1692 Chatham Parkway
Savannah, GA 31405
www.themidwifegroup.com

OB PATIENT INFORMATION

NAME: LAST_____FIRST_____MIDDLE_____
DATE OF BIRTH_____MARITAL STATUS_____SOCIAL SECURITY NUMBER _____
ADDRESS_____CITY_____STATE_____ZIP_____
PHONE: HOME_____CELL_____WORK _____
EMAIL ADDRESS (for patient portal access): _____
EMPLOYER_____OCCUPATION_____
RACE:

○ White	○ Asian	○ Other
○ Black/African American	○ Hispanic or Latino (no race info available)	○ Decline to Report
○ American Indian or Alaskan Native	○ Native Hawaiian or Pacific Islander	

ETHNICITY:

○ No, not Spanish/Hispanic/Latino	○ Decline to Answer	○ Unknown
○ Yes/Cuban ○ Yes/Puerto Rican	○ Yes, Mexican, American, Chicano	○ Yes, Other Hispanic ○ (Specify)_____

PREFERRED LANGUAGE:

○ English	○ Spanish	○ Japanese	○ Chinese	○ Italian	○ Hindi
○ Portuguese	○ Russian	○ French	○ Guatemalan	○ Tagalog	○ Arabic
○ Bosnian	○ Vietnamese	○ Laotian	○ German	○ Gujarati	

INSURANCE INFORMATION

please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section
NAME: LAST_____FIRST_____MIDDLE_____
DATE OF BIRTH_____GENDER_____SOCIAL SECURITY NUMBER _____
ADDRESS_____CITY_____STATE_____ZIP_____
PHONE NUMBER_____PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY_____
GROUP NUMBER_____POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____
_____

SECONDARY INSURANCE INFORMATION (if applicable)

please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section
NAME: LAST_____FIRST_____MIDDLE_____
DATE OF BIRTH_____GENDER_____SOCIAL SECURITY NUMBER _____
ADDRESS_____CITY_____STATE_____ZIP_____
PHONE NUMBER_____PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY_____
GROUP NUMBER_____POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____
_____

PATIENT NAME (please print)_____DATE OF BIRTH _____

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SPOUSE/SIGNIFICANT OTHER

NAME: LAST_____FIRST_____MIDDLE_____
DATE OF BIRTH_____MARITAL STAUS_____SOCIAL SECURITY NUMBER _____
PHONE: HOME_____CELL_____WORK_____
EMPLOYER_____OCCUPATION _____

PARENT/GUARDIAN (if applicable)

NAME: LAST_____FIRST_____MIDDLE_____
ADDRESS_____CITY_____STATE_____ZIP_____
PHONE_____RELATIONSHIP TO PATIENT _____

ALTERNATIVE CONTACT (other than spouse/significant other – if applicable)

NAME: LAST_____FIRST_____MIDDLE_____
ADDRESS_____CITY_____STATE_____ZIP_____
PHONE_____RELATIONSHIP TO PATIENT _____

PREFERRED PHARMACY

NAME_____LOCATION _____

PREFERRED LAB

We send all lab work to LabCorp. Your insurance provider may require the use of a different lab. Please select:

◎ LabCorp	◎ Other (specify):_____

LIVING WILL

Do you have a living will?

◎ Yes	◎ No	◎ I'd like information about establishing a living will

PATIENT SIGNATURE_____DATE_____

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PRIVACY NOTICE

This privacy notice describes how your medical information may be disclosed and used by this practice. This notice also discusses your rights to access your medical information.
The HIPAA Privacy Rule allows your health information to be disclosed to carry out treatment, payment, and other healthcare operations. We are required to abide by the information outlined in this privacy notice. We reserve the right to update this policy as changes occur in the HIPAA Privacy Rule. HIPAA grants you the right to access and control your health information.

USES AND DISCLOSURES

Treatment: Your health information will be disclosed to provide, coordinate, and manage your healthcare. All of the providers in our practice may have access to your medical records. Additionally, our medical consultants and ultrasonographer review some records to assist us with your care. Your health information may be disclosed to any other physician or healthcare provider that may become involved in your care.
Healthcare Operations: Your health information will be used to support the business activities of the practice. Examples include, but are not limited to: quality assessment, employee reviews, nursing and midwifery student training, licensing, and other business activities. Health information may be shared in our group prenatal sessions.
Payment: Your health information will be used to obtain payment for services provided by this practice. Disclosures may be given to health plans, insurance providers, and collection agencies.
Business Associates: Your health information may be shared with third party business associates. Examples include billing and legal services. We have established written contracts that contain the terms that will protect your health information with all third-party business associates. All business associates must comply with HIPAA guidelines.
Disclosures Requires by Law and Workers Compensation: We are permitted to disclose your health information to comply with workers compensation laws and legal proceedings. If required, you will be notified of disclosure. The protected health information of members of the armed forces may be disclosed to authorized federal officials, under certain circumstances.
Abuse or Neglect: We may disclose your protected health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.
Emergencies: If you are incapacitated, we may use our best judgement to disclose information that is only directly relevant to your care.
Research and Health Oversight: We are permitted to disclose your information to researchers with an institutional review board has reviewed a research proposal and established protocols to ensure your health information will be kept confidential. We are permitted to disclose your health information to a health oversight agency for activities authorized by law. Examples include: audits, investigations, and inspections.
Written Authorization: Unless not required by law, your written authorization will be required for all disclosures of your protected health information. You can revoke authorization at any time via written request. It is important to note that we are unable to undo any disclosures previously made with your authorization.
Voicemail: Employees may only leave detailed voicemail messages if the greeting appropriately identifies the patient or another person who is authorized to receive information regarding the patient. If there is not appropriate identification, only the minimum necessary information will be left. This includes the caller's name, practice name, and a contact number. Patients have the right to opt out of voicemail messages.

PATIENT RIGHTS

You have the right to inspect and copy your protected health information. You may obtain your medical record that contains medical and billing information. As permitted by federal or state law, we may charge you a reasonable copy fee to provide a copy of your records. You may request an amendment of your protected health information. We reserve the right to deny your request. If we deny your request for amendment, you have the right to file a statement of disagreement. We may provide you with a copy of any rebuttal. Federal law prohibits you from inspecting or copying psychotherapy notes and information compiled in reasonable anticipation of, or use of, civil or criminal proceedings, or administrative actions or proceedings.

PRIVACY COMPLAINTS/ CLIENT GRIEVANCES

Should you believe that your privacy rights have been violated, and wish to file a complaint, you may contact us by calling our office at (912)629-6262 and asking to speak with our privacy officer. The director or her designee will personally respond within 10 business days to any complaint registered by a client about any aspect of Family Health and Birth Center. You may also contact our accrediting organization, The Commission for the Accreditation of Birth Centers at 240 Independence Drive, Hamburg, PA 19526, phone number 1-877-241-0262. Unresolved complaints may be directed to the Georgia Department of Community Health, Health Facilities Regulation Division, Attention: Complaints, 2 Peachtree Street NW, Atlanta, GA 30303-3142, phone: 1-800-878-6442.

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DISCLOSURE OF CONFIDENTIAL INFORMATION (select one)

○ I choose to have voicemail left with minimally necessary information. In the event that I am not available, you may leave a message	○ I choose to opt-out of voicemail messages.

I authorize you to disclose information about my care and allow the following individual/s to schedule, reschedule, and cancel appointments on my behalf:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT SIGNATURE_____DATE_____

CONFIDENTIALITY AGREEMENT FOR PARTICIPATION IN GROUP PRENATAL CARE (for pregnant patients only)

You have the right to expect what is said in class to remain private and confidential. Along with our commitment to maintain your privacy, you also have a responsibility to respect and protect each other's privacy. If you have any questions about this policy, you may ask our HIPAA compliance officer.

I have read the Privacy Notice and understand these policies.

PATIENT SIGNATURE_____DATE_____

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OUR FINANCIAL POLICY / RELEASE AND ASSIGNMENT

Full payment is due at the time of service. We accept cash, checks, and credit cards. Our practice is committed to providing the best treatment for our clients, and our charges are reasonable and customary for our area.

I am responsible for payment regardless of the insurance company's arbitrary determination of reasonable and customary rates or decisions regarding non-covered services. I agree to pay collection fees associated with any outstanding balance on my account.

I hereby authorize The Midwife Group and Birth Center/Family Health and Birth Center, Inc. to release any of my medical records deemed necessary to process my insurance claim. I authorize payment of medical benefits to The Midwife Group/Family Health and Birth Center Inc., or its providers for services rendered to me. I fully understand that I am responsible for all charges incurred as a result of services rendered to me and any balance remaining after my insurance pays. I, the undersigned, a patient at this facility, hereby authorize the providers (and whomever they may designate as their assistants) to administer treatment as necessary. I hereby certify that I have read and fully understand this authorization for medical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

PATIENT SIGNATURE_____ DATE_____

OR SIGNED FOR PATIENT BY_____ RELATIONSHIP _____

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HIV TESTING IN PREGNANCY (for pregnant patients only)

The HIV test is a routine screening in pregnancy. While I do have the right to refuse HIV testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to HIV testing and understand that the result will become a part of my medical record.

PATIENT SIGNATURE_____DATE_____

DRUG TESTING IN PREGNANCY (for pregnant patients only)

Because the use of illegal drugs/substances is potentially harmful for me and my fetus, drug screening is a routine screening in pregnancy. While I do have the right to refuse drug testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to drug testing and understand that the results will become a part of my medical record.

PATIENT SIGNATURE_____DATE_____

NO SHOW FEE

We understand that there are times when you may miss an appointment due to emergency or unexpected obligations for work or family, however, when you do not call to cancel your appointment in a timely manner, you may be preventing another patient from getting an appointment. If an appointment is not cancelled at least 24 hours in advance, you may be charged a $40 fee. This fee will not be covered by your insurance company.

PATIENT SIGNATURE_____DATE_____

PARTICIPATION IN EDUCATION

I hereby give my permission for the participation of students in my care. Students will always be supervised by a Certified Nurse Midwife, Nurse Practitioner, Medical Doctor, Radiologic Technologist, or Registered Diagnostic Medical Sonographer. I may refuse student involvement at any time.

PATIENT SIGNATURE_____DATE_____

AABC PERINATAL DATA REGISTRY (for pregnant patients only)

The purpose of this data registry is to help improve and maintain quality of care of childbearing families, provide for ongoing and systematic collection of data on normal birth, and facilitate research on maternity care practices that support optimal birth. By consenting to participate in this registry I understand that all information about me and my pregnancy will be kept confidential. As required by HIPAA, no identifying information will be seen by those conducting the project except for my date of birth and zip code. Statistical data will be kept on file and may be used later by other researchers who are studying specific parts of birth center or midwifery care. I freely consent to participate, and also give permission for data about my newborn to be used.

PATIENT SIGNATURE_____DATE_____

PRINTED PATIENT NAME _____

DISPLAY NAME AND DUE DATE ON BULLETIN BOARD CONSENT

Some parents choose to display their first name and due date (as well as baby's name, date of birth and weight after delivery) on our bulletin board. The HIPAA privacy law requires that our office have written consent to display this information at our facility. HIPAA also requires that we allow you to choose an expiration date at which time your information will be removed from display.

- ○ I give permission to have my name, due date, baby's name, date of birth, and weight displayed on the bulletin board. It will be taken off display and provided to me at my six week postpartum visit (or destroyed)

- ○ I do not give the birth center permission to display information about me or my baby

SIGNATURE_____DATE _____

PHOTO DISPLAY CONSENT

Some parents choose to send us photographs of their babies to display on the bulletin board. The HIPAA privacy law requires that our office have written consent to display any photographs that you send to our facility. HIPAA also requires that we allow you to choose an expiration date at which time your photograph will be removed from display and discarded.

- ○ I give permission to have any pictures I send to the birth center displayed on the bulletin board indefinitely

- ○ I do not give the birth center permission to display any photos I may send

- ○ I give permission to have any pictures I send to the birth center displayed on the bulletin board until the following date : _____

SIGNATURE_____DATE _____

PRINT NAME _____

OB HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. Please complete *ENTIRE* form.

Name *(Last, First, M.I.):*	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Significant other's name:	He/She is ☐ present for pregnancy ☐ deployed ☐ incarcerated
Is this pregnancy planned or unplanned?	Do you have supportive family and friends?
Highest level of education:	Employment: What is your job?
Who do you live with?	
What are your living arrangements? ☐ House ☐ Apartment ☐ Mobile Home ☐ Other	

PERSONAL MEDICAL AND SURGICAL HISTORY:
Please complete this portion of your health history in the *patient portal PRIOR* to your appointment. This is a very important part of your care and we want to make the most of your visit with the midwife by having the most updated and complete information*. If the patient portal is not completed, we may be required to reschedule or have you return for an additional visit to complete the appointment.*

FAMILY HEALTH HISTORY:
Your family history is very important for certain health screening as well as anticipating your health care needs. Please ensure you complete this section in the *patient portal PRIOR* to your appointment.

OB/GYN HEALTH HISTORY			
Last Menstrual Period:			
Last pap test:	Have you ever had an abnormal Pap test?		
Age period began?	Length of periods?	#days between periods?	
Any recent changes in your periods?		☐ Yes	☐ No
Are you sexually active?		☐ Yes	☐ No
Do you use birth control?		☐ Yes	☐ No
Do you do regular self-breast exams?		☐ Yes	☐ No
Since your last period, have you had any illnesses, rash, fever or exposure to x-rays or toxic chemicals?		☐ Yes	☐ No
Were you born premature (<37 weeks)		☐ Yes	☐ No
Are you currently breast feeding another baby?		☐ Yes	☐ No
Have you had a UTI (urinary tract infection) within 6 months of this pregnancy		☐ Yes	☐ No

Have you experienced any of the following (check all that apply): ☐ NONE

☐ Sexual or physical abuse or assault ☐ Domestic violence

☐ Emotional Abuse ☐ Childbirth trauma

☐ Major accident or illness or other traumatic event

Name:_____

Pregnancy History	Total # pregnancy:_____# Premature births_____#miscarriages/ abortions:_____# term births?_____

LAST NAME:						DOB:
Baby date of birth day/month/year	Weight	Sex	Weeks pregnant	Type of birth	Length of labor	Complications/ Comments

NUTRITION & EXERCISE

Exercise	Do you exercise? Yes ☐ No ☐ What type of exercise do you enjoy? How often?		
Diet	Are you on any special diet or have dietary restrictions? If so what?	☐ Yes	☐ No
	Do you eat three meals a day?	☐ Yes	☐ No
	Do you have a working stove?	☐ Yes	☐ No
	Do you have running hot and cold water?	☐ Yes	☐ No
	Do you receive WIC?	☐ Yes	☐ No
	Are you able to purchase the foods you need?	☐ Yes	☐ No
	Would you like to speak to someone about your diet and foods?	☐ Yes	☐ No
	#meals you eat in an average day?	How much water a day?	How much caffeine a day?

How often do you eat:	Never	2-3 times/month	Once/week	2-3 times/week	Once/day	2-3 times/day
Fast/restaurant food	☐	☐	☐	☐	☐	☐
Frozen meals	☐	☐	☐	☐	☐	☐
Home-cooked meals	☐	☐	☐	☐	☐	☐
Beef	☐	☐	☐	☐	☐	☐
Chicken/Turkey	☐	☐	☐	☐	☐	☐
Pork	☐	☐	☐	☐	☐	☐
Fish, Type?	☐	☐	☐	☐	☐	☐
Deli meat	☐	☐	☐	☐	☐	☐
Beans	☐	☐	☐	☐	☐	☐
Cookies/Cakes/Muffins	☐	☐	☐	☐	☐	☐
Other refined grains (white bread, white rice, white pasta)	☐	☐	☐	☐	☐	☐
Whole grains	☐	☐	☐	☐	☐	☐
Vegetables (fresh, frozen)	☐	☐	☐	☐	☐	☐
Fruit (Fresh, frozen)	☐	☐	☐	☐	☐	☐
Canned vegetables/fruit	☐	☐	☐	☐	☐	☐
Dairy (milk yogurt, cheese, butter)	☐	☐	☐	☐	☐	☐
Fried food	☐	☐	☐	☐	☐	☐
Artificial sweetener	☐	☐	☐	☐	☐	☐
Meal replacement bars or shakes	☐	☐	☐	☐	☐	☐

NAME:_____

Genetic Screening:			Comments
Are you older than 35 at the time of birth?	☐ Yes	☐ No	
Family history of thalassemia (Italian Greek, Mediterranean or Asian)	☐ Yes	☐ No	
History of Neural tube defect (meningomyelocele, spina bifida)	☐ Yes	☐ No	
Congenital heart defect	☐ Yes	☐ No	
Downs Syndrome	☐ Yes	☐ No	
Tay-sachs (Ashkenazi Jewish, Cajun, French-Canadian)	☐ Yes	☐ No	
Canavan Disease (Ashkenazi Jewish)	☐ Yes	☐ No	
Familial dysautonomia (Ashkenazi Jewish)	☐ Yes	☐ No	
Sickle cell disease or trait	☐ Yes	☐ No	
Hemophilia or other blood disorder	☐ Yes	☐ No	
Muscular dystrophy	☐ Yes	☐ No	
Huntington Chorea	☐ Yes	☐ No	
Mental retardation or autism	☐ Yes	☐ No	
Other inherited genetic of chromosomal disorder	☐ Yes	☐ No	
Maternal metabolic disorder (diabetes type 1 or PKU)	☐ Yes	☐ No	
You or baby's father had a child with birth defects not listed above	☐ Yes	☐ No	
Recurrent pregnancy loss or stillbirth	☐ Yes	☐ No	
Medications including supplements, vitamins, herbs, illicit drugs, recreational drugs or alcohol or exposure to toxic chemicals or X-rays since last menstrual period	☐ Yes	☐ No	
Infection history:			Comments:
Do you live with someone with TB or exposed to TB?	☐ Yes	☐ No	
Have you ever had chicken pox or had the vaccine?	☐ Yes	☐ No	
Have you had the HPV vaccine?	☐ Yes	☐ No	
Do you or your partner have a history or herpes?	☐ Yes	☐ No	
Have you had a rash or viral illness since your last period?	☐ Yes	☐ No	
Do you have a history of Hepatitis B or C?	☐ Yes	☐ No	
Do you have a history of STDs (gonorrhea, chlamydia, HPV, HIV or syphilis)?	☐ Yes	☐ No	

Reviewed by:_____Date: _____