



5333 McAuley Dr., R-5016  
Ypsilanti, MI 48197

Caritas Center for Women's Health

Philip V. Fleming, MD  
Mary E. Bieniasz, CNP

Phone: (734) 712-1990  
Fax: (734) 712-1991

Caring for Life

Date \_\_\_\_\_

Dear \_\_\_\_\_,

This is to confirm your first obstetric appointment on \_\_\_\_\_ at \_\_\_\_\_ with Dr. Fleming at our office in the Reichert Health Building at St. Joseph Mercy Hospital. We are looking forward to caring for you during your pregnancy and sharing this special time in your life. **It is very important that you read all of the enclosed information and bring the packet with you to your first appointment with all of the forms completed.** If they are not completed at the time of your appointment, we may have to reschedule or delay your visit. If you are unable to keep your appointment, please notify our office at least 24 hours in advance.

Enclosed you should find:

1. Prenatal Vitamin Prescription (We recommend you begin taking these as soon as possible.)
2. Patient Information
3. Authorization for Services
4. Financial Policy (2 pages)
5. Advance Directive
6. HIPAA Notice of Privacy Practices
7. Medical History Forms
8. Insurance and Payment Information
9. Pregnancy Health Information and Recommendations (morning sickness, vitamins, general health)
10. Map to Our Office

At your first obstetric visit, you will receive an ultrasound along with your detailed history and physical exam. This ultrasound will confirm the health of your pregnancy and make sure that your dates are correct.

The financial matters of your care are handled by our billing company. Our billing department will verify your benefits after your first visit with us. It is crucial that you notify us promptly if there is a change in your benefits or insurance plans. If you have billing/insurance questions, please call our main office at 734-712-1995.

If you have an urgent medical need, please call the office. During office hours, one of our nurses will be available to answer your call. After hours or on the weekend, you will be instructed on how to reach the physician on call.

We look forward to seeing you and wish you the best as your pregnancy progresses.

Sincerely,

*The Staff of Caritas*



## Natural Family Planning

As a new patient to this office, we would like to welcome you and tell you a little bit about what we feel is a very unique and exciting approach to obstetrical and gynecological care. In our desire to offer the best and most respectful gynecological care, we have tried to base our medical evaluation and treatment upon appreciation for and deep understanding of the normal menstrual cycle— in other words, fertility awareness (often also called Natural Family Planning).

This emphasis gives a whole new perspective to the practice of obstetrics and gynecology and allows us to diagnose and treat problems often in a less interventional way. Fertility awareness allows every woman to know how her body works and to understand the reproductive processes that are integral to her person as a woman.

We believe that a woman's reproductive processes are good and beautiful in themselves, that fertility is a condition of a healthy woman, and that the result of that healthy function, a child, is always a gift worthy of our care, protection, and nurturing. Because of this, we also believe that the best way for couples to plan the spacing and ultimate number of children is by utilizing the knowledge of the fertile and infertile phases of the woman's cycle to either achieve or avoid pregnancies.

The art and science of Natural Family Planning has progressed tremendously in the last 30 years and now provides 98% effectiveness for couples who are trained by experienced teachers and thus is both safer and more effective than oral contraceptives or barrier methods such as condoms.

We realize that this approach may be unfamiliar to you, but we would encourage you to consider it. If you are presently on birth control pills, we would welcome the chance to discuss this with you or send you more information about Natural Family Planning. We also would be happy to see you for any other problem or issue. However, you should be aware that *we will not be able to prescribe or recommend any contraceptive methods at that visit.*

We look forward to seeing you at your appointment.

*Sincerely,*

Philip V. Fleming, MD

Mary E. Bieniasz, CNP

### Demographic Information

- Single           Caucasian
- Married       African-American
- Separated     Hispanic
- Divorced      Asian
- Widowed      Other

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
(How would you like us to address you?)

Spouse/Significant Other Name: \_\_\_\_\_ Spouse/Significant Other Occupation: \_\_\_\_\_

Your Date of Birth (MM-DD-YYYY) \_\_\_\_\_ Your Social Security # \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Religion \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

### Contact Information

It is sometimes very important that we contact you. Please complete this section carefully and completely.

Your Home Phone \_\_\_\_\_ 1 2 3 \_\_\_\_\_ sign

Your Cell Phone \_\_\_\_\_ 1 2 3 \_\_\_\_\_ sign

Your Work Phone \_\_\_\_\_ 1 2 3 \_\_\_\_\_ sign

(Please rank in order of preference.)

(Please check box and sign to give us permission to contact you and leave a message.)

Your E-mail \_\_\_\_\_ sign

Emergency Contact Name: \_\_\_\_\_ Phone number: \_\_\_\_\_  
(This contact will only be used to get a message to you about contacting us if all your personal contact information fails. NO medical information will be given to the emergency contact.)

### Insurance Information

Primary Insurance \_\_\_\_\_ Effective Date (if known) \_\_\_\_\_

Group # \_\_\_\_\_ Contract # or ID \_\_\_\_\_ Plan code \_\_\_\_\_

Copay Amt \_\_\_\_\_ Office Visit Coverage? Y N

Subscriber's Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Effective Date (if known) \_\_\_\_\_

Group # \_\_\_\_\_ Contract # or ID \_\_\_\_\_ Plan code \_\_\_\_\_

Copay Amt \_\_\_\_\_ Office Visit Coverage? Y N

Subscriber's Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_



## Communication Authorization

Caritas may speak ONLY with me.

or

I give permission for Caritas Center for Women's Health to speak with \_\_\_\_\_ regarding

my medical care

financial matters

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Date of Birth \_\_\_\_\_

**AUTHORIZATION FOR SERVICES  
CARITAS CENTER FOR WOMEN'S HEALTH, P.C.**

1. Consent for medical treatment

I, \_\_\_\_\_, freely consent to any routine medical, diagnostic, therapeutic or minor surgical procedure that may be recommended by my doctor and performed by, or under the supervision of, my doctor. Specific procedures will be explained to me along with the expected benefits and possible risks prior to any procedure being conducted. I know that I can ask questions at any time and will do so if I have any questions or concerns. I recognize that the practice of medicine and surgery is not an exact science: no one can make promises or assure me about the results of an examination, treatment or procedure that I receive. I also reserve the right to refuse any treatment.

Note: State relationship if patient is unable to sign.

\_\_\_\_\_  
Patient (18 or older) Signature

\_\_\_\_\_  
Date

2. Authorization for Release of Patient Records

I authorize this physician's office to release information contained in my patient records to the party responsible for payment of my care, including but not limited to Medicare/ Medicaid programs, my insurance carrier, my employer's insurance carrier and/ or any other party, including a family member or other individuals whom I have indicated will be responsible for payment of my care. I intend that this authorization for release of patient information to these parties shall extend to any information including alcohol and drug abuse treatment (protected under the regulations in Code 42 of the Federal Regulations, Part 2), and any information about mental health services and social services, including communications made by me to a social worker or mental health professional. Further, this authorization will include release of information about the diagnosis or testing for HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and ARC (AIDS Related Complex) and records of any other communicable diseases.

Note: State relationship if patient is unable to sign

\_\_\_\_\_  
Patient (18 or older) Signature

\_\_\_\_\_  
Date

3. Authorization for Payment of Insurance Benefits

I authorize payment of insurance benefits, including Medicare/ Medicaid benefits to be made directly to this provider. I understand that I am financially responsible to this provider (including physician, nurse practitioner, midwife, physician's assistant) for services not covered or payable by my insurance carrier.

Note: State relationship if patient is unable to sign.

\_\_\_\_\_  
Patient (18 or older) Signature

\_\_\_\_\_  
Date

4. FOR YOUR INFORMATION:

In accordance with the Michigan Public Health Code, if a health professional or other office personnel experiences an exposure to your blood or other body fluids, you may be tested for evidence of the HIV virus. The cost of the test will not be charged to you or your insurance company. The performance and results of this test are confidential. This information will not be released without your written consent, except to those individuals or organizations that have been given access by law, who are also required to keep your records confidential.

Caritas Center for Women's Health  
Financial Policy

Because payment for services is the responsibility of the patient in the patient/physician relationship, we would like to explain our payment expectations to ensure understanding and compliance.

We (Caritas Center for Women's Health) participate with various insurance companies and managed care plans, for which we will file claims on your behalf directly to the insurance carrier for payment. You will be responsible to pay your copay at the time of service.

There are several commercial insurance plans with which we do not participate. If you are covered by one of these commercial insurance plans, we will "courtesy file" your claims to them, however you will be responsible to pay a portion of the charges at the time of service. You will also be responsible for any charge not paid for by your insurance.

Insurance copayments and non-covered services are expected to be paid at the time of service. We accept cash, check, Visa, MasterCard, and Discover.

We work closely with Cadillac Accounts Receivable Management, Inc. (CARM) regarding collection activity on delinquent accounts. Our hope is that by working together we can avoid any involvement with CARM in our collection activity.

Additional Fees:

On all patient checks returned for non-sufficient funds or closed account status, there will be a \$20.00 fee charged back to the patient. Thereafter, we will be unable to accept any personal checks until the account balance associated service fee is paid in full. In this is a repeated occurrence, we will only be able to accept cash or credit card as a method of payment on your account.

Additional Information:

It is your responsibility to understand the benefits and limitations of your insurance plan. You are also responsible for obtaining any referrals that may be required by your insurance plan prior to your office visit. Any service not covered by your insurance plan due to the lack of a referral will be your responsibility.

---

By signing below, I acknowledge that I have read and understand the financial policy of Caritas Center for Women's Health and agree to the payment terms and my obligations under the financial policy.

\_\_\_\_\_  
Signature of Patient or Person Responsible for Account

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Caritas Center for Women's Health  
Waiver Form

We would like our patients to know that our physicians do bill for services performed in accordance with billing documentation and coding criteria, which are established by National Coverage Policy determined by Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA). We are mandated to comply and follow government and insurance guidelines.

Caritas Center for Women's Health provides many different types of medical services to our patients including routine gynecological exams, routine follow up care, obstetrical care, lab work, and various diagnostic testing and procedures. Although some insurance companies will cover most services there are some insurance companies that do not cover certain types of services such as routine/screening exams and testing. Many insurance companies have specific criteria for how frequently an exam, test or procedure may be performed. More frequent exams, tests, or procedures may not be covered by your insurance and would ultimately be your responsibility.

Our staff makes every effort to assist you in understanding your insurance benefits. Because it is impossible for us to know all of the many different employer group benefits from one employer to the next, we are providing this notice to inform you of the following responsibilities as it related to benefit coverage and payment responsibilities by the patient and by Caritas Center for Women's Health/

Caritas Center for Women's Health Responsibilities:

1. Caritas Center for Women's Health is not responsible for knowing what services are covered by the patient's insurance plan and is not responsible for informing the patient whether a particular service is covered.
2. Caritas center for Women's Health will assist the patient to obtain payment from their insurance company through submitting the claims.
3. Caritas Center for Women's Health will resubmit a claim to the patient's insurance if an error or omission on our part has been made.

Patient Responsibilities:

1. It is the patient's responsibility to know and understand her own health insurance benefit coverage and limitations.
2. The patient is ultimately responsible for payment for all services provided by the Caritas Center for Women's Health, within contractual guidelines.
3. The patient must pay any copayment and the charge for any service not covered by their insurance company at the time of service.

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Caritas Center for Women's Health.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



# CARITAS

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Caring for Life

Dear Patient:

Michigan Law requires physicians to advise patients about their right to create an advance directive. An advance directive, sometimes referred to as a durable power of attorney, is a document that provides you with the means appoint someone to appear in person to make health care decisions for you, should you become incapacitated.

Our office has advance directive forms available for your review. We ask that you indicate your desire by marking the appropriate box below, sign and date the form and return it to us. If you want the form, our receptionist will give you a copy to take home to read and complete. Once you complete the form, we ask that you return a fully executed copy to us for safe keeping in your medical chart.

---

Yes I would like a copy of the advance directive

No I do not want a copy of the advance directive at this time

---

Patient Name (Please Print)

---

Patient Signature

---

Date

---

To be completed only if patient requests advance directive:

I certify that the above patient was given a copy of the advance directive on

---

Date

---

Staff Signature



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Caring for Life

Philip V. Fleming, MD  
Mary E. Bieniasz, CNP

THIS AREA BLANK

**I have received a copy of the Caritas Center for Women's Health, P.C.'s  
HIPAA NOTICE OF PRIVACY PRACTICES**

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Patient Name- Printed)

\_\_\_\_\_  
(Date)

\*\*\*\*\*

Patient refused to sign- witnessed by:

\_\_\_\_\_  
(Caritas Employee Signature)

\_\_\_\_\_  
(Date)

EFFECTIVE DATE OF THIS NOTICE: APRIL 9, 2003

*Caritas Center for Women's Health*

5333 McAuley Dr. R-5016  
Ypsilanti, MI 48197  
Phone: (734) 712-1990 Fax: (734) 712-1991

**NOTICE OF PRIVACY PRACTICES**

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

Your medical information is personal and we are committed to protecting your privacy. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your medical information and what rights you have regarding information. If you have any questions, please contact Jill Tait.

**We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that our practice has created or maintained and for any generated in the future. Our practice will post a copy of our current Notice in our office in a visible location and you may request a copy of our most current Notice at any time.**

**HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION**

The following categories describe the purposes for which we may use and disclose your medical information. We routinely use your medical information inside our office for these purposes without any special permission. For clarification, we have included some examples. Not every possibility is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories.

**TREATMENT.** Our practice may use and disclose your medical information to treat you. Common reasons for use and disclosure may include performing exams, ordering or performing tests, ordering prescriptions, referring you to other medical professionals, or obtaining copies of information from other providers. Additionally, we may disclose your medical information to others who may assist in your care, such as your spouse, children, or parents.

**PAYMENT.** We may use and disclose your medical information in order to bill and collect payment for services. For example, we may provide your insurer with treatment information to certify eligibility. We also may use and disclose your medical information to obtain payment from third parties that may be responsible for costs, such as family members.

**HEALTH CARE OPERATIONS.** Our practice may use and disclose your medical information to operate our business. Examples may include using your medical information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

**APPOINTMENT REMINDERS.** Our practice may use and disclose your medical information to contact you and remind you of an appointment.

**TREATMENT OPTIONS AND HEALTH RELATED BENEFITS.** Our practice may use and disclose your medical information to inform you of potential treatment options or health-related benefits or services that may be of interest to you.

**DISCLOSURES REQUIRED BY LAW.** Our practice may use and disclose your medical information when we are required to do so by federal, state, or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of births and deaths, certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

**HEALTH OVERSIGHT ACTIVITIES.** Our practice may use and disclose your medical information to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**LAWSUITS AND SIMILAR PROCEEDINGS.** If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office. We also may disclose your information in response to a discovery request, subpoena, or other lawful process by another party involved, but only if we have tried to inform you of the request or to obtain an order protecting the information the party has requested.

**LAW ENFORCEMENT AND/OR NATIONAL SECURITY.** We may disclose your medical information for law enforcement purposes. For example, we may provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened elsewhere. Further, we may disclose your medical information to federal officials for intelligence and national security activities authorized by law including to protect the President or other officials including foreign heads of state, to conduct investigations, or for military purposes.

**DECEASED PATIENTS.** Our practice may release medical information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs or, when requested, to facilitate organ, eye or tissue donation.

**RESEARCH.** Under certain circumstances, we may use and disclose your medical information for health related research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

**SERIOUS THREATS TO HEALTH OR SAFETY.** Our practice may use and disclose your medical information to prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**INCIDENTAL DISCLOSURES.** Our practice may disclose your medical information if it is an unavoidable byproduct of conducting business, including receiving services from cleaning personnel and those maintaining or repairing equipment.

**BUSINESS ASSOCIATES.** Our practice may disclose your medical information to business associates who perform health care operations for us and who commit to respect the privacy of your health information.

Other uses and disclosures of your medical information not covered by the Notice will be made only with your written authorization. If you provide us such an authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization.

### **YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

You have the following right regarding the medical information that we maintain about you:

**CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we communicate with you in a particular manner. For instance, you may ask that we contact you at home rather than work. To request a type of communication, you must make a written request to the division contact listed on page one of this notice. We will accommodate reasonable requests.

**REQUESTING RESTRICTIONS.** You have the right to request a restriction in our use or disclosure of your medical information for treatment (except in emergencies or when required by law), payment or health care operation. We are not required to agree to your request; if we do agree, we are bound by our agreement. You also have the right to request that we restrict our disclosure of your medical information to only certain individuals involved in your care. To request a restriction, you must make your request in writing to the contact listed on page one.

**INSPECTION AND COPIES.** You have the right to see and copy your medical information. You must submit your request in writing to the contact listed on page one. Our practice may charge a fee for the costs of copying and mailing your information. By law, our practice may deny your request to see and/or copy your information in certain limited circumstances, however, you may request a review of our denial. For information regarding such a review, contact the contact listed on page one of this notice.

**AMENDMENT.** If you feel that medical information we have about you is incorrect or incomplete, you may send us a written request to amend the information. The request must include a reason supporting your request and should be sent to the contact listed on page one. We may deny your request if it is not in writing or does not include a reason. Further, we may deny your request if you ask us to amend information that is, in our opinion, accurate and complete, not part of the information kept by us, not part of the medical information which you would be permitted to see and copy, or if it was not created by us.

**LIST OF DISCLOSURES.** You have the right to request a list of disclosures our practice has made of your medical information for non-treatment, non-operations purposes. Use of your medical information as part of the routine patient care in our practice is not required to be documented and, therefore will not be on the list. Further, the list will not include disclosures made with your authorization, incidental disclosures or those required by law. In order to obtain a list of disclosure, you must submit your request in writing to the contact listed on page one. All requests must state a time period (not to exceed six years) and may not include dates before April 14, 2003. You are entitled to one such list per year free of charge; additional lists may require payment.

**RIGHT TO A PAPER COPY OF THIS NOTICE.** You are entitled to receive additional copies of this notice of privacy practices at any time. To obtain a copy of this notice, please call our office at the telephone number listed on page one.

**RIGHT TO FILE A COMPLAINT.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, write to the contact listed on page one. This office will not penalize you in any way for submitting a request.

## Obstetric History Questionnaire

Caritas Center for Women's Health

Your Age \_\_\_\_\_ Single  
 Your Marital Status Engaged  
 (circle one) Married  
 Separated  
 Divorced  
 Widowed

Baby's father:  
 Name: \_\_\_\_\_  
 involved/not involved  
 his age is \_\_\_\_\_  
 his health status \_\_\_\_\_

Pregnancy Concerns:

### Past Medical History

Do you have a history of (circle response):

Frequent urinary tract or bladder infections?	Y	N
Vaginal infections?	Y	N
Chlamydia/Gonorrhea/PID?	Y	N
Abnormal pap?	Y	N
(if yes, give details) _____		
Chicken pox?	Y	N

### Chronic Illnesses

(Have you ever had any of the following?)

Asthma	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
Diabetes/Gestational Diabetes	Y	N
Thyroid Problems	Y	N
Heart Disease	Y	N
Migraines/Chronic Headaches	Y	N
Seizures/Convulsions	Y	N
Liver disease/Hepatitis	Y	N
Stomach, Bowel or Gallbladder Problems	Y	N
Bladder/Kidney Problems	Y	N
Blood Disorders (anemia, sickle cell, etc)	Y	N
Blood Transfusion	Y	N
Mental Illness (depression, schizophrenia, bipolar, anxiety, postpartum depression, panic)	Y	N
Cancer	Y	N
Any other medical problems?	Y	N

Please list any other medical problems:

Your height? \_\_\_\_\_ Prepregnancy Weight? \_\_\_\_\_

### Substance Use

Do you smoke?	Y	N
If yes, how many per day? _____ For how long? _____		
Do you drink alcohol?	Y	N
If yes, what type & how much per day? _____		
Have you ever tried to quit? _____		
Has anyone told you to decrease your drinking? _____		
Is anyone worried about your drinking? _____		

How much caffeine do you take in one day? \_\_\_\_\_

Have you recently used cocaine?	Y	N
Have you recently used marijuana?	Y	N
Do you use any other drugs?	Y	N
If yes, what drugs? _____		

## OB History: Congenital Anomalies Genetics

At your baby's estimated birthdate, will you be over 35 years of age?      Y      N

Please look over the following list of genetic and developmental conditions. Put a checkmark by ANY and ALL conditions that are known in **your** family AND in the **father of the baby's** family. Write next to the condition who has it.

- |  |   |
|--|---|
| <input type="checkbox"/> Blood disorder                        | <input type="checkbox"/> Cystic fibrosis                          |
| <input type="checkbox"/> Hemophilia                            | <input type="checkbox"/> Chromosomal abnormality                  |
| <input type="checkbox"/> Sickle cell disease or carrier        | <input type="checkbox"/> Downs Syndrome (Trisomy 21)              |
| <input type="checkbox"/> Thalassemia                           | <input type="checkbox"/> Short stature (under 5 feet)             |
| <input type="checkbox"/> Brain development disorder            | <input type="checkbox"/> Developmental disorders or birth defects |
| <input type="checkbox"/> Anencephaly                           | <input type="checkbox"/> Bone disorder                            |
| <input type="checkbox"/> Hydrocephalus (or water on the brain) | <input type="checkbox"/> Cleft lip and/or palate                  |
| <input type="checkbox"/> Spina bifida                          | <input type="checkbox"/> Heart defect                             |
| <input type="checkbox"/> Neurological disorder                 | <input type="checkbox"/> Kidney disease                           |
| <input type="checkbox"/> Neurological degeneration disorder    | <input type="checkbox"/> Urinary tract abnormality                |
| <input type="checkbox"/> Muscular dystrophy                    | <input type="checkbox"/> Limb (arm/legs) defect                   |
| <input type="checkbox"/> Cerebral palsy                        | <input type="checkbox"/> Malformations                            |
| <input type="checkbox"/> Mental retardation                    | <input type="checkbox"/> Neurofibromatosis                        |
| <input type="checkbox"/> Epilepsy/seizure disorder             | <input type="checkbox"/> Skin disorder                            |
| <input type="checkbox"/> Deafness                              | <input type="checkbox"/> Mental illness                           |

Please indicate your heritage or nationality. Check as many as apply.

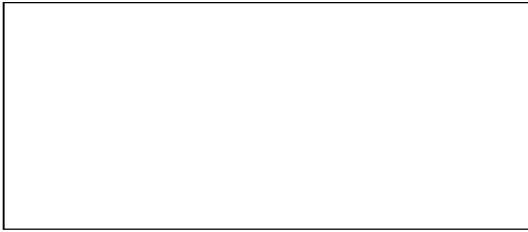
- |   |  |
|---|--|
| <input type="checkbox"/> African American | <input type="checkbox"/> Canadian      |
| <input type="checkbox"/> Asian            | <input type="checkbox"/> Mediterranean |
| <input type="checkbox"/> Caucasian        | <input type="checkbox"/> Other         |

Please indicate your religious background.

- Jewish  
 Christian  
 Other (Please write if you'd like to be specific \_\_\_\_\_)

Please indicate any other situations related to genetic or developmental diseases that you are concerned or worried about: \_\_\_\_\_

\_\_\_\_\_



## OB History: Menstrual Information Pregnancy Dating Sexual History

### Menstrual History:

Age at first menses: \_\_\_\_\_ Usual cycle length: \_\_\_\_\_ # days of flow: \_\_\_\_\_

Pain with periods? Yes No Heavy flow? Yes No

Any other problems with your periods \_\_\_\_\_

### Family Planning History:

Current method of family planning: \_\_\_\_\_

Methods used in the past:

\_\_\_\_ Birth control pills      \_\_\_\_ Condom/Barriers      \_\_\_\_ Depo-Provera  
\_\_\_\_ IUD      \_\_\_\_ Diaphragm      \_\_\_\_ Norplant  
\_\_\_\_ Natural Family Planning (which method? \_\_\_\_\_)

### Calculating Your Due Date:

When was your last normal menstrual period? \_\_\_\_\_ Was this normal in every way? Y N

How long is it between the first day of one period until the first day of the next period? \_\_\_\_\_

Were you nursing a baby when you became pregnant? Y N

Were you using any birth control method when you became pregnant? Y N

Were you using any hormonal birth control method in the last 6 moths before conception? Y N

If yes, please tell what type and when last used: \_\_\_\_\_

When did you first have a positive pregnancy test? \_\_\_\_\_ Urine \_\_\_\_\_ Blood test \_\_\_\_\_

### Sexual History:

Age at first intercourse \_\_\_\_\_ Age at first pregnancy \_\_\_\_\_

# of lifetime sexual partners \_\_\_\_\_ Do you have pain with intercourse? Y N

Have you has a new sexual partner in the last 3 months? Y N

Any history of STDs? (genital warts, condyloma, HPV, Herpes, Chlamydia, or Gonorrhea?) Y N

### Comments:

# Medical History

Does not include pregnancy-related events.

No.	Date	Surgeries/Hospitalizations	Physician/Provider
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Family History										
	High Blood Pressure	Stroke/ Blood Clots	Diabetes	Breast Cancer	Ovarian Cancer	Uterus Cancer	Colon Cancer	Other	Comments	Update
Father										
Mother										
Sisters										
Brothers										
Mat. GM										
Mat. GF										
Pat. GM										
Pat. GF										
Others										

Comments \_\_\_\_\_

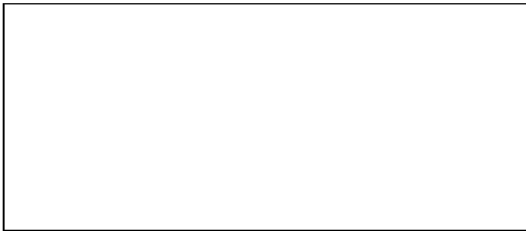
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# Pregnancy Record



Please fill this record out as completely and accurately as possible. You will not have to fill this out ever again! Include all documented miscarriages, ectopic pregnancies, and pregnancy terminations.

	Name of Baby	Sex	Date Mo/Yr	Length of Preg (Wks)	Hours of Labor	Complications for mother?	Baby's birth weight	Complications for baby?	Vag/C-sec?	Delivered where?	Delivered by?
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											

Notes:

**Medical Insurance, Your Doctor, the Hospital and You:**  
**Understanding Medical Fees**

Dear Patient:

We want to extend a warm welcome to you as you start care for your pregnancy with us. Because questions often arise regarding payment for care during a pregnancy, this letter will outline the standard charges for pregnancy care, and help you to understand the relationship between you, your insurance carrier, the hospital and us, your physicians.

**An Overview**

During a pregnancy, many medical care services are utilized to help care for you and your baby. As your physicians, we will provide overall management for the pregnancy. This management includes services that we render in the office (standard prenatal care), and also includes services we order for you but which are provided by the laboratory (for example, blood tests), the hospital (for example, labor and delivery), or another physician (such as anesthesia for delivery).

We will bill you or your insurance for the services we provide for you in the office and in the hospital. Your insurance company/you will also receive separate bills from the laboratory, the hospital, or any other physicians who see you and provide specific services.

The **standard prenatal care and delivery** package for your care before, during and after deliver is billed in a lump sum (see below). This standard prenatal care package includes physician services during your pregnancy. Things generally covered include prenatal visits, patient education and information, nursing support services, management of labor, delivery and the postpartum period including the six-week postpartum visit.

1. Standard prenatal care package	\$1250
Normal vaginal delivery	<u>\$1375</u>
Total	\$2625
2. Standard prenatal care package	\$1250
Vaginal delivery after previous c-section	<u>\$1545</u>
Total	\$2795
3. Standard prenatal care package	\$1250
Cesarean section	<u>\$1910</u>
Total	\$3160

\* The standard prenatal care package includes up to 13 prenatal visits. If you have a complicated pregnancy and require more visits, the costs may be adjusted to reflect the extra prenatal care visits.

In some situations, medical complications arise during a pregnancy which require additional office visits or procedures. These visits and procedures are billed in addition to the standard prenatal care and delivery package.

During the course of a pregnancy, we usually collect blood and other specimens for prenatal lab studies such as a Pap smear, prenatal blood panels and testing for gestational diabetes. These specimens are processed and evaluated in the lab and typically the bill for lab services ranges between \$165 and \$340 for an uncomplicated pregnancy. Additionally, you may have a non-stress test and/or an ultrasound. The bill for these services typically ranges between \$280 and \$750.

You or your insurance company will also be billed for hospital services after your delivery. This bill ranges from \$6000 to \$9000, depending on the services you utilize.

If you have an epidural anesthesia, you or your insurance company will also receive a bill of about \$300 for this service. If you have questions regarding your bills from the lab or the hospital, please call (734) 712-3700 to speak to a hospital patient financial counselor.

### **Insurance Coverage**

After looking at all the numbers in the overview above, you may be asking yourself if you can afford to have a baby, and here you are, pregnant already! Fortunately, most people have medical insurance that covers a portion or all of the medical expenses of a pregnancy. Even if you don't have insurance, Medicaid or McAuley Support Services may be available to you. If you need financial help for your care, please let us know.

Insurance policies vary widely in what services they cover or pay for. The coverage and amount paid by your policy affects how much you will have to pay to make up the difference. Ultimately, you are responsible for any charges for care you receive during your pregnancy. We will bill your insurance company for those services that are covered under your insurance contract. However, the final responsibility for payment of any amount not covered by your insurance, including co-pays and deductibles, is yours.

Near the beginning of your pregnancy, we will contact your insurance carrier, help you evaluate your coverage, and determine what costs you can anticipate. We will also set up a payment plan so you can pay the amount you owe by the 28<sup>th</sup> week of your pregnancy. Most people find it easiest to pay a portion of their co-insurance payment each time they come for a prenatal care visit. However, you can make your entire co-insurance payment in a lump sum, if you wish.

Insurance issues can be confusing, so if you are still having difficulty or have questions after reading this letter, please contact our main office at 734-712-1990. We look forward to taking care of you during your pregnancy!



### *Vitamins: Are They Really Necessary?*

Eating a healthy, well-balanced diet with plenty of fresh fruits and vegetables usually provides all the vitamins necessary for you and your baby during a normal pregnancy. However, most physicians prescribe a prenatal vitamin tablet which contains multiple vitamins and minerals. Why are vitamins necessary?

Pregnancy is a time when both you and your baby are growing quickly. This rapid growth increases the demand for all nutrients, and the development of your baby and placenta are directly influenced by your nutritional status. Recent research has shown that adequate amounts of one vitamin, folic acid (also called folate), significantly reduces or prevents the occurrence of neural tube defects (a potentially serious form of birth defect) in babies. Although a carefully balanced diet *can* provide all of the vitamins and nutrients you and your baby need, sometimes it is difficult to eat as well as you would like to.

Some women also find that the demands of work and a busy life, along with the nausea and vomiting of early pregnancy, make it difficult to get a complete, balanced diet from food alone. Consequently, we offer all our pregnant patients a prenatal vitamin supplement. Prenatal vitamins are a way of ensuring adequate reserves of all nutrients for your well-being and for your baby's good health. Your baby will draw whatever he or she needs from your existing supply.

If you are unable to take or tolerate the prenatal vitamins we prescribe for you, please call us, as there are many forms and kinds to choose from. For example, if you are unable to swallow large pills, **one** tablet of *FLINSTONES COMPLETE* with Calcium, Iron, and Minerals is a chewable vitamin tablet that might make life easier.

You can get too much of a good thing. Vitamins are vital, but in moderate amounts. Excessive amounts of some vitamins (especially vitamins A, D, and E) can be harmful to your baby. Extremely large amounts of vitamin C (over 10,000 mg per day) can cause damage to your kidney and urinary tract. Large amounts of vitamin A (over 25,000 units per day) have also been associated with birth defects. One prenatal vitamin tablet per day taken with a meal is sufficient to meet all the demands of your body and your growing baby. If you feel you need more for any reason, please consult with us before starting to take them.

Remember, vitamins are a supplement to your diet and are not a substitute for good nutrition. Nutrition, weight gain, and diet are covered in another handout which you will receive soon. The care you take of yourself by eating a healthy diet with adequate amounts of vitamins will help lay the foundation for a healthy future for your baby.



## Suggestions for Controlling Morning Sickness or Nausea in Pregnancy

***Before going to bed.*** Be sure to have plenty of fresh air in the room where you sleep. The odor of soiled clothes and other household odors in the room where you sleep may upset your stomach. Place some dry cereal or bread within reach of your bed. You can use Melba toast, dry bread, dry biscuits, uncooked oatmeal, ready to eat cereals, or crackers.

***Before getting up in the morning.*** Eat some of the dry bread or cereal. A little jelly on the bread may make it taste better, but do not use butter or margarine because fats and oils tend to increase nausea.

***When getting up.*** Get up very slowly; take several minutes. Avoid sudden movements when getting out of bed. Sit on the edge of the bed for a few minutes before standing.

***Before cooking breakfast.*** Eat more dry bread or cereal a little while after you get up and before you cook your breakfast.

***Meals.*** Eat several small meals a day instead of three large ones, because you are more likely to feel nauseated when your stomach is empty. Do not drink fluids or eat soups at meal times. If you are thirsty, try eating chips of ice made from water, Gatorade, or juices. Sometimes during the day you will find you can eat a regular meal. Be sure not to overeat at this time.

***Foods to avoid.*** Fats and greasy foods tend to upset your stomach, so try to avoid fried foods, high fat meats, and foods cooked in grease or oil. Examples of foods with high fat or oil include butter, margarine, gravy, bacon, salt pork, oils, mayonnaise, salad dressings, pie crusts, or pastries.

Highly seasoned foods, such as those cooked with garlic, onion, pepper, chili, and other spices may upset your stomach. Lightly seasoned foods produce less nausea. Avoid foods that give you gas while you are pregnant.

***Between meals.*** Drink small sips of liquids frequently between meals. Take milk, water, fruit juices, decaffeinated coffee or tea, and soups **only** between meals. When you feel nauseated, small sips of carbonated beverages, grapefruit juice, orange juice, or grape juice may help settle your stomach.

***When cooking.*** Have enough windows open to get rid of the smell of cooking foods or use a crockpot so you don't have to be exposed to cooking smells as much.



## A Suggested Plan for Eating to Control Nausea

**Before getting up:** Crackers, any bread, toast, or dry cereal. Jelly or jam if you wish.

**Breakfast:** Cereal and  $\frac{1}{4}$  cup of milk or less, toast (no butter or margarine), a boiled or poached egg (not fried).

**Between meal:** (At least 30 minutes after breakfast) Citrus fruit, juice or milk- about two sips at a time.

**Lunch:** Cottage cheese or lean meat and bread, vegetable, or fruit.

**Between meal:** (At least 30 minutes after lunch) Milk, decaffeinated tea or coffee, fruit juice, or soup- about two sips at a time.

**Dinner:** Lean meat, fish, poultry, potato, dark green or yellow vegetable, bread, dessert.

**Before Bed:** (At least 30 minutes after dinner) Milk or other liquid- about two sips at a time.

Some women find taking Vitamin B6 helps relieve nausea. 25 mg taken three times a day (with meals) may be helpful. It will take two or three days before enough of this vitamin is in your system to make a difference in how you feel. Also taking Unisom, an over-the-counter sleep aid, when combined with the vitamin B6 may be helpful. When you purchase Unisom, make sure you select the one with the ingredient doxylamine succinate. Take one Unisom at bedtime. You may also take  $\frac{1}{2}$  a Unisom in the morning, if it does not make you too drowsy.

This eating plan does not give you all the foods you need during pregnancy. When you are nauseated, getting some food to stay down is more important than a balanced diet. As soon as you are no longer nauseated, try to eat a well-balanced diet with fruits, vegetables, dairy products and protein.

Please call our office if you have been unable to keep anything down for more than 24 hours or if you are experiencing symptoms of dehydration (dry mucus membranes, temperature greater than 100.6 with dizziness, decreased or very concentrated urine).



## Recommendations for Pregnancy

You should allow yourself plenty of rest. If you can, get a nap mid-day, or at least try to sit down, relax, and put your feet up.

**Exercise** is good for you. It gives you energy, helps prevent constipation, and helps you handle stress. However, there are a few recommendations: you are more prone to accidents, falls, and injuries, so wear good supportive shoes. This is not the time to take up a new sport, but any exercise program you are use to doing is fine to continue. While exercising, do not become short of breath or raise your heartbeat above 140 beats per minute.

In general, you should avoid all drugs including over the counter medications and aspirin. If you are taking medications prescribed by another physician, please call our office and discuss it with a nurse so that potentially harmful drugs can be discontinued or changed as soon as possible. There are a few drugs that are safe to take during pregnancy:

<b>Tylenol</b>	For mild discomforts and headaches
<b>Chlor-Trimeton</b> (plain, with chlorpheniramine maleate as the only active ingredient) or <b>Claritin</b> (plain) or <b>Zyrtec</b> (plain)	Only if necessary - for runny nose, sneezing, itchy eyes and throat
<b>Robitussin</b> (plain or DM)	For cough due to cold
<b>Mylanta/Maalox</b> (antacids)	For indigestion
<b>Lomotil</b>	For diarrhea

You should limit your consumption of **caffeinated drinks**, such as coffee or cola, to no more than one or two cups per day. Large caffeine intake has been linked to birth defects in animals.

**Alcohol** consumption should be avoided during pregnancy. Alcohol can cause birth defects; we do not know levels that are safe. If you have further questions regarding alcohol consumption, please talk with the nurse or doctor at your appointment.



It is safe to have **dental work** during pregnancy such as teeth cleaning and also more extensive work using a local anesthetic. Dental x-rays should be avoided if at all possible. Nitrous oxide (anesthetic gas) may increase your risk of miscarriage. Avoid it if possible.

**Saunas or hot tubs** should be avoided during pregnancy because they can raise your body temperature, which can be harmful to the baby.

Although your hair may not take a **permanent** as well during pregnancy, permanents are not harmful to your baby.

If you work with a **computer terminal**, to date there is no conclusive evidence of any harm to your baby. However, you may notice some increased eye strain.

You should not **douche** during pregnancy because it is possible to introduce air into your circulatory system at this time; in the last months of pregnancy, this could also break your bag of water.

Exposure to **toxic substances** in the environment should be avoided during pregnancy (i.e. insecticides for fumigating an area, paints, gases, and other chemical substances). If it is necessary for a chemical substance to be used where you work or live, you should leave the area for 24 hours. Prior to reentering the area it should be adequately aired out.