children.

Photography and Videotaping

To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within this clinic. This includes but is not limited to the following: cell phones, digital cameras, video cameras, laptops, etc. If images from your ultrasound were obtained from your scan, a link will be sent to your email on file for you to be able to access them.

Insurance Providers

A list of insurance companies with whom we participate may be found on our website and is available to you upon request. For participating insurance carriers, we will submit claims directly to your plan on your behalf. You, the patient, are responsible for paying the appropriate deductible, coinsurance or copay amount as determined by your insurance company. Co-payments and unpaid balances are due at the time of service prior to your appointment. Any additional patient responsibility identified by your insurance company on their Explanation of Benefits (EOB) will be due upon receipt. If your insurance has been terminated or is not effective for any reason, the patient will be solely and financially responsible for any unpaid balances in full. It is the patient's responsibility to understand their individual responsibilities.

Referral Authorization/ Pre-Certification

As many insurance companies require referral authorizations and/or pre-certifications for specialty services, we ask that you please familiarize yourself with your insurance company's requirements. If the appropriate authorization has not been received in our office prior to your visit with us, your appointment may need to be rescheduled. If your insurance company denies a claim for lack of pre-authorization it is your financial responsibility to pay the bill in full. Please note that many primary care physicians require 4 days advance notice to provide authorization.

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Payment Options

Payment is due at the time of services rendered. We accept Visa, MasterCard, Discover and American Express payments. Our billing services are provided by Healthcare Data Management. Any questions or concerns relating to your account can be directed to HDM at: Phone: 1-866-869-6132

Collections

Patient accounts that are past due will be referred to a collection agency. In the event of a defaulted account, the patient further agrees to pay reasonable collection charges and/or attorney fees and/or court costs.

Medical Record

All requests for copies of medical records must be submitted in writing. A medical records fee in accordance with Maryland Law must be received in our office prior to release of the record.

I certify that I understand and agree to the terms set above:

______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Patient's Name Printed	Date of Birth

MFMofMD Representative Initials: __________

RELEASE AND ASSIGNMENT

I,______________, hereby authorize Maternal-Fetal Medicine Associates of Maryland, LLC to release to my insurance carrier(s) all information concerning my illness and treatment and hereby assign to Maternal-Fetal Medicine Associates of Maryland, LLC, all payments for medical services rendered to myself and/or dependents. I understand that I am fully responsible for any amount NOT covered by my insurance carrier.

______________________________ ______________________

Patient Signature Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I,______________, hereby authorize Maternal-Fetal Medicine Associates of Maryland, LLC to release my medical records to my referring physician (OB/GYN), any other PCP or specialist that will be treating me during my illness and treatment at MFMofMD. I understand that any records not related to my illness and treatment will NOT be released.

______________________________ ______________________

Patient Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICE

I,_______________, have received a copy of Maternal-Fetal Medicine Associates of Maryland, LLC notice of Privacy Practices.

______________________________ ______________________

Patient Signature Date

CONSENT FOR TESTING

In order to comply with the Occupational Safety & Health Administration (OSHA) Bloodborne Pathogen Regulation and Maryland State Law, we are requesting your consent to submit to testing of your blood for bloodborne pathogens (hepatitis B, hepatitis C and HIV) if an exposure occurs (needlestick injury, blood splatter) to one of the staff. Testing will be done at no cost to you. All information regarding an exposure is confidential.

______________________________ ______________________

Patient Signature Date

Maternal-Fetal Medicine Associates of Maryland, LLC

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below (for example: spouse, parent, friend).

Description of the specific information to be discussed:

- ☐ Appointment Dates/Times
- ☐ Diagnosis:
- ☐ Medications
- ☐ Lab Test/Results
- ☐ Summary of Medical Record
- ☐ Care Plan
- ☐ Other (specify): ______________________________

Indicate Confidential Information (please specify):

Patient Name: ______________________________
Date of Birth: ______________________________
Information to be given to:

Name: ______________________________
Relationship: ______________________________
Address: ______________________________
Phone: ______________________________

This authorization shall remain in effect from the date signed below until (please check one):

- ☐ _______________ (specify expiration date or event)
- ☐ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office—attention: Administrator.
- This authorization is giving MFMofMD the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.)

______________________________ Signature:

______________________________ Date:

PATIENT INFORMATION

Last Name:	First Name:	M.I.:		
Social Security #:	Date of Birth:	Age:	Occupation:	Employer:
Street Address:	Apt. #:	City, State, Zip		
Email:	Marital Status: S / M / D / W / Other			
Cell #:	Work #:	Home #:		

RESPONSIBLE PARTY'S INFORMATION (BILL TO)
(If patient, leave blank. If patient is under 18, please complete with parent/guardian's information.)

Last Name:	First Name:	M.I.:
Street Address:	Apt. #:	City, State, Zip
Date of Birth:	Social Security #:	Contact #:

REFERRAL INFORMATION

Referring Obstetrician/Gynecologist:	Office Phone: Office Fax:
Primary Care Physician:	Office Phone: Office Fax:

INSURANCE INFORMATION

Primary Insurance:	Referral Required: Yes: No:				
Subscriber's Name:	Policy #:	Group #:			
Date of Birth:	Social Security #:	Contact #:			
Occupation:	Employer:				
Relationship to Subscriber:	Self	Spouse	Child	Other:	Effective Date:

Secondary Insurance:	Referral Required: Yes: No:				
Subscriber's Name:	Policy #:	Group #:			
Date of Birth:	Social Security #:	Contact #:			
Occupation:	Employer:				
Relationship to Subscriber:	Self	Spouse	Child	Other:	Effective Date:

CONTACT INFORMATION

Emergency Contact Name:	Relationship to Patient:	Contact Phone #:

MEDICAL HISTORY

Name: ______________________ Date: ______________________
Birthdate: ______________________ S.S.#: ______________________
Obstetrician: ______________________ Preferred Pharmacy/Phone: ______________________
Are you allergic to latex? YES __________ NO __________ ______________________
Height: Weight: ______________________

OBSTETRICAL HISTORY:

Last menstrual period: ______________________ No. of prior pregnancies: ______________________

Live Birth	Date	Weight	Full Term	M/F	Vag/C-Sect.	Complications (if any)
1						
2						
3						
4						

Miscarriage(s): Date(s) and Week(s): ______________________
Termination(s): Date(s) and Week(s): ______________________
Blood Type: A:________ B:________ AB:________ O:________ RH positive: ________ RH negative:________

MEDICAL HISTORY

HAVE YOU EVER HAD...	Yes	No	Complications (if any) (please limit response to 60 characters)
Anemia			
Arthritis			
Asthma			
Back Problems			
Blood Clots			
Blood Transfusion			
Cancer			
Depression			
Diabetes			
Heart Problems/Murmurs			
Hepatitis			
High Blood Pressure			
Lupus/Autoimmune Disorders			
Migraines			
Seizures			
Sexually Transmitted Disease			
Surgery (OB/GYN)			
Thyroid			
Other Medical Conditions			

During your pregnancy, have smoked cigarettes? Yes ________ No ________ If yes, how much? ______________________
During your pregnancy, have you drank alcohol? Yes ________ No ________ If yes, how much? ______________________
Are you currently taking medications (prescription and over the counter)? Yes ________ No________
If yes, which ones and what dose? ______________________
Are you allergic to any medications? If yes, please list: ______________________

Date: ______________________ Reviewed: ______________________

FAMILY HISTORY

Name: ______________________________________ Partner's name: ___________________ Age: ________
Your birthday: ______________________________ Partner's birthday: ______________________________
Religion: ___________________________________ Partner's religion: ______________________________
Ethnic background (yours): ____________________ Ethnic background (your partner's): _________________
Have you or your partner ever had genetic screening? Yes____ No ____

FAMILY HISTORY:
Do you, your partner, your children or any family member have any of the following condition?

	Yes	No	Whom/Explain (please limit response to 60 characters)
Autism			
Blindness			
Cancer of early onset (under 45)			
Chromosome Abnormality			
Cleft Lip and/or Palette			
Cystic Fibrosis			
Deafness			
Down Syndrome			
Dwarfism			
Epilepsy/Seizure Disorder			
Genital Abnormality			
Heart Defect (as a child)			
Hemophilia/Bleeding Disorder			
Huntington's Disease			
Hydrocephaly (Fluid on the Brain)			
Infant Death			
Infertility			
Multiple Miscarriages (>2)			
Kidney Defects			
Limb Defects			
Psychiatric Illness			
Intellectual Disability			
Muscular Dystrophy			
Neurofibromatosis			
Preeclampsia			
Sickle Cell Disease/Thalassemia			
Spina Bifida/Anencephaly			
Stillbirth			
Sudden Death			
Other Medical Conditions			

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Fax: (301) 315-2169

INFORMED CONSENT FOR ULTRASOUND

Your physician has requested that you undergo a diagnostic procedure known as an ultrasound. Simply stated, this procedure involves the transmission of sound waves reflected off your womb and fetus, which will be monitored and recorded on a videotape or film to obtain information concerning your pregnancy. This test is believed to carry with it very little risk to you or your fetus.

The standard ultrasound exam takes approximately 10-30 minutes to perform and may provide information concerning placenta location, fetal position, multiple gestations, approximate gestational age, and the possible presence of certain gross fetal malformations. This test, however, is not definitive for the absence of fetal malformations, and despite a normal interpretation of the test, some babies are born with anomalies not identified by the examiner during the ultrasound study. Thus, although ultrasonography is a helpful diagnostic tool, it does not absolutely determine the absence of fetal defects. This type of exam is also done prior to performing genetic amniocentesis.

Should you have any questions concerning ultrasonography, please discuss them with your referring physician before undergoing the procedure. You are requested to sign this document prior to the performance of your ultrasound exam, thereby acknowledging that: I HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED HEREIN, AND I AM AWARE OF THE RISKS INVOLVED.

____________________	____________________
Patient's Signature	Date
____________________	____________________
Print Patient Name	MFMofMD Representative Signature and Date

AMERICAN INSTITUTE OF ULTRASOUND MEDICINE OFFICIAL STATEMENT

Clinical Safety
Approved 11/28/2006

Diagnostic ultrasound has been in use since the late 1950s. Given its known benefits and recognized efficacy for medical diagnosis, including use during human pregnancy, the American Institute of Ultrasound in Medicine herein addresses the clinical safety of such use:

There are no confirmed biological effects on patients or instrument operators caused by exposures from present diagnostic ultrasound instruments. Although the possibility exists that such biological effects may be identified in the future, current data indicate that the benefits to patients of prudent use of diagnostic ultrasound outweigh the risks, if any, that may be present.