Obstetrical Services Policy

During your pregnancy, there may be additional services that you request that are not covered under your Global Obstetrical Care by your insurance plan. Listed below are additional charges that will apply if these services are requested.

- Disability Forms: $36.00
- Disability/FMLA Forms (prior to 36 weeks): $60.00
- Disability/FMLA Forms (after 36 weeks): $72.00
- FMLA Forms: $36.00
- Letters (fee based on length/complexity): $24.00-$60.00
- Lost prescriptions/orders/referrals: $20.00

Please note all fees must be paid for at the time they are requested.

If your employer requests that you have Disability and/or FMLA forms completed, these forms must be presented to us at least **7 business** days prior to your employer's requested due date. This is to ensure that we have adequate time to complete the paperwork and forward it appropriately.

At least **7 business days** are required for completion of all forms due to the abundance of forms that we receive.

In agreement with our Obstetrical Services Policy, please sign below.

______________________________ ______________________________

Patient Signature Date

____

Patient Printed Name

VIRGINIA WOMEN'S HEALTH ASSOCIATES
1800 Town Center Drive, Suite 220
Reston, VA 20190
Telephone: 703-435-2555

DATE:____________________
ACCOUNT #:____________________
NAME:____
LAST FIRST MIDDLE
PT HOME #:_______________ PT CELL #:_______________ PHARMACY #_______________
NEWBORN'S PHYSICIAN:_______________ REFERRED BY:_______________ FINAL EDD:_______________

DOB	AGE	RACE	MARITAL STATUS	HUSBAND/FATHER OF BABY:

OCCUPATION: □ HOMEMAKER □ STUDENT □ OUTSIDE WORK	LAST GRADE COMPLETED:	EMERGENCY CONTACT AND PHONE #:
	TYPE OF WORK:	

TOTAL PREG	FULL TERM	PREMATURE	AB. INDUCED	MISCARRIAGES	ECTOPICS	MULTIPLE BIRTHS

MENSTRUAL HISTORY

LAST MENSTRUAL PERIOD:_______________ MENSES MONTHLY □ YES □ NO
□ DEFINITE □ APPROXIMATE (MONTH KNOWN) PRIOR MENSES:________DATE
□ UNKNOWN □ NORMAL AMOUNT/DURATION ON BCP AT CONCEPT: □ YES □ NO
□ FINAL________ POSITIVE PREGNANCY TEST ___/___/___

PAST PREGNANCIES (LAST SIX)

DATE MO/YR	# WEEKS PREGNANT	LABOR LENGTH	BIRTH WT	TYPE DELIVERY	PLACE OF DELIVERY	PRE TERM LABOR?	COMMENTS/ COMPLICATIONS

PAST MEDICAL HISTORY

	Neg 0 Pos +	Detail of Positive remarks		Neg 0 Pos +	Detail of Positive Remarks
1. Diabetes			13. D (Rh) sensitized		
2. Hypertension			14. Pulmonary (TB, Asthma)		
3. Heart Disease			15. Allergies (Drugs)		
4. Autoimmune Disorder			16. Breast		
5. Kidney Disease/UTI			17. Gyn Surgery		
6. Neurologic/epilepsy			18. Operations/Hosp Year/Reason		
7. Psychatric					
8. Hepatitis/Liver Disease			19. Anesthesia complicatons		
9. Varicosities/Phleritis			20. History of abnormal pap		
10. Thyroid Dysfunction			21. Uterine Anomalies		
11.Trauma/Violence			22. Infertility		
12. History of Blood Trans			23. Relevant Family History		

	amt/day pre-preg	amt/day preg	#yrs used
1. Tobacco			
2. Alcohol			
3. Street Drugs			

Comments:

GENETICS SCREENING
(INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY)

	YES	NO
1. Patients Age ≥ 35 Years		
2. Thalassemia (Italian, Greek, Mediterranean or Asian background): MCV < 80)		
3. Neural Tube Deffect (Meningomyelocele or Open Spine or Anencephaly)		
4. Down Syndrome		
5. Tay-Sachs (eg. Jewish background)		
6. Sickle Cell Disease or Trait		
7. Hemophilia		
8. Muscular Dystrophy		
9. Cystic Fibrosis		
10. Huntington Chorea		
11. Mental Retardation (if Yes, was the person tested for Fragile X?)		
12. Other Inherited Genetic or Chromosomal disorder		
13. Patient or baby's Father had a child with birth defects not listed above		
14. ≥ 3 First Trimester spontaneous abortions or a stillbirth		
15. Medications or street drugs since last menstrual period		
16. Other significant family history (see comments)		

COMMENTS:

INFECTION HISTORY

	YES	NO
1. High Risk Aids		
2. High Risk Hepatitis B		
3. Live with someone with TB or exposed to TB		
4. Patient or Partner have history of Genital Herpes		
5. Rash or viral illness since last period		
6. History of STD, GC, Chlamydia, HPV, or Syphilis		
7. Other (see comments)		

COMMENTS:

Patient Communication Preferences, HIPAA Privacy Rule, & Consent

In a continued effort to better serve our patients, we have developed a new communications process and ask that you indicate your preferences below. These preferences will be used for automated *appointment confirmations, normal lab result notifications, health maintenance reminders, inclement weather alerts, and other notifications.*

Please select only **ONE** option

↙ **or** ↘

☐ Please **TEXT MESSAGE** me with all notifications.
Preferred Phone Number: ___________________

☐ Please **CALL** me with all notifications.
Preferred Phone Number: ____________________

NOTE**:** The HIPAA Privacy Rule permits providers to communicate with patients regarding their health care via mail and phone. Additionally, the HIPAA Privacy Rule allows providers to leave messages for patients on their answering machines regarding their healthcare. If you do **NOT** wish to receive any voice messages with private health information, please indicate that below.

☐ **I DO NOT** want VWHA to leave voice messages – affiliated with the phone number(s) I have provided the practice – with private health information, to include lab results.

Email Address: ____

(To be used with Patient Portal - **coming soon**)

As the patient, I am in understanding that should my telephone number(s) change, it is my responsibility to update contact information with my doctor's office (VWHA).

Patient Signature: _________________________________

Patient Printed Name: _________________________________

Date: _________________________________

Camilla C. Hersh, M.D. **Stephanie Swanson, M.D.**
Amy B. Rembold, PA-C **Chana-Rivka Foster, M.D.**

PERSONAL HEALTH INFORMATION AUTHORIZATION FORM

Patient Name: ____ DOB: ___________________

I, _________________________________, give permission to Virginia Women's Health Associates (VWHA) to use or disclose my personal health information to the following person(s):

Name: ____

Relationship to Patient: ____

☐ _________________________________By signing here, I authorize *ANY AND/OR ALL* of my personal health information to be shared with the individual(s) listed above.

☐ _________________________________By signing here, I authorize my personal health information to be shared with the individual(s) listed above *with the following LIMITATIONS AND/OR SPECIAL INSTRUCTIONS*:____
____

By signing below, I certify that I have read and understand authorization to Virginia Women's Health staff to share all/limited personal health information to the above individual(s). Furthermore, I understand that I may revoke this authorization at any time by asking to complete a revocation form that VWHA will provide me upon request. I understand that such revocation will become effective on the date I complete the request form and will have no effect on the uses and/or disclosures made prior to that date. THIS AUTHORIZATION WILL EXPIRE ONLY AFTER I COMPLETE A REVOCATION FORM

I acknowledge that I have had an opportunity to read and understand the contents of this authorization form and my signature confirms that this authorization form accurately reflects my wishes.

Patient Signature: ______________________________ Date: ____________________________

Preventative Medical Visit – Patient Information & Consent

A preventative medical visit, more commonly known as an "annual exam", is a comprehensive preventative medical evaluation and management of care, to include an age and gender appropriate history, examination, anticipatory guidance and counseling, risk factor reduction interventions, and the ordering of routine laboratory and/or diagnostic procedures.

Insurance carriers may or may not provide coverage for preventative services. Furthermore, coverage and payment for preventative services vary from carrier to carrier, and most insurance plans ***do not*** require a copayment for this type of visit.

However, if an abnormality is encountered or a preexisting problem is addressed in the process of performing your annual exam, and/or the problem encountered is significant enough to require additional work to perform key components of a problem-oriented evaluation, then a separate office visit code may be charged. The use of this additional code may require a copayment, due at the time of service, if one is charged by your insurance plan.

By signing below, I certify that I have read and understand the differences between preventative and problem-oriented visits, and agree to pay the associated copayment should the nature of my visit change.

Patient Signature: ________________________________

Patient Printed Name: ________________________________

Date: ________________________________