Mid-South Maternal Fetal Medicine, PC

Ultrasound Policy

Mid-South Maternal Fetal Medicine is committed to providing you and your unborn baby excellent care.

Mid-South Maternal Fetal Medicine is an AIUM accredited practice that believes in the diagnostic and prudent use of ultrasound technology for the assessment of the fetus and mother. However, ultrasound alone cannot detect all aneuploidies nor anomalies.

3D/4D ULTRASOUND IS UTILIZED FOR DIAGNOSTIC PURPOSES ONLY

During your visit with us, please observe the following:

1. All cell phones **MUST** be turned off during ultrasound.
2. No video or audio recording of ultrasound is permitted under any circumstance.
3. **No children will be allowed inside the clinic**.
4. Remove all piercings (naval and vaginal). This does not include earrings or facial piercings. Piercings can damage ultrasound equipment.
5. You may have **one** support person, over the age of 18, present for your ultrasound. You will not be permitted to change support persons during ultrasound. **This policy is subject to change at any time.**

We will provide you with pictures of your baby (if technically feasible) at your initial visit. For repeat visits, you will receive baby pictures when your baby is measured for growth.

_____ _____

Patient Name Date

_____

Patient Signature

MID-SOUTH MATERNAL FETAL MEDICINE, P.C.

Ray Bora-Kerfoot, M.D.
Christy Smith, W.H.N.P., MSN
Sheila Thomas, R.N.P.

Accredited by AIUM in obstetrical and fetal echo ultrasound

6266 Poplar Memphis, TN 38119
901-682-2595 office 901-682-2549 fax

History and Review of Systems

Please complete entire form to better help us in meeting your medical/health needs.

Patient Name:_____ **Age:**_____ **Today's Date:** _____

Reason you are here today: _____

Allergies to medications or foods? _____

Medications you are currently taking: _____

_____

Reproductive History:

Who is your OB doctor? _____
When was your last period? _____ What is your due date? _____
Is this pregnancy the result of IVF or IUI? _____ What was the date of implant? _____
Use of own eggs? ____ Donor eggs? _____ Donor sperm? _____ Age of eggs at retrieval? _____
How many times have you been pregnant? (include miscarriages, abortions and current pregnancy) _____
How many of your pregnancies were miscarriages? _____
How many living children do you have? _____

Birth Year	Vaginal or C-section	Boy or Girl	Weight	How many weeks were you at delivery	Any complications? (Preterm labor, short cervix, high blood pressure, diabetes, etc.…)	Is the child(ren) living now?

Do you have a history of blood clots?____; HELLP?____; Toxemia?____; Small baby? ____
When was your last PAP smear? _____
Have you ever had an abnormal PAP smear?____Were any procedures performed on your cervix for the abnormal PAP smear? _____
Have you ever had a cervical cerclage? _____ When? _____ By what doctor? _____
How old were you when you started your period the first time? _____
Do you have a history or recent diagnosis of any STD (including Gonorrhea, Chlamydia, Trichomonas, Herpes, Syphilis, Genital warts, HIV)? _____

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Name:_____ **DOB:**_____ **Today's Date:** _____

Personal History:

Do you have any health problems? (for example: High blood pressure, diabetes, seizures, blood clots, thyroid, etc.…)

_____

Have you ever had surgery?_____ For what? _____

What was your weight **before** you became pregnant?_____ How tall are you? _____

Social:

Marital Status: _____ Do you work? _____ Full time/Part time? _____

Do you smoke cigarettes (tobacco or e-cigarettes)?_____ How many a day? _____

How many years have you smoked?_____ If you have quit, when did you quit? _____

Do you use marijuana? _____ How often? _____ When was the last time? _____

Do you use any street drugs?_____What do you use? _____

How often?_____ When was the last time you used? _____

Do you take steroids or NSAIDS (Advil, ibuprofen, naproxen, etc.…)? _____

Have you drunk alcohol with this pregnancy? _____ What did you drink? _____

How much did you drink? _____ When did you last drink? _____

Do you drink caffeine? _____ How much? _____ How often? _____

Do you have indoor pets? _____

Do you have any spiritual beliefs or values that may affect your care? _____

Family: (Blood relatives only)

# of brothers living ____ # of brothers not living ____ Cause of death: _____

# of sisters living _____ # of sisters not living _____ Cause of death: _____

Mother: living ___ not living ___ What did she die from? _____ How old was she? _____

Father: living ___ not living_____What did he die from? _____ How old was he? _____

Maternal grandmother (your Mom's mom): living____not living____Cause of death? _____

Maternal grandfather (your Mom's dad): living ___ not living ___ Cause of death? _____

Paternal grandmother (your Dad's mom): living ___ not living ___ Cause of death? _____

Paternal grandfather (your Dad's dad): living ___ not living ___ Cause of death? _____

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Do any of your blood relatives have? AND Who has the problem?

	Mom	Dad	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Your brother	Your sister	Your Child
High blood pressure									
Diabetes									
Thyroid problems									
Genetic disorder									
Mental retardation									
High blood pressure with pregnancy		N/A		N/A	N/A	N/A	N/A		N/A
High Cholesterol									
Heart attack									
Heart problems									
Sickle cell disease									
Sickle cell trait									
Strokes									
Blood clots									
Cancer									

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Name:_____ **DOB:**_____ **Today's Date:** _____

Have you had or are you having:

Constitutional: ____Fever ___Chills
___Significant change in your weight (gain or loss)
Eyes: ___Change in vision ___Seeing of spots in your vision
___**Last Eye Exam-**_____
___**Have seen an eye doctor-**_____
ENT: ___Sinus congestion ___Sinus drainage
Respiratory: ___Problems with asthma ___Cough ___Sore throat
___Shortness of breath
___**Have seen a Pulmonologist/Lung doctor-**_____
Heart: ___Irregular heartbeat ___Dizziness ___Passing out
___High blood pressure
___**Last EKG** _____
___**Have seen a Cardiologist/Heart doctor-**_____
Blood: ___Bleeding gums ___Bruise easily
___**Have seen a Hematologist/Blood doctor-**_____
GI: ___Heartburn/Indigestion____Change in appetite ___Diarrhea
___Constipation ___Nausea ___Vomiting
___**Last Dental Exam-** _____
___**Have seen a Gastroenterologist/Stomach doctor-**_____
***OB:** ___Contractions ___Vaginal bleeding ___Leaking of fluid
___Vaginal discharge ___Vaginal itching ___Vaginal irritation
___Good fetal movement ___Decreased fetal movement
___**Have done the Glucola screen/"Sugar Test"-**_____
___**Have seen my OB-**_____
Endocrine: ___High blood sugars ___Low blood sugars
___**Have seen my Endocrinologist-**_____
___Have had a change in my medication-_____
Kidney: ___Pain with urination ___Urinary frequency ___Blood in urine
___**Have seen a Nephrologist/Urologist-**_____
Muscles: ___Joint pain
Skin: ___Rash ___Itching
___**Have seen a Dermatologist-**_____
Neuro: ___Headache ___Dizziness ___Last seizure-_____
___**Have seen my Neurologist-**_____
___Have had a change in my medication-_____
Psychological: ____Problems with depression ___Problems with anxiety
___Have thoughts of hurting myself or others
___**Have seen a therapist or Psychologist-**_____
___Have had a change in my medications-_____

Have there been any changes in your health since your last visit in our office? _____

Is there anything else you feel like we should know today? _____

Patient Signature:_____ Date: _____

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Name:_____ **DOB:**_____ **Today's Date:** _____

CONSULT NOTES

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Privacy Management - Protected Health Information & Communications

Patient Name _____

Protected Health Information:

I hereby authorize release of my protected health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment, to persons I have listed below. Any person who is not listed will not be able to obtain protected health information. It is not necessary to list other treating physicians or insurance companies. This authorization will remain in effect until revoked by the patient.

Name of authorized person	Relationship	Phone number
1.		
2.		
3.		
4.		
5.		

Patient Communications /Automated Messages:

Our practice utilizes an electronic medical records system with an integrated Patient Portal which allows patients, providers & practice staff to communicate more securely and efficiently.

Please indicate your automated messaging preference(s), one you will be sure to see, for each of the following items:

Health Notifications: When Lab results and health reminders are available on the Patient Portal you will be notified via the method you choose. Which notification method do you prefer?

□ Email □ Phone □ Text message

Appointment Reminders: Reminders about scheduled appointments and/or appointments needing to be scheduled.

□ Email □ Phone □ Text message

Announcements: Notifies you of an appointment cancellation/reschedule, office closure or delayed opening and other important office announcements.

□ Email □ Phone □ Text message

Billing: Notification of new Billing Statements & outstanding balances. Statements and outstanding balances can be viewed and paid on the Patient Portal at any time.

□ Email □ Phone □ Text message

These notification preferences only apply to **automated messages** from our office. Our office may still contact you via phone if an urgent matter requires your attention.

Patient Signature:_____Date: _____

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HIPAA Privacy and Release of Information Authorization

Patient Name _____

I hereby authorize Mid-South Maternal Fetal Medicine, P.C. and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to the practice. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority and the right to exchange immunization data with my state immunization registry.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Patient Signature: _____ Date: _____

MID-SOUTH MATERNAL FETAL MEDICINE, P.C.
FINANCIAL & ADMINISTRATIVE POLICIES

Consent to Treat

- I hereby give my permission to Mid-South Maternal Fetal Medicine, P.C.(MSMFM) and the divisions' thereof for medical treatment including but not limited to examination, injections, blood tests, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment.

DISCLOSURE OF INSURANCE COVERAGE: COMMERCIAL / TENNCARE / MEDICAID

- I certify that I have provided ALL INSURANCE INFORMATION to the practice & it is my responsibility to notify the practice of any changes.

PATIENT PAYMENT POLICY AND COVERED SERVICES

- I understand that I am responsible for all charges associated with my care. It is the policy of MSMFM to collect all patient balances, co-pays, and deposits due from patients at the time of service.
- Health insurance plans **may not** provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for treatment. It is my responsibility to know and understand the services covered by my insurance, and if insurance does not cover these services, I will be responsible for payment.
- I authorize MSMFM to release any information concerning my treatment and irrevocably assigned to them all insurance benefits for my care.
- Our office may contact your insurance carrier to verify your insurance coverage and benefits. An **estimate** of your financial responsibility will be determined according to the contractual agreement between MSMFM and your insurance company. Our Benefits Coordinators may review your benefits with you to explain your financial obligations, and you may be required to pay a deposit prior to services being rendered.
- If an insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for services, and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from the practice and denied future care and services by all providers within MSMFM. Additionally, a collection fee of up to 40% will be added to your account balance. I understand I am responsible for the collection fees and/or attorney fees incurred in the collection of this account.
- You are responsible for knowing which hospital your insurance carrier allows you to utilize for procedures, tests, and admissions.
- If you do not have medical coverage with an insurance for which MSMFM participates or if you are a new patient and cannot supply a valid insurance card or for which coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by the reference lab.
- If you are required to have a referral or other prior authorization for medical services, it is your responsibility to obtain this.
- We will require accounts with self-pay balances TO pay their balances to zero ($0) prior to receiving further services by our practice.

RETURNED CHECK CHARGE

- MSMFM will charge the patient account $35.00 for any returned checks to cover MSMFM's cost for any related bank charges.

CANCELLATION POLICY

- MSMFM requires a 24-hour cancellation notice for any scheduled medical appointment or surgery/procedure.
- No shows and cancellations without a 24-hour notice may receive a $20.00 charge for missed office visits and $150.00 for missed surgeries or procedures. This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.
- If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.

PERSONAL INFORMATION VERIFICATION

- It is our policy to verify your demographic and insurance information **at every visit** to help ensure that claims are processed timely and accurately. Although it may seem unnecessary at the time, this is extremely important to our billing process. Please bring your insurance card with you **EVERY VISIT**. Additionally, a photo ID will be requested from all patients.

FORMS AND PAPERWORK

- There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages.
- A $35.00 fee will be charged to complete FMLA and standard disability forms. We ask that this fee be paid at the time of the request. Forms that are faxed to us will not be completed until the fee is paid.
- Please allow 2-3 working days for completion. Please call office first if you are picking up your forms. If to be mailed, please supply an envelope with the mailing address.

Practice Guidelines

- Routine medication refills are handled during office hours only. We do not refill any prescriptions (including narcotics) after hours or on weekends. When calling for prescriptions, please have your pharmacy phone number available.
- If you have a question for the nurse or your provider, we will return your call as soon as possible, giving priority to emergencies and scheduled patients in the office. At the time of your call, please let us know if you will be unavailable at a certain time.
- Physician excuses for days missed from work or school are written only for the days you are seen in our office and additional days needed for recovery. We are unable to write excuses for illnesses not evaluated in our office. We also do not backdate excuses.

A photocopy of this statement is considered to be as valid as the original.

Patient Signature _____ Date: _____ RE: 07.2020