



Christensen Maternal & Fetal Medicine

Welcome to Christensen Maternal & Fetal Medicine

Your primary OBGYN, has referred you to our office for a high-risk pregnancy consultation. We are delighted to co-manage your pregnancy. What this means is that your primary OBGYN will continue to manage your pregnancy and remain your delivering physician. In order for us to continue co-managing your pregnancy, it is an absolute requirement that you keep your appointments with your primary OBGYN. If there is a high-risk indication in which your OBGYN decides that they should transfer your care to us, it must be a doctor to doctor phone call and you will be notified by your OB's office. Thank you in advance for understanding and complying with this request.

Due to the nature of our practice, we apologize in advance for any delays that may occur while visiting our office. Please be patient as problems may arise. We desire to give our patients the utmost in care and will give you the same careful attention as soon as we can. Allow 3 to 4 hours for a first visit.

To accommodate all patients that need to be seen in our office, we request that you cancel or reschedule your appointments at least 24-48 hours in advance. There will be a **\$75** 'No-show/No-call' charge for missed appointments.

Due to the nature of our practice, we ask that you do not bring children less than 8 years of age with you to your appointments. Thank you for understanding and complying with this request as it may be distracting for other patients as well as employees. Again we strive to provide you with the best care possible and wish to keep our focus on our patients.

If you should need to have blood work done, Dr. Christensen will give you an order to have it done at a lab that is contracted with your insurance. If you prefer to do it in our office, there is a **\$20** convenience and disposal fee.

To commemorate your visit with us, we offer a CD with the still pictures saved from your ultrasound examination. We charge **\$5** for the CD. Unfortunately, you may not bring your own disk from home, as they may upload harmful material onto our ultrasound systems.

We offer 3-D ultrasounds for established patients. The cost is **\$95** for 30 minutes of 3-D imaging. This appointment must be booked separately from your routine ultrasound visits. If you book an appointment for 3-D, the same request applies as far as canceling or rescheduling. There will also be a **\$75** 'No-show/No-call' charge for these appointments as well.

Please sign that you acknowledge and fully understand the above requests. In signing, you agree to the consequences listed for non-compliance with the Practice policies.

Patients Printed Name: _____

Patients Signed Name: _____

Date: _____

Witness: _____

Date: _____



We Listen, We Care

Christensen Maternal & Fetal Medicine

NEW PATIENT INFORMATION

ACCOUNT # _____

Patient's Name: _____
Nombre del Paciente
 Home Address: _____
Dirección
 City: _____ State: _____
Ciudad Estado
 Zip Code: _____
Código de Zona
 Driver's License #: _____
Licencia de Conducir
 Employer: _____
Lugar de Trabajo
 ER Contact/Relationship: _____
Contacto de Emergencia/Relacion

Home Phone #: _____
Teléfono del la casa
 Work/Cell Phone #: _____
Teléfono del Trabajo o Celular
 Date of Birth: _____
Fecha de Nacimiento
 Social Security # _____
Número del Seguro Social
 Marital Status: S M D W Spouse: _____
Estado Civil Esposo/Esposa
 Referred By: _____
Referido por
 ER contact phone#: _____
Teléfono de contacto de emergencia

PATIENT'S PRIMARY INSURANCE

Policyholder's Name: _____
Nombre del Asegurado
 Relationship to Patient: _____
Relacion con Paciente
 Social Security #: _____
Número del Seguro Social
 Date of Birth: _____
Fecha de Nacimiento
 Name of Insurance: _____
Nombre del Seguro
 Address: _____
Dirección
 City: _____ State: _____
Ciudad Estado
 Zip Code: _____ Telephone #: _____
Código de Zona Número de Teléfono
 ID # / Policy #: _____
Número de Identificación / Número de póliza
 Group #: _____
Grupo #
 Employer: _____
Lugar de Trabajo

PATIENT'S SECONDARY INSURANCE

Policyholder's Name: _____
Nombre del Asegurado
 Relationship to Patient: _____
Relacion con Paciente
 Social Security #: _____
Número del Seguro Social
 Date of Birth: _____
Fecha de Nacimiento
 Name of Insurance: _____
Nombre de Seguro
 Address: _____
Dirección
 City: _____ State: _____
Ciudad Estado
 Zip Code: _____ Telephone #: _____
Código de Zona Número de Teléfono
 ID # / Policy #: _____
Número de Indentificación / Número de póliza
 Group #: _____
Grupo #
 Employer: _____
Lugar de Trabajo

I hereby authorize payment of Insurance Benefits Directly to Christensen Maternal & Fetal Medicine for Services Rendered, and release of any Medical Information necessary to process claims. I am responsible for all Co-Payments, Non-covered Services and for any Deductible or Coinsurance Amounts.

Signature: _____

Date: _____

Signature of Person responsible for Bill: _____

Autorizo a Christensen Maternal & Fetal Medicine, a recibir los pagos directamente de los beneficios de mis Seguros y además le doy autorización para dar información médica como parte del proceso de reclamo. Me hago responsable de pagar cualquier cargo por deducibles, deducibles anuales o por servicios no pagados.

Firma: _____

Fecha: _____

Christensen Maternal & Fetal Medicine

PATIENT HISTORY

Name _____ Date of Birth _____ Age _____ Race/Ethnicity _____

Marital Status: S M D W Occupation: _____

Total # of pregnancies (including this one) _____ # of babies delivered? _____ # of miscarriages? _____ # of abortions? _____

Please list each of your pregnancies below, in chronological order, including ANY complications you or the baby may have had during the pregnancy, delivery or afterward:

| Year | Miscarriage/Abortion Vaginal/C-Section | Gestational Age (# of weeks) | Baby's weight | Complications (eg High blood pressure, diabetes, preterm labor, fetal abnormalities...) |
|-------|---|---------------------------------|------------------|--|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Circle all medical problems that you have now or had in the past: high blood pressure, diabetes, asthma, heart problems, lung problems, kidney problems, genital herpes, syphilis, HIV, bowel problems, thyroid problems, Lupus, blood clotting disorders (MTHFR - Factor V - Prothrombin mutations), blood clots (DVT/pulmonary embolism), birth defects, other/describe _____

List all surgeries you've had, including LEEP or cone biopsy: _____

Circle any problems that have occurred in the baby's father, his family or your family: autism, birth defects, chromosomal abnormalities, mental retardation, genetic or inherited diseases, sickle cell disease or trait, thalassemia disease or trait, anemia of any kind, blood clotting disorders, stroke, blood clots, blood clotting mutations, problems at birth, problems that developed later in childhood, other/describe _____

Do you: smoke cigarettes? yes no (if yes, how many? _____) use alcohol? yes no (if yes, how much? _____)

Use street drugs (eg cocaine, marijuana, etc)? yes no (if yes, which ones and how often? _____)

Any current or previous domestic violence, physical or sexual abuse? yes no (if yes, explain _____)

Are you allergic to any medications? yes no (if yes, which ones? _____)

Which medications (including prenatal vitamins and over-the-counter medicines) have you used during this pregnancy? _____

Patient Signature

Provider Signature

Date

Christensen Maternal & Fetal Medicine

SONOGRAM LIMITATIONS

SAFETY

As part of your evaluation here, you may have a fetal or cervical sonogram performed. To date, there are no known risks or damages to the fetus from sonography; however, we cannot predict what information may become known at a later time. To that end, we only perform fetal sonography when there is a medical indication for the test.

LIMITATIONS

New technologies have allowed us to see the fetus in impressive detail. However, it is very important to recognize that a fetus that appears to be “normal” on sonographic evaluation may in fact have birth defects, mental retardation, or other abnormalities that cannot be detected by current technology. The ability to diagnose many birth defects, particularly those involving the brain, spine, face, heart and extremities, is also limited by the gestational age at examination, the fetal position, the amount of amniotic fluid present, and the mother’s habitus. Additionally, some birth defects may not be apparent at early gestational ages, and may only become sonographically identifiable as the pregnancy progresses or after birth. This is especially true for the brain, heart, and gastrointestinal anomalies, and defects caused by viral infections. Chromosomal abnormalities (Down’s syndrome, for example) cannot be reliably diagnosed, or ruled out, using sonography alone. An amniocentesis is necessary to make that diagnosis.

Cervical Measurements can be quite variable and can change dramatically over a short period of time. A normal cervical evaluation does not rule out the possibility of rapid cervical change, incompetent cervix or preterm delivery.

This information is not meant to make you worry about your baby; most of the time if the sonogram appears to be normal, the baby does not have any birth defects. This information is simply to make you aware of limitations of sonography to make diagnoses and that a “normal” sonogram cannot guarantee the baby will not have some abnormality. No test can do that. If you have any questions about your sonogram, please ask. We will be happy to answer any questions you have.

ACKNOWLEDGEMENT

I have read the above information and I understand the limitations of sonography to diagnose birth defects, other abnormalities of my baby, and cervical abnormalities.

Patient Name

Patient Signature

Date

CHRISTENSEN MATERNAL & FETAL MEDICINE

**AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT,
PAYMENT, OR HEALTH CARE OPERATIONS**

I hereby authorize the release or use of my individually identifiable health information (“protected health information”) and medical record information by Christensen Maternal & Fetal Medicine (the “Practice”) in order to carry out treatment, payment, or health care operations. You should review the Practice’s Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: _____

I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

- _____ HIV/AIDS Information
- _____ Mental Health Information
- _____ Substance Abuse Information
- _____ Sexually Transmitted Disease Information
- _____ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manner(s) (please initial the appropriate spaces below):

_____ Via e-mail to the Patient’s designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.)

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.

_____ Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).

_____ Via fax to my designated fax number which is: _____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) *do not sign this Consent Form*. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date: _____ Time: _____ AM/PM

Signature of Patient or authorized representative

Please print Name

- Please explain Representative’s relationship to the Patient and include a description of Representative’s authority to act on behalf of the Patient:

CHRISTENSEN MATERNAL & FETAL MEDICINE

Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Printed Name _____

Signed Name _____

Date: _____

Witness: _____

Patient Name: _____

Account#: _____



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Carrier Screening in Pregnancy for Common Genetic Diseases

Everyone is at risk of having baby with problems. There are a few common disorders that can occur even without a family history and can be tested for today. You can have one simple blood test before the baby is born to determine if you *carry* the gene (DNA change) that causes the disorders shown below.

What is a carrier?

A carrier is a person who has a gene that increases the risk of having children with a genetic disease. People do not know if they are carriers or not until they have a blood test or an affected child. Some disorders occur only if both parents are carriers and other disorders occur only when the mother is a carrier.

What is carrier screening?

Carrier screening involves a blood test from one or both parents to determine if they carry a specific gene that increases the risk that their baby is affected. If you turn out to be at risk, prenatal testing such as amniocentesis or chorionic villus sampling (CVS) is available to determine if your unborn baby is affected. All testing is optional and you can choose which disorder(s) to be tested for. If you have questions or concerns regarding these tests, Dr. Christensen will be happy to counsel you further.

| Disease | Cystic Fibrosis | Fragile X Syndrome | Spinal Muscular Atrophy (SMA) |
|---|--|---|--|
| Symptoms of Disease | <i>Most common inherited disease in North America.</i> A chronic disorder that primarily involves the respiratory, digestive and reproductive systems. Symptoms include pneumonia, diarrhea, poor growth and infertility. Some people are only mildly affected, but individuals with severe disease may die in childhood. With treatments today, people with CF can live into their 20's and 30's. CF does not affect intelligence. | <i>The most common inherited cause of mental retardation.</i> Fragile X syndrome is a disorder that causes mental retardation, autism, and hyperactivity. It affects primarily boys. Women who are carriers are at risk to have a child with mental retardation. | <i>Most common cause of inherited infant death.</i> SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling their head or neck, and crawling or walking. The most common form of SMA affects infants in the first months of life and can cause death between 2-4years of age. Less commonly the disease starts later and people can survive into adulthood. SMA does not affect intelligence. There is no cure or treatment. |
| Inheritance | If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with Cystic Fibrosis. | If a mother is a carrier, there is up to a 50% chance to have a child affected with Fragile X Syndrome. | If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with SMA. |
| General Population Carrier Frequency | 1 in 25 Caucasians 1 in 46 Hispanics 1 in 65 African Americans ~1 in 90 Asian Americans | 1 in 260 Females Occurs in all ethnic backgrounds | 1 in 41 Occurs in all ethnics backgrounds |
| Are you interested in being tested through a simple blood test? (please circle one) | YES NO Yes indicates that you desire for us to obtain blood from you to complete this test. | YES NO Yes indicates that you desire for us to obtain blood from you to complete this test. | YES NO Yes indicates that you desire for us to obtain blood from you to complete this test. |

Patient Signature _____

Date _____