Fair Oaks Women's Health
Obstetrics and Gynecology
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

www.fowh.com
obgyn@fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

Contents of NEW OB Forms Packet
[This packet is designed to be printed ONE-SIDED.
Please DO NOT print this on two sides. Thank you.]

We know that this is A LOT of paperwork and for this we apologize.

This is only for NEW OB patients to the practice. Thank you very much for your time.

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WELCOME TO OUR PRACTICE

Thank you for choosing Fair Oaks Women's Health for your ob/gyn medical care! In preparation for your upcoming appointment, we would like you to get a head start with some of the paperwork and also tell you a bit about our practice. Our services include comprehensive medical care for women of all ages, including well woman exams, contraception, STD testing, routine and high-risk prenatal care and delivery, bio-identical hormone therapy, menopause management, gynecologic and laparoscopic surgery (including robotic surgery) and more. We also have the MonaLisa Touch® vaginal laser used to successfully treat vaginal dryness and painful intercourse due to loss of estrogen from menopause.

COVID-19

At the time of writing this letter, we are in the midst of the COVID-19 pandemic. With luck, by early to mid 2021, things will have returned close to a normal state in terms of hospital and office policies, services and visitation guidelines. The materials presented to you are meant to reflect "normal" policies and services and many of these will not apply during the pandemic. We apologize for any discrepancies between what you read in our documents and what is taking place currently.

EMR (electronic medical record)

Our practice uses a computerized health record, called an EMR. It takes time to enter your information into the computer. It would be very helpful if you would complete your New Patient forms and then mail (or fax or e-mail) them to us before your appointment. If you do not send these forms, your visit could be delayed while we update the computer before you see the doctor. Email your forms to: obgyn@fowh.com.

We charge for a "no-show"

Please call us at least 24 hrs in advance if you are unable to keep your appointment. There is a $25 charge for a no-show appointment (waived if you make and keep the next appointment). When you do not show up or call ahead to cancel, we have lost the chance to have another patient use that appointment time.

Please arrive early for your FIRST appointment

It takes time time to enter or update your personal, insurance and health information. At your first visit we scan your driver's license and insurance card for entry into our EMR. *We guarantee to keep all of your personal information private.* This is the law (a Federal law called HIPAA).

Parking – we do not validate

Please note that you pay the cashier BEFORE returning to your car. To save money (but with a little more walking) some patients park in the Huntington Hospital EAST Parking structure, a building just south of ours. The entrance is off Fairmount Ave. across from the Emergency Dept.

Lab

For your convenience, we have an on-site lab, called Primex. This is where most of our standard lab tests are run. Primex is a separate entity and is not affiliated with our practice in any way. Not all insurance plans contract with Primex. It is your responsibility to know which lab your insurance is contracted with. ***If your insurance requires you to use a different lab please let us know.***

Marina's Oasis Medi-Spa

Marina's Oasis, our on-site medical aesthetics center, provides a wide range of non-invasive corrective services to enhance the health and appearance of your skin.
For more information please call Marina Jick, MSN, FNP at 626-MY-OASIS (626-696-2747) or go to www.marinasoasis.com.

Feel free to call us at any time if you have any questions. Call (626) 304-2626.
Thank you for trusting us with your medical care. We look forward to seeing you!

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PATIENT INFORMATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. Thank you very much. All information provided is completely confidential.

DATE TODAY _____

LAST NAME _____ FIRST NAME _____ M.I. ____

PREFERRED FIRST NAME _____ DATE OF BIRTH _____ SSN# _____

ADDRESS _____ (PO Boxes Not Allowed)

CITY _____ STATE _____ ZIP _____

HOME PH# _____ MOBILE PH# _____ WORK PH# _____

PREFERRED Ph# WEEKDAYS (**CIRCLE** ONE): **HOME** **MOBILE** **WORK**

EMAIL _____ PREFERRED CONTACT METHOD: _____

MARITAL STATUS _____ DRIV LIC. # _____

Optional - We invite you to share your race, ethnicity, sexual orientation, and gender identity information:

RACE _____ ETHNICITY _____

SEXUAL ORIENTATION _____ GENDER IDENTITY _____

SEX AT BIRTH _____ PRONOUN ___she/her ___they/them ___he/him

Are you employed? _____ If yes, YOUR OCCUPATION _____

EMPLOYER NAME _____ PH.# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

(If you are married/committed, may we have your spouse/sig other information)

SPOUSE/SIG OTHER NAME _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

MOBILE PH# _____ WORK PH# _____

HOW DID YOU HEAR OF US? _____

WHO IS YOUR PRIMARY CARE DR. (PCP)? _____

PHARMACY NAME AND ADDRESS _____

PHARMACY CITY,STATE,ZIP _____ PH# _____

EMERGENCY CONTACT NAME _____ RELN _____

MOBILE PH# _____ OTHER PH# _____

Please sign below if you give us permission to message you (such as test results) via voice mail or e-mail:

SIGNED _____ DATE _____

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INSURANCE INFORMATION FORM

Please take a few minutes to complete this form. All information provided is completely confidential. Thank you. We use this information only for medical insurance verification and billing.

PATIENT NAME _____ DATE OF BIRTH _____

_____ I am insured under my own plan _____ I am insured under someone else's plan

INSURANCE COMPANY NAME _____

CLAIM FILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

BILLING PH# _____

NAME OF POLICY HOLDER (GUARANTOR): ☐ MYSELF or _____

MEMBER ID NUMBER of POLICY HOLDER _____

POLICY GROUP NUMBER _____

DATE POLICY ISSUED _____

DATE POLICY EXPIRES _____

CO-PAY AMOUNT (SPECIALISTS) _____

CO-INSURANCE PERCENTAGE _____

PRIMARY CARE PROVIDER _____

TYPE OF INSURANCE: ☐ INDEMNITY ☐ PPO ☐ POS ☐ EPO ☐ MEDICARE

RELEASE OF INFORMATION

By signing below, I authorize Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment.

NAME _____ DATE _____

SIGNATURE _____

Insurance Verification

_____

_____

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EXPLANATION OF MEDICAL BILLING

For all medical services we provide, we will submit a claim to your Insurance Plan. It is extremely important that we have accurate information about your plan. After we receive the EOB (explanation of benefits form), we will determine the amount, if any, that you still owe. Your statements will reflect this amount.

IMPORTANT!: Is our group "in-network" or "out-of-network"? Is the lab we use for blood or urine or cultures or pap smears in or out of network? Is the imaging center we use for mammograms in or out of network? What about the Hospital (Huntington) or the Surgery Center? **If our group, the lab, the imaging center, the hospital or the surgicenter is out of network, then covered benefits can be less or even zero, co-pays can be higher, and deductibles can be higher.** You have to check what your in-network and out-of-network benefits are. Sometimes there are no out-of-network benefits at all.

Introduction

Medical insurance involves 3 common forms of payment to physicians.
These are the **co-pay**, the **deductible** and the **co-insurance**.

The fee

Medical billing is called fee-for-service. The doctor provides services, and for each service, there is a fee (or a charge). The amount you owe is usually less than the full fee due to fee-reduction contracts between the doctor and your health insurance company. Contrary to what many people believe, insurance does not "cover everything".

The co-pay

The co-pay is the amount of money that you owe up front for every doctor visit. Each insurance plan is different. The co-pay might vary in amount or there might be none. The co-pay needs to be paid in advance at the time of your visit. Some co-pays are as high as $50. We are specialists, so that type of co-pay applies.

The deductible

Many patients have an annual deductible. This is money that the insurance company will determine is owed to the physician, but is paid directly to the physician by the patient. When a claim is processed and a balance due is applied to your deductible, you owe this money to the practice. *See the example below*.

The co-insurance

This is the percentage of the fee that is owed to the practice based on your plan, AFTER YOU HAVE MET YOUR DEDUCTIBLE. The amount depends on what the insurance has approved for payment. You owe the co-insurance amount to the practice. *See the example below*.

Example using the above terms

You go to the doctor for a problem. The visit ***fee*** is $150. Your ***co-pay*** is $10 and this is paid at the time of the visit. A claim is filed with your insurance company. They approve a payment of $100.00, but you have a 20% ***co-insurance***.

The $100 is what your insurance has approved for the full payment for this visit. You have already paid $10 of this as your co-pay so the insurance owes $90. You have a ***co-insurance*** of 20%, so they will only pay 80% of the $90. Thus, they will pay only $72 because your co-insurance is $18. So you have paid $28 total ($10 co-pay plus the 20% or $18 co-insurance) and your insurance has paid $72.

If you have an unmet ***deductible***, the insurance will "apply" the $100 to your deductible. In this case, you owe the full $100 to the practice and your deductible goes down by $100.

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OFFICE and FINANCIAL POLICIES

We would like to thank you for choosing Fair Oaks Women's Health as your women's health care provider. This document explains our current office and financial policies. It is important that you read and agree to these policies.

No-Shows: If you cannot keep your scheduled Gyn appointment, please call our office at least 24 hours in advance to reschedule. This will allow us to offer that time to another patient. Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment is a no-show and may result in a charge of $25. This fee may be waived depending on your circumstances and will be waived if you make and keep your next appt.

Late Arrivals: You are expected to arrive on time for your scheduled appointments. New patients should plan to arrive 30 minutes early to allow for completing forms and updating your electronic medical record in the computer. If you are more than 15 minutes late, we may have to reschedule your appointment.

Financial Responsibility: Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their visit will be financially responsible for all charges incurred.

Insured Patients: Please bring your insurance card with you to your appointment. If your insurance plan requires an office visit co-pay, this will be collected at the time of service. The co-pay cannot be waived by our office; it is a requirement placed on us by your insurance carrier. You are financially responsible for any co-insurance, deductible or non-covered service. If you are a member of a health plan that Fair Oaks Women's Health participates with, we will submit a claim to your insurance company on your behalf. You must provide us accurate and up-to-date information about your policy, and you agree to update us as soon as possible if anything changes.

Uninsured Patients: Payment in full will be due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Office Manager.

Unpaid copay at time of service: I agree to pay a $10.00 administrative fee if I fail to pay my copay at the time of service.

Large Deductibles: Patients with large deductibles may be asked to pre-pay a portion of their medical expenses (for example, pregnancy or gyn surgery patients).

Balance Due: Once we have received payment along with an Explanation of Benefits (EOB) from your insurance plan, you will receive a statement from our office indicating what your insurance has paid. Any remaining balance will then be due and payable.

Credit Card Authorization: I agree that Fair Oaks Women's Health may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $200.00, I will receive a courtesy call prior to my card being charged.

Medicare Patients: You are personally responsible for your deductible, co-insurance and any services that Medicare deems as "Medically Unnecessary". Medicare patients may also be asked to sign an Advanced Beneficiary Notice (ABN) form.

Returned Checks: A $25 fee will be charged for any check returned for insufficient funds. After that, only cash or credit cards will be accepted for payment.

Disability Forms: A $25 fee will be charged for processing and mailing each disability form. These forms require significant administrative time to handle.

Medical Records Request: A $25 fee will be charged for a medical records request for yourself. Payment for these records will be collected prior to records being released. A free copy of your records will be sent to the physician of your choice. This fee can be waived for hardship, please speak to the office manager.

Collection Accounts: Fair Oaks Women's Health reserves the right to turn an account over to collections if it is deemed that the account is in default of payment or not in compliance with this policy. In the event you breach this agreement, you agree to pay all collections fees, including court costs, collections agency fees and attorney's fees incurred by us in enforcing the terms herein, whether or not formal legal proceedings are commenced.

Financial Hardship: We understand that sometimes it is a hardship to pay your medical bills timely. Please meet with our Office Manger so we can work out a payment plan. Ignoring medical bills is not advisable. Let us know your situation so we can work with you.

Pharmacy Benefits: Our electronic medical record allows us to download your prescription medication history directly into your electronic chart. This step allows us to have more accurate information about your medications (name of medicine, dosage) and saves us from having to enter your medications separately. Your permission is required for this.

Newborn Circumcisions: Many insurance plans do not pay for newborn circumcisions. If a circumcision is done and is denied by your insurance, you will owe the full fee.

Which Lab should we use? As a courtesy to our patients, we have arranged for Primex Labs to collect tests in our office. Fair Oaks Women's Health provides this as a service to our patients only. We are not affiliated with Primex Labs. They are a separate company and conduct separate billing for their services. You are free to use any lab that you want.

Some patients must go to other labs (for example Quest or LabCorp) due to their health insurance. It your responsibility to know if your health plan has a contract with Primex. There are hundreds of plans and contracts and their terms change over time, so it is not possible for us to know if your plan is contracted with Primex.

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Acknowledgement of Receipt of and Agreement with Office and Financial Policies

I have read, and I understand the handout, ***Office and Financial Policies***.

I authorize the physicians of Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocably assign to Fair Oaks Women's Health all insurance payments for services rendered and all major medical benefits, and this consent does not expire unless I indicate this in writing to the office.

I agree to allow pharmacy benefit information (my medication history) to be electronically downloaded into my electronic medical record.

I am responsible for knowing which lab is contracted with my current health plan and will communicate this to the staff at Fair Oaks Women's Health.

By signing below, I am stating that I understand, and I agree to the above policies.

NAME _____ DATE _____

SIGNATURE _____

(Please sign and return this page to us. We will provide a copy upon request).

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OBSTETRICAL FEES POLICY

PATIENT NAME _____ Today's Date _____

The Obstetrical Fee (called the Global OB Fee) includes:

- OB Physician Consultation and all routine prenatal visits
- Vaginal delivery (C/S is charged a higher fee)
  - Includes when delivery is by an on-call physician
- All postpartum care in the hospital
- All routine office postpartum visits

The Global OB Fee Does Not include:

- Cesarean Section Assistant Surgeon fee
- Cord Blood Collection fee
- High Risk Pregnancy – additional fees may apply
- Hospital Services: such as epidural anesthesia, Labor and Delivery fees, C/S O.R. fees
- Injectable medications given in the office
- Lab fees – blood, urine, cultures, etc.
- Newborn care by the Pediatrician
- Newborn circumcision
- Non-Stress Tests (NST's)
- NT and afp lab fee (Calif Prenatal Screening Program)
- Nuchal Translucency Ultrasound
- Office Visits not specifically part of routine pregnancy or postpartum
- Physician hospital visits for non-delivery related hospital stays
- Pregnancy Confirmation Visit
- Prenatal education classes
- Rhogam injections
- Services provided by Physicians not in our Group
- Sex-check and 3-D ultrasounds are available for a fee, but are not billable to insurance
- Tubal ligation fee
- Ultrasound (sonogram) exams

updated Aug 2020

Your Insurance

The insurance will not be billed for the delivery until after you have delivered. After your insurance is billed, you will still have a balance due. Our policy is to collect 75% of this estimated balance due in advance. This needs to be paid by the end of your 7th month. We have provided services throughout the pregnancy and patients should not owe a large balance after they have delivered. Planned circumcisions also need to be paid for in advance as they are often not covered by insurance.

☐ Expected Vaginal Delivery ☐ Expected Cesarean Delivery

We have verified your insurance benefits with the following insurance company:

Primary Insurance Co: _____

Deductible Remaining: $ _____

Co-insurance: _____

Out of Pocket Max: $ _____

Copay: $ _____

Your estimated out-of-pocket cost (for global charges) is: $ _____

The final amount due can only be determined at the end of your pregnancy when our claim is submitted to your insurance plan and the claim is processed. Estimates given by your insurance company are not a guarantee of payment. Any difference between quoted estimate amounts and amounts owed will be your responsibility. Overpayments will be refunded.

Payment Options:

☐ Pay the estimated amount in full today.

☐ Set up a payment plan to be paid in full by the end of Month 7: _____

Acknowledgement of Receipt of and Agreement with the Obstetrical Fees Policy

I have read and I understand the Obstetrical Fees Policy.

I authorize the physicians of Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocably assign to Fair Oaks Women's Health all insurance payments for services rendered and all major medical benefits.

I understand that I am personally obligated to pay for all medical services rendered regardless of whether or how much my insurance company has paid.

By signing below, I am stating that I agree to and I understand all of the above policies.

NAME _____ DATE _____

SIGNATURE _____

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ULTRASOUND DURING PREGNANCY

Dear Obstetrical Patient,

Benefits of Ultrasound

One of the most useful imaging tests we provide during pregnancy is diagnostic ultrasound. There are many medical benefits which include: confirming the baby's heartbeat, position, movement, size and anatomy; locating the placenta; looking at the cord; measuring blood flow through the cord; measuring the length of the cervix; looking for conditions such as the baby being too big or too small, having a cord around the neck, or having too much or too little amniotic fluid, and more. Obstetrical ultrasound is an extremely important and useful medical technology.

Ultrasounds are being denied by Insurance Plans

Ultrasounds during pregnancy are not included in routine prenatal care. They are an additional service provided based on a physician's judgment. These ultrasounds are normally billed to the patient's insurance and then we are reimbursed. More and more health insurance providers are now denying payment for obstetrical ultrasounds which they claim are not needed. For example, we believe an ultrasound is indicated at 32 weeks for every pregnant patient to assess fetal growth, but most health insurance payers think this is an "unnecessary test" and they will not pay for it. For high-risk obstetrical patients, we check for fluid and growth every 1-2 weeks in the final stage of pregnancy and these ultrasounds are also often denied.

We strive to care for our patients in the best way possible and offering ultrasounds in our office allows us to provide quality and efficient care; however, it is costly to provide this service for our patients. Ultrasound machines are expensive and should be replaced about every 5-6 years. The probes must be sterilized after each use and the technology we use for this is costly. Our technologists are highly skilled, licensed technologists and they have to be paid. It is not possible to provide all the ultrasounds that are necessary for optimal obstetrical care unless these services are paid for.

Agreement

To continue to provide obstetrical ultrasounds, we have no choice but to ask our patients to cover the cost for those obstetrical ultrasound scans denied by the insurance provider. Please sign below that you acknowledge and agree to this policy.

Please discuss your concerns with our office manager. Thank you for your understanding.

Signature

My signature indicates that I have read and understood this document and agree to its terms.

Patient Name	Signature	Date

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY.

HIPPA PRIVACY NOTICE

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer (see end of Notice).

How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. (We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information.) We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice. However, this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the paragraphs headed treatment, payment, health care operations, and notification and communication with family, of this Notice of Privacy Practices, or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area. We will also post the current notice on our website (www.fowh.com)

Complaints. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services in Washington, DC. You will not be penalized for filing a complaint.

Privacy Officer: Mercedes Bin
Effective July 2016

Fair Oaks Women's Health
Specialists in Obstetrics & Gynecology
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

www.fowh.com
www.pasadenapregnancy.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES and PERMITTED DISCLOSURES

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area and that a copy of any amended Notice of Privacy Practices is available at each appointment. Our privacy officer is Mercedes Bin, the office manager. Her phone number is (626) 304-2626.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail.

e-mail address: _____

Print Name: _____ Phone: _____

Signed: _____ Date: _____

☐ If not signed by the patient, please indicate relationship of who signed:
- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

DISCLOSURE TO OTHERS

I hereby authorize Fair Oaks Women's Health to discuss/reveal the following personal protected health information with the person(s) listed below:

☐ Any or all of my medical care, treatment and/or test results

☐ Same as above except: _____

☐ Only the following information: _____

Authorized person(s):

Name	Date of Birth	Relationship
_____	_____	
_____	_____	

Signed _____

☐ DECLINED: I DO NOT AUTHORIZE ANY DISCLOSURES TO OTHERS (except when permitted as specified in the FOWH HIPAA Practice Privacy Notice)

Signed X _____

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COST OF TESTING FOR PRENATAL DNA
(non-invasive prenatal testing - NIPT)
(genetic carrier testing)

Dear OB Patient,

Non-invasive prenatal testing (NIPT) is an amazing breakthrough in genetic testing. We can analyze the pregnant woman's blood for fetal DNA conditions including Down Syndrome and others (including fetal gender). This can help prevent the need for an amniocentesis or a CVS test, both of which are invasive procedures.

Genetic Carrier testing checks for DNA conditions in the mother or father that might be silent in one or both parents but could cause a genetic disease in the baby if the abnormal DNA is inherited from both parents.

These types of advanced DNA tests can be expensive and insurance companies have different policies on whether they will approve or deny the tests and even if they approve them, we do not know how much they will cover and how much the patient will owe.

The DNA labs want to help keep your out of pocket costs low. We usually work with Integrated Genetics and LabCorp for the NIPT test (Sequenom MaterniT 21 plus) and the genetic carrier test (Inheritest: Comprehensive). They can help lower your out of pocket costs if the test is denied by your insurance provider, or when it is approved but the amount is high and is applied to your deductible.

If you go online and submit your information, they can help lower your out-of-pocket cost to as low as $299 for the NIPT test and $299 for the DNA Genetic Carrier Screening test, Inheritest. The website below will help provide your estimated cost for DNA prenatal testing with Integrated Genetics:

www.integratedgenetics.com/patients/cost-estimator.

The lab needs you to go here first so you can enroll in their program and thus be entitled to a lower cost for the tests as mentioned above.

You could also try contacting your insurance company to see if the testing is covered. See below for the billing codes. Try to find out how much they will pay and what your out of pocket cost will be. In our experience, this may take a while.

The insurance (CPT) codes are: Mat21 Plus - 81420 and 81422.
Inheritest - 81223, 81404, 81405, 81406, 81407, 81408 and 81479.

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SIGNED ACKNOWLEDGMENT
COST OF TESTING FOR PRENATAL DNA
(non-invasive prenatal testing - NIPT)
(genetic carrier testing)

By signing below, I acknowledge that I have read the handout regarding the cost of blood testing for PRENATAL DNA (non-invasive prenatal testing – NIPT, and/or genetic carrier screening). I understand the issues discussed in the handout. I am aware that it is ultimately my responsibility to determine if my insurance will pay for these tests or not, and what my own out-of-pocket cost might be.

Patient Name _____ Date _____

Signature _____

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This form is for our pregnant patients. If you are NOT pregnant, please fill out the GYN History Form. Thank you for answering the following questions. Your health is important to us. Congratulations!

OBSTETRICS PATIENT HISTORY FORM

TODAY'S DATE _____ Your age_____ DATE OF BIRTH _____

YOUR NAME (Last) _____ (First)_____ (M.I.) _____

Your spouse/partner's full name _____

Your Ethnicity_____ REFERRED HERE BY _____

CURRENT PREGNANCY

What was the FIRST day of the last menstrual period? _____ Is this date definite? (Y/N) _____

Cycles regular? (Y/N) _____ Cycle length (avg=28 days) _____ Date of first pos. preg. test _____

Conception (check one): _____normal Date of conception? _____ ____ IUI (date_____)

_____IVF frozen embryo (transfer date _____), what day # was embryo? (e.g. day 5, day 6…)

Was this pregnancy from an egg donor? YES NO If yes, please enter the age of the donor: _____

What was your weight just before becoming pregnant? _____ What is your height? _____

When was your last pap smear? _____By whom? _____ Was it normal? YES NO

PAST PREGNANCY DETAILS

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Multiple Gestation (Y/N)	Number of Living Children

Date	Term Preterm or Miscarriage	M / F	Birth Weight	Type of Delivery	Weeks Gestation	Length of Labor	Anesthesia	Complications/ Problems	Location

Notes: _____

Pt Name:
_____

PATIENT MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate)

X if YES	Condition	Comments
	Diabetes (type 1, type 2 or previous gestational diabetes). Any medication taken?	
	High Blood Pressure (hypertension now or in the past or with a prior pregnancy):	
	Heart Disease (fainting, heart murmurs, abnormal rate or rhythm, prior heart attack, abnormal valves):	
	Autoimmune Disorder (Lupus, Rheumatoid Arthritis, Sjogren's or other related conditions):	
	Kidney Disease or Urinary Tract Infections (UTI) (recurrent UTI, kidney stones):	
	Seizure Disorder or Neurologic Disease (migraines, epilepsy, history of TIA or stroke):	
	Mental Health Condition (includes anxiety or panic attacks, OCD, bipolar disorder, eating disorder):	
	History of Depression or Postpartum Depression (mild or severe, suicide attempts, hospitalization	
	Gastrointestinal or Liver Disease (irritable bowel syndrome [IBS], Crohn's Disease, Ulcerative Colitis,	
	Varicose Veins or Blood Clots in Veins (pulmonary embolism, DVT – deep vein thrombosis):	
	Thyroid Disease (under or over active thyroid, thyroid cancer or radiation):	
	Domestic Violence (now or ever in the past):	
	History of Blood Disorders or Transfusion (anemia, blood clotting problem, transfusion ever):	
	Smoking History (current or former smoker):	
	Alcohol Use History (current or past use or abuse of alcohol):	
	Illicit or Recreational Drug Use History (current or past use or abuse):	
	Rh Disease or Rh Negative	
	Lung Disease (asthma, chronic bronchitis, TB):	
	Seasonal Allergies (hay fever, asthma):	
	Breast Disease or Breast Surgery (implants above the muscle, under the muscle, breast reduction):	
	Complications of Anesthesia (describe):	
	History of Abnormal Pap Smear (any treatments such as freezing, LEEP or cone biopsy and when):	
	History of Uterine Abnormality (double uterus, unicornuate uterus):	
	History of Infertility or IVF, IUI, inseminations?	
	Low Back Problems or Back Surgery?	

ADDITIONAL PAST MEDICAL HISTORY DETAILS:

_____

_____

_____

_____

Pt Name:

_____

SURGERY or HOSPITAL ADMISSIONS

Surgery or Hospital Admission - Details	Year

SYMPTOMS SINCE BECOMING PREGNANT

(Are you currently experiencing any of the following symptoms?)
(If so, please indicate with an X)

General
_____ Fatigue or Weakness
_____ Fever, Chills or Sweats
_____ Excess Weight Gain or Loss

Eyes, Ears, Nose and Throat (HEENT)
_____ Nose Bleeds
_____ Sore Throat
_____ Trouble swallowing

Breasts
_____ Breast Lump
_____ Breast Pain or Tenderness
_____ Nipple Discharge (other than white)

Cardiovascular
_____ Chest Pain
_____ Irregular Heartbeat or Palpitations

Respiratory
_____ Chronic Cough
_____ Shortness of Breath or Wheezing

Gastrointestinal
_____ Diarrhea (watery stool)
_____ Heartburn
_____ Nausea or Vomiting
_____ Severe Constipation
_____ Abdominal Pain

Urinary
_____ Burning with Urination
_____ Blood in Urine
_____ Leakage of Urine
_____ Waking at night 2 or more times

Gyn
_____ Vaginal Discharge
_____ Vaginal Itching or Burning
_____ External Vulvar Pain
_____ External Vulvar Rash, Sores or Bumps

Musculoskeletal
_____ Joint Pain (Back, Knee, Wrist, Hip)
_____ Muscle Cramping or Pain
_____ Joint Swelling

Neurologic
_____ Dizziness
_____ Headaches or Migraines
_____ Numbness

Psychological
_____ Anxiety, Worries, Stress (Excessive)
_____ Depressed
_____ Insomnia

Skin
_____ Itching
_____ Moles or Sores
_____ Rash

Comments or Additional Symptoms Not Listed Above?

_____

_____

_____

GENETIC SCREENING QUESTIONS

(If you or **ANY** close relative of yours - such as brothers, sisters, parents, other children - has EVER HAD or CURRENTLY HAS any of the problems listed below, please CIRCLE YES)

_____Check Here if All are No

IS PATIENT GOING TO BE AGE 35 BY THE DUE DATE?	YES	NO
HISTORY of THALASSEMIA or HEMOGLOBIN (BLOOD) DISORDER	YES	NO
HISTORY of NEURAL TUBE DEFECT (spina bifida)	YES	NO
HISTORY of CONGENITAL HEART DEFECT	YES	NO
HISTORY of DOWN SYNDROME (or any known chromosomal condition)	YES	NO
IS THE MOTHER OR FATHER OF THE BABY ASHKENAZI JEWISH or CAJUN? If yes, has any genetic testing been done?	YES Yes	NO No
HISTORY of SICKLE-CELL ANEMIA or SICKLE-TRAIT	YES	NO
HISTORY of HEMOPHILIA	YES	NO
HISTORY of MUSCULAR DYSTROPHY	YES	NO
A. HISTORY of CYSTIC FIBROSIS B. IS THE MOTHER or THE FATHER OF THE BABY CAUCASIAN/EUROPEAN?	YES YES	NO NO
HISTORY of HUNTINGTON'S DISEASE (HUNTINGTON'S CHOREA)	YES	NO
HISTORY of INTELLECTUAL DISABILITY OR AUTISM If yes, has testing for Fragile X chromosome been done?	YES Yes	NO No
HISTORY of ANY INHERITABLE GENETIC CONDITION or ANY BIRTH DEFECTS	YES	NO
HISTORY of MATERNAL PKU OR OTHER METABOLIC SYNDROME	YES	NO
PATIENT OR BABY'S FATHER HAD A CHILD WITH ANY BIRTH DEFECTS	YES	NO
HISTORY OF STILLBIRTH OR 2 OR MORE MISCARRIAGES	YES	NO
HISTORY OF ILLICIT SUBSTANCE USE SINCE LAST MENSTRUAL PERIOD	YES	NO
HAVE YOU PREVIOUSLY DONE ANY GENETIC TESTING?	YES	NO

INFECTION HISTORY QUESTIONS

_____Check Here if All are No

HAVE YOU EVER TESTED POSITIVE FOR HEPATITIS B OR C ?	YES	NO
DO YOU LIVE WITH SOMEONE WHO MIGHT HAVE TUBERCULOSIS?	YES	NO
DO YOU or YOUR PARTNER HAVE A HISTORY OF **GENITAL** HERPES?	YES	NO
HAVE YOU HAD A SKIN RASH or VIRAL ILLNESS SINCE YOUR LAST PERIOD?	YES	NO
HAVE YOU EVER HAD HIV, GONORRHEA, CHLAMYDIA, HPV, SYPHYLLIS or VENEREAL WARTS? (circle any that apply)	YES	NO
HAVE YOU EVER TESTED POSITIVE FOR VAGINAL STREP B (GROUP B STREP)?	YES	NO
ARE THERE ANY OTHER INFECTIONS YOU HAVE BEEN TREATED FOR?	YES	NO
HAVE YOU TRAVELED OUTSIDE THE U.S. SINCE BECOMING PREGNANT?	YES	NO

PRESCRIPTION MEDICATIONS YOU ARE TAKING

List name of medication, dose taken, how often and reason

Pt Name: _____

DRUG STORE MEDICATION, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

List name of product and dose taken

ALLERGIES (circle choices)

Do you have any known allergies? NO ALLERGIES Allergic to Latex? YES NO

If yes, please list all allergies and your allergic reaction

Allergic to	**Reaction**

FAMILY MEDICAL HISTORY

*(If **ANY** close relative of yours - such as maternal and/or paternal grandparents, parents, brothers, and sisters – has EVER HAD or CURRENTLY HAS any of the problems listed below.*

CONDITION	Please CIRCLE CONDITION and indicate who has that specific condition.
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE	
2. HIGH BLOOD PRESSURE, HEART ATTACK, STROKE	
3. TUBERCULOSIS, ASTHMA, OTHER LUNG DISEASE	
4. BREAST DISEASE, BREAST CANCER	
5. STOMACH, GI or COLON DISEASE or CANCER	
6. KIDNEY DISEASE, KIDNEY STONES	
7. GYN DISEASES, OVARIAN CANCER, UTERINE FIBROIDS	
8. MUSCULOSKELETAL DISEASE, OSTEOPOROSIS	
9. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES	
10. SEVERE DEPRESSION or OTHER PSYCHIATRIC CONDITION	
11. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND	
12. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE	
13. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT	
14. ANY TYPE of CANCER or MALIGNANT TUMORS	

ADDITIONAL PREGNANCY ISSUES

1. In the past 3 months have you or your partner traveled to any country on the CDC list of known locations of the Zika Virus?	YES	NO	MAYBE
2. Was this pregnancy a result of fertility treatment? If yes, can you please have copies of recent blood tests and ultrasounds sent to us?	YES	NO	
3. Have you ever had your blood drawn to test for any genetic conditions? If yes, can we get a copy of those test results?	YES	NO	MAYBE
4. Have you been vaccinated against Whooping Cough (TDaP)? If yes, can we get a copy of those records?	YES	NO	MAYBE
5. Have you heard about NIPT (non-invasive prenatal testing)? This allows us to test for fetal DNA in the mother's bloodstream.	YES	NO	MAYBE
6. Have you heard about Nuchal Translucency testing? (We will discuss this during your first visits.)	YES	NO	MAYBE
7. Do you get 3 servings per day of dairy products (milk, yogurt, cheese)? If not, we advise a daily Calcium Supplement (like CitraCal) with Vit D usually about 500 mg calcium and about 500 to 1,000 units of Vitamin D.	YES	NO	MAYBE
8. Do you own any cats? If so, it is advised that pregnant women not change the cat litter	YES	NO	
9. Are there any known or suspected hazards in your workplace?	YES	NO	MAYBE
10. Do you have plane travel planned during this pregnancy? If so, we generally advise not flying after 32 weeks gestational age.	YES	NO	MAYBE
11. In the past year, have you been threatened or injured by someone you know?	YES	NO	TALK TO ME
12. Do you use a seat belt 100% of the time while driving? We strongly urge all pregnant women (and everyone!) to wear seat belts all the time.	YES	NO	
13. Are you considering having a tubal ligation (permanent sterilization)?	YES	NO	MAYBE
14. If you have a boy, do you want him circumcised?	YES	NO	MAYBE
15. Do you plan to save the baby's umbilical cord blood at the time of delivery or would you like more information about this?	YES	NO	MAYBE
16. If you already have a Pediatrician, please enter their name. Is this doctor on staff at Huntington Hospital?	Dr. _____ YES	NO	MAYBE
17. Please see our OB guide on the web at: www.pasadenapregnancy.com			

It is not necessary to have made all the above decisions yet.
We will discuss all pregnancy issues and your concerns at your consultation and throughout your pregnancy.
The above list is to help you as you begin to explore some of these issues

Notes or Questions for the Doctor: _____

_____

_____

_____

_____

_____

_____