Southwest General Medical Group, Inc.

Women's Health

Pregnancy Forms

SGMG WOMEN'S HEALTH

NAME: ____BIRTHDAY: ___________DATE: __________

CELL PHONE NUMBER: ______________________________EMAIL: _____________________________

Would you like a Chaperone during your exam (nurse)? YES or NO

Preferred Pharmacy Name: __________________ City: _____________ Street: ____________________

Are you here today for an **ANNUAL** exam? : YES or NO

Are you here today for a **MEDICARE** annual exam? : YES or NO

If you are here for a MEDICARE annual exam, there WILL be a $60 fee billed to you for part of your visit today.

Are you having any problems? If yes, please briefly describe: ____

LAB CONSENT

You may be having a Pap and/or lab work performed that will be sent to a laboratory for evaluation. Please mark **ONE** facility that your insurance will approve for us to send your Pap and/or lab work to. If you do not know where to send your tests, **please contact your insurance company. Please do not leave blank or we will automatically send your test to Southwest General Medical Center Laboratory.**

___________ I authorize my test to be sent to Southwest General Medical Center Laboratory

___________ I authorize my test to be sent to Quest Diagnostics

PERMISSION TO DISCUSS TEST RESULTS

Please read and sign either option A. or option B.

A. I would like the person specified below (family member or friend) to have access to my medical information. My signature below gives the doctor and staff of *SGMG, A Multispecialty Group* my permission to discuss test results and/or health status with that individual.

____ _____________________________________

SIGNATURE: ***DATE:***

____ _____________________________________

SPECIFIED PERSON: ***RELATIONSHIP:***

B. My signature below indicates that **I DO NOT** give my permission to release information about my health to anyone other than the insurance company and myself.

____ _____________________________________

SIGNATURE: ***DATE:***

SGMG Women's Health – Insurance Verification

IT WILL BE NECESSARY FOR YOU TO CONTACT YOUR INSURANCE COMPANY TO FIND OUT THE ANSWERS TO THE FOLLOWING QUESTIONS TO BETTER UNDERSTAND WHAT YOUR POLICY COVERS

PLEASE RETURN THIS COMPLETED SHEET ON YOUR NEXT OB VISIT

PATIENT NAME: ____DATE OF BIRTH: ________________

INSURANCE COMPANY:____

POLICY NUMBER: ____GROUP NUMBER:__________________

WHO CARRIES THE INSURANCE:____

EFFECTIVE DATE:____________________________ DEDUCTIBLE: ______YES ______NO

DEDUCTIBLE AMOUNT: _____________ CO-PAY: _____________ OUT OF POCKET AMOUNT: ____________

PLEASE CHECK TO SEE IF REFERRALS ARE REQUIRED FOR THE FOLLOWING SERVICES:

REFERRAL TO PERINATOLOGIST: ____

REFERRAL FOR ULTRASOUND: ____

REFERRAL FOR FETAL NON STRESS TESTING: __________________________________

REFERRAL OR PRE-CERTIFICATION FOR OB CARE: ______________________________

PRE-CERTIFICATION FOR INDUCTION OF LABOR: _______________________________

PRE-CERTIFICATION FOR ADMISSIONS TO HOSPITAL: ___________________________

YOU CAN CALL YOUR INSURANCE TO PRE-CERTIFY YOUR OB CARE AND FIND OUT THE NUMBER OF DAYS ALLOWED FOR YOUR DELIVERY

PRE-CERTIFICATION #: __________________________________

PERSON YOU SPOKE WITH: ______________________________

DATE: ________________________ INSURANCE COMPANY PHONE #: _________________________________

Southwest General Medical Group- Women's Health
Easy Pay Policy

Thank you for choosing Southwest General Medical Group, Women's Health as your health care provider. Our physicians have implemented a new credit card easy pay policy. At your initial OB visit or at your appointment to set up your surgery we will require you to provide us with a copy of a valid credit card. We will hold this copy in our billing department in a confidential safe area until after your insurance has been billed and they have responded. At that point if there is a balance due you will be billed. You can pay the balance by credit card, check or cash. If the balance is not paid within 30 days our billing dept will contact you to make payment arrangements. If they cannot reach you or don't receive a response after three attempts to reach you, the credit card easy pay policy will take effect. Once again, your credit card will ONLY be charged IF YOUR ACCOUNT IS OUTSTANDING and there is no response.

There are three options for payment of your patient balance after we have billed your insurance company. You must select one:

☐ **Payment of balance via credit card**- after the insurance has paid their portion of the services provided, the remaining portion that is the patients responsibility will be charged to the credit card provided after the patient is notified and verbal permission is given over the phone.

☐ **Payment of balance via cash/check**- after the insurance has paid their portion of the services provided, the remaining portion must be paid in full within 30 days via cash or check. We will hold your credit card information in case the balance is not paid within the 30 days. After the 30 days when the account is going to be entering pre-collection and a response from the patient has not been received we will then charge the credit card for the amount due.

☐ **Prepayment of balance**- a member of the office staff will contact the insurance company for the amount of the patients responsibilities for the services that will be provided. The balance must be paid in full prior to providing the services. If the account is paid in full a credit card is not needed. If the amount can not be paid in full, the credit card will be required in order to proceed with the services. If you wish to set up a payment plan so that the balance at the end of the services provided is not a large amount, we will be glad to help you in doing so. A credit card will be required if the patient decides to set up a payment plan.

I have read the policy above and understand the policy as it is stated. By signing this I am acknowledging and agreeing to the policy.

____

Print Patients Name

____ Date: _____________

Patients Signature

Credit Card#: _______________________________ Expiration Date: ___________

SGMG WOMEN'S HEALTH

Middleburg Hts.
7255 Old Oak Blvd., Suite C202
Middleburg Hts., OH 44130
Phone: 440-816-5390
Fax:440-816-6784

Strongsville
18181 Pearl Road, Suite B206
Strongsville, OH 44136
Phone: 440-816-4930
Fax: 440-816-4939

PLEASE COMPLETE THIS QUESTIONNAIRE WHICH WILL INFORM US OF ANY RISK FACTORS THAT YOU MAY HAVE

PATIENT'S NAME:________________________________ DATE OF BIRTH: _________________

Menstrual History

1. What was the first day of your last period? ______________
2. Prior to pregnancy, did you get your period monthly? Yes or No
3. Were you using Birth control at the time you conceived? Yes or No
   If yes, what kind? ___________

Pregnancy History

Please List Your Previous Pregnancies

1. How many pregnancies have you had? ________
2. How many pregnancies were:
   - Full Term___________
   - Premature__________
   - Multiple Births ______
   - Ectopic ___________
   - Miscarriage_______
   - Abortion _________

3.

What was Baby's Birth Date	How many weeks were you?	How long was your labor?	Birth Weight	Baby's Sex	Type of Delivery	Where did you deliver?	Who was your doctor?	Were there any Complications?
				M or F	Vaginal or Csection			
				M or F	Vaginal or Csection			
				M or F	Vaginal or Csection			
				M or F	Vaginal or Csection			
				M or F	Vaginal or Csection			
				M or F	Vaginal or Csection			
				M or F	Vaginal or Csection			

SGMG WOMEN'S HEALTH

Please Circle one

1. Will you be age 35 or older when you have this child? Yes or No

2. Have you or your partner or anyone in either of your families ever had:

   A. Down's Syndrome (Mongolism)? Yes or No
   B. Spina Bifida or Meningomyelocele (Open Spine)? Yes or No
   C. Hemophilia? Yes or No
   D. Muscular Dystrophy? Yes or No
   E. Cystic Fibrosis? Yes or No
   F. Huntington Chorea? Yes or No

3. Have you or your partner had a child born dead or alive with a birth defect not listed in the Question number 2 above? Yes or No

4. Do you or your partner have any close relatives who are mentally retarded or have birth defects? Yes or No

   If "Yes", list cause, if known: ____

5. Do you or your partner or close relative, in either family, have any inherited genetic or chromosomal disorders not list listed above? Yes or No

6. Have you or your partner had three or more spontaneous pregnancy losses, miscarriages, stillbirths, etc.? Yes or No

7. Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)? Yes or No

   If "Yes", have either your or your partner been screened for Tay-Sachs Disease? Yes or No

   If "Yes", please indicate results and who was screened: __________________________________
   ____

8. Do you or your partner have any close relatives descended from Mediterranean countries: (Example: North Africa, Southern Europe, Italy, Greece, Middle East) Yes or No

   If "Yes", has you or your partner been screened for Thalassemia (Cooley's Anemia)? Yes or No

   If "Yes", please indicate results and who was screened: __________________________________
   ____

9. Are you or your partner African-American or biracial? Yes or No

If "Yes", have either you or your partner or any close relative been screened for sickle cell trait and found to be positive? Yes or No

If "Yes", please indicate results and who was screened: ________________________________
____

10. Have you had alcoholic beverages during this pregnancy? Yes or No

If "Yes", describe when and amount: ____

11. Did you take any medications either by prescription or bought over the counter at the drug store (including prenatal vitamins)? Yes or No

If "Yes", please list drug and dosage schedule: ______________________________________
____

Patient's Signature: ____ Date: ______________