Eastwind Women's Health

Congratulations on your pregnancy! We ask that you fill out the enclosed history sheets:

You have chosen EASTWIND WOMEN'S HEALTH to oversee your obstetric care. Generally, you will be seen monthly through the seventh month, bimonthly in your eighth month, and weekly in your ninth month of pregnancy. Circumstances during your prenatal care may necessitate varying your schedule of appointments to better monitor your pregnancy. You may also be scheduled to see your doctor's partner for at least one appointment.

You may call the office to speak to a nurse if you have an urgent concern that should not wait for your appointment. If you consider your problem to be an emergency, please let the receptionist know. Emergency concerns may include vaginal bleeding, acute or persistent pelvic pain, vaginal fluid leakage, preterm contractions (more than 4 or 5 in an hour), decreased fetal movement, actual labor, or any other urgent concerns that you may have.

After office hours, and on weekends and holidays, a physician is on- call for your urgent concerns. The Physicians at the office of Karin Moorma, M.D. and Carol Jenkins, M.D., share some weekend and weekday evening coverage for emergency calls.

Due to the nature of our specialty, we may run behind in our schedule at the office, but you will receive our full attention when you see a doctor. Your patience and understanding of the needs of others is appreciated. You may call in advance of your appointment time and see how the schedule is running if that helps you.

Although we agree limiting medication during your pregnancy is ideal, occasions arise where using a safe, effective medication can diminish uncomfortable symptoms. The following are considered safe to use during pregnancy, provided you have no allergy to the medications, and take them as directed on the manufacturer's label. If symptoms persist, or you do not tolerate the over-the-counter remedy, please call the office.

- Acetaminophen (Tylenol) for analgesic use for headaches, body aches, feavers
- Guaifenesin (Robitussin) plain for cough. Cough drops or throat lozenges to soothe
- Claritin, Benadryl, and Sudafed for nasal/ sinus congestion
- Mylanta, Riopan, Tums for indigestion
- Fibercon, Metamucil, Citacil for constipation

Caffeine is a chemical and we recommend you limit its use during pregnancy. If an artificial sweetener is your preference, NutraSweet has not been associated with harmful fetal effects; however, its use in pregnancy should also be limited. Sweet & Low has been associated with adverse fetal effects in laboratory animal studies, and probably should be avoided. Smoking tobacco and consuming alcohol have been shown to damage babies and should be entirely avoided during pregnancy.

*******You SHOULD NOT use aspirin (ASA), Ibuprofen (Motrin, Advil, etc.), Aleve, Laxatives, douches, or enemas********

When you meet with the nurse at the initial prenatal appointment you will be given information about the hospitals, birthing classes, the above tests, and your vitamin prescription. If you have concerns, please make her aware of those.

We look forward to caring for you,
Dr. Arora, Rheaume, Buchenroth, & Staff

TO OUR OBSTETRIC PATIENTS:

Recently recommendations of our specialty organization, The American College of Obstetrics and Gynecology (ACOG), have been changing the testing of patients in order to identify patients who may be at a higher risk during their pregnancy. The purpose of this letter is to inform you, the patient, of the screen tests, please do not hesitate to request more information from our doctors.

1. Antepartum Rh Immune Globulin Prophylaxis: approximately 15% of the population of the United States carries the Rh negative factor in their blood. The factor is insignificant except for the possibility of blood transfusion or in the event of pregnancy. If the mother is Rh negative and the father is rh positive, then the potential exists for the baby to be Rh positive. If any mixing of the mother's and baby's blood occurs, the possibility of sensitization of the fetus is present. In the past this has been a significant problem with Rh negative mothers, but since the advent of Rh immune globulin (RhoGAM) in the early 1970's the problem has been largely eliminated. Recently a recommendation had come from the ACOG that the Rh immune globulin to be administered at approximately seven month gestation (28-32 weeks) in addition to the routine use following delivery. At your initial visit your blood type and Rh will be determined, and if Rh positive, RhI.G. Will again be administered in the hospital.

2. Screen for Diabetes: As you are well aware, pregnancy can induce significant amounts of stress on the human body. On the occasion, certain women will exhibit symptoms of pregnancy- induced sugar tolerance (diabetes) . In order to check for the possibility of the presence of sugar problems, it has been recommended by the ACOG that all pregnant patients be screened during their pregnancy for diabetes. This will be performed at approximately 6-7 months gestation (26 weeks). During a visit around this time, a soft drink containing 50 grams of glucose (sugar) will be administered. Your blood sugar will then be checked following the interval of one hour. For this screening, it will not be necessary for you to have any special diet or to be NPO (nothing by mouth) for any length of time. If the results of the blood sugar test are interpreted as abnormal, then further testing will be recommended as indicated.

3. Tay-Sachs Disease; Tay- Sachs disease is an inherited disease involving metabolism of certain amino acids. This disease is usually prevalent only in people of Jewish descent. Recently test have been made available to check for the presence of the carrier state of Tay- Sachs disease. If there are any family history of this particular disease, or if you are jewish decent, testing for this particular disease can be performed at Children's Hospital.

4. Alpha-fetoprotein Screening: There has been, for sometime, a test available that utilized a sample of maternal blood to evaluate the fetus. This is called Maternal Serum Alpha-fetoprotein. The test was initially designed to diagnose neural tube defects. A neural tube defect is a malformation of the spine resulting in the failure to close the lower portion of the spine, otherwise known as spina bifida, or the failure to close the upper end of the spine which can result in anencephaly (the absence of the upper portion of the head and brain).

While antepartum diagnosis cannot alter the development of the baby, being aware of such malformation may come into play when planning the mode of delivery. For instance, a cesarean section delivery might be necessary in certain circumstances.
Initially, the Maternal Alpha-fetoprotein was only for antepartum diagnosis of neural tube defects. However, since we have been utilizing this test for quite some time, abnormal values have been associated with other situations besides neural tube defects. A perfectly healthy baby can be present, and yet the

change in the level of Maternal alpha-fetoprotein may be affected by the placental function.
In some circumstances, this has been associated with such an occurrence as small birth weight infants, preterm labor, pre-eclampsia (toxemia of pregnancy), and even stillbirth. Furthermore, the test has been associated with predicting a higher or lower incidence of Down's Syndrome.

Because of the association with problems that may occur in the later part of pregnancy, and because of that it may be possible to intervene when knowledge of this high risk situation is known ahead of time, we are strongly recommending that everyone have this test run as part of their normal prenatal care.

5. Genetic Screening for Down's Syndrome: there is a well established correlation between maternal age and risk of Down's Syndrome. As maternal age increases, so does the risk of having a baby with Down's Syndrome. At the maternal age of 30, the risk of Down's Syndrome is 1 in 885. At the age of 35, this risk increases to approximately 1 in 365. And by the age of 40, the incidence of Down's Syndrome had increased to approximately 1 in 109.

Down's Syndrome can be diagnosed prenatally through a procedure called amniocentesis. This involves withdrawing amniotic fluid from around the baby through a sterile needle through the mother's abdomen. Ultrasound is utilized for location of the fluid, and to help avoid trauma to the placenta and to the fetus. There is a risk associated with this procedure. That risk is a chance of miscarriage of approximately 1 in 200 times. Because of this associated risk with amniocentesis, unless there are extenuating circumstances such as previous child with Down's Syndrome or a close relative with Down's Syndrome, amniocentesis to diagnose Down's Syndrome in not typically recommended prior to the maternal age 35. The American College of Obstetrics and Gynecology recommends that any woman who will be age of 35 prior to her due date, should be counseled on the potential availability of prenatal diagnosis. The doctors will attempt to discuss this situation further with anyone whom this applies. If you have questions regarding this type of prenatal diagnosis , please don't hesitate to ask.

HELPFUL BOOK SUGGESTIONS:

- What To Expect When You're Expecting
    - By: Eisenberg, Murkoff & Hathaway
- Your Pregnancy Week by Week
    - By: Glade B. Curtis M.D. / OB- GYN
- While Waiting
    - By: George Verrilli, M.D. & Anne Mueser, Ed. D.
- The Complete Book of Breastfeeding
    - By: Marvin Eiger, M.D. & Sally Wendkos Olds

Non-Invasive Prenatal screen and Carrier Screening:

A non-invasive prenatal detects whether a pregnancy is at increased risk for certain chromosome conditions including Down's Syndrome, trisomy 13 and trisomy 18. You and your healthcare provider may also choose to screen for conditions involving sex chromosomes, X, and Y, as well as other more rare conditions.

What are the advantages of getting screened?

- If your results are negative, you will have the reassurance that the risk of your pregnancy begin affected with any of the chromosome conditions screened for is significantly reduced.
- If the results are positive there is a significantly increased chance that your pregnancy is affected. In this case, your healthcare provider will discuss the option of diagnostic testing to determine if your pregnancy is affected
- Regardless of whether you choose to have a diagnostic test, having the information provided by Non-Invasive Prenatal Screening can help you plan and prepare.

Carrier Screening:

Carrier screening can help you determine if you and your partner could pass inherited health conditions on to your children. Being a carrier means that you inherited a normal gene from one parent and a gene with an irregularity, also called mutation, from the other. As long as you have one normal copy of a gene, you typically don't have any symptoms for the condition. If both parents have a mutation in the same gene there is a 1 in 4 (25%) chance, for every pregnancy, that your baby will inherit the mutation from both parents and develop symptoms of the associated condition. There are also a few conditions, called X-linked conditions, where only the female needs to carry the mutation for her child to be at risk of developing symptoms.

Some of the conditions you may be screened for:

Cystic Fibrosis (CF)	CF affects many different organs in the body, including the lungs, pancreas, and liver, lining them with abnormally thick, sticky mucus. CF may cause chronic breathing problems and lung infections. CF patients have a lower life expectancy.
Spinal Muscular Atrophy	SMA causes certain nerves in the brain and spinal cord die. Impairing the person's ability to move. SMA is the number one genetic cause of infant death.
Fragile X Syndrome	Fragile X syndrome causes serious intellectual impairment and behavioural problems. It is the more common inherited intellectual disability.

I have read all the information about Non-Invasive Prenatal Screening and have had a chance to discuss my questions.

These are my desires regarding these screening tests:

_____ I decline all chromosomal screening

_____ I DO want cell- free DNA testing

_____ I DO NOT want cell-free DNA testing

_____ I DO want Sickle Cell testing

_____ I DO NOT want Sickle Cell testing

_____ I DO want Cystic Fibrosis Screening

_____ I DO NOT want Cystic Fibrosis Screening

_____ I DO wan AFP Quad Screening

_____ I DO NOT want AFP Quad Screening

We want to clarify and inform all patients that the optional Counsyl cell Free DNA testing which we will continue to offer is not billed through Eastwind Women's Health; any questions regarding this optional testing needs to be directed to Counsyl.

Any questions regarding billing can be directed to:
1-888- COUNSYL (1-888-268-6795)
Counysl.com/contact

Print Name: _____ DOB:_____

Signature:_____ Date: _____

Maternity Ultrasounds

The coverage for ultrasounds in pregnancy varies from insurance carrier to insurance carrier. Therefore, it has become increasingly difficult for us to maintain adequate knowledge of all insurance plans. This can be further complicated when an individual is covered under two different insurance policies.

In this regard, we are asking that you take the initiative to contact your insurance carrier to find out what is required regarding ultrasounds. The questions to ask include: How are my ultrasounds going to be covered? Does my OB-GYN? Do I need a referral? Is there a copay? Does my deductible apply to this service if I have not met my deductible?

Once this information is obtained, our nurses will be more than happy to assist you in the precertification process, or obtaining a referral if necessary. In the event that we are unaware of what is required, it could result in your insurance denying payment for the procedure and put you at liability for the cost of the ultrasound.

We are asking you to help us in this regard. In the process, it will hopefully give you a better insight and knowledge of your own insurance.

Thank you,
Amol Arora, M.D., F.A.C.O.G.
Patrick Shayne Rheaume, M.D., F.A.C.O.G.
Britta Buchenroth, M.D.
Jessie Anderson, CNP
Alexis Shelley, CNP
Tara Freter, CNP

I have read this letter and understand my responsibility in obtaining information regarding insurance coverage for ultrasounds during pregnancy under my policy or policies.

Print Name:_____DOB:_____

Patient Signature: _____ Date: _____

Prenatal Record:

Date:	Patient Name:
Hospital of Delivery:	
Pediatricians's Name:	
Provider Name/Group: Eastwind Women's Health	
Practice Address: 904 Eastwind Drive, Westerville, OH 43081-3329	
FINAL EDD:	

Mother D.O.B:	Age:	Race:
Marital Status:	Occupation:	
Education Level:	Language:	
Address:	City, State, Zip:	
Insurance Carrier:		
Member I.D:	Group Number:	
Support Person:	Phone:	
Father of the Baby:	Phone:	

Gravidity/ Parity Status:

Total Pregnancies: _____ Term: _____ Pre- Term: _____

Induced AB: _____ Spontaneous AB: _____ Ectopics: _____

Multiple Births: _____

Emergency Contact:
Name: Phone:

1st Day of Last Menstrual Period: Definite/Approximate (circle one)

WERE YOU ON BIRTH CONTROL AT CONCEPTION? Yes/ No
If yes, What type? _____
At what age did you start your menstruation cycle? : _____

PAST PREGNANCIES, INCLUDING MISCARRIAGES

Pregnancy #	Date	Weeks	Labor Hrs	Weight	Sex	Procedure	Hospital	Comments:

COMPLICATIONS OF PREGNANCY

Pregnancy #	Year	Associated Problem	Therapy	Year	Outcome	Comments:

FAMILY HISTORY

Disease	Family Member	Comments:

PERSONAL MEDICAL HISTORY

	Y/N		Y/N		Y/N
Diabetes		Varicosities		GYN Surgery	
Hypertension		Thyroid Dysfunction		Anesthetic Complications	
Heart Disease		Trauma/Violence		Abnormal PAP Smear	
Autoimmune Disorder		Hx Blood Transfusions		Uterine Anomaly	
Kidney Disease		D (RH) Sensitized		Infertility	
Neurologic/Epilepsy		Pulmonary (TB/Asthma)		ART Treatment	
Psychiatric		Seasonal Allergies		Relevant Family Hx	
Depression		Drug/Latex Allergy Reaction		Operations	
Hepatitis/Liver Disease		Breast Disease		Hospitalizations	

	Type/Form of Use	Pre-Pregnancy Use Amount	Pregnancy Use Amount	# of Years Used
Tobacco				
Alcohol				
Illicit Drug Use				

INFECTION HISTORY

	Y/N		Y/N
Live with or exposure to TB		History of Gonorrhea	
Patient/Partner has history of genital herpes		History of Chlamydia	
Rash or Viral illness since last period		History of HPV	
History of Hep B or C		History of HIV/AIDS	
History of Sexually Transmitted Infections		History of Syphilis	

PAST MEDICAL/SURGICAL HISTORY

Medical History	Month	Year	Surgical History	Month	Year

SYMPTOMS SINCE LAST MENSTRUAL PERIOD

(Example: Nausea/Vomiting, Breast Tenderness, etc…)

CURRENT MEDICATIONS

When Started	Medication	Strength	Dosage	How Taking	Reason

MEDICATION TAKEN SINCE LAST MENSTRUAL PERIOD

Medication Name	Reason

ALLERGIES

Description	Reaction

SEE NEXT PAGE

GENETIC SCREENING

	Yes	No	Relationship
Patient's age 35 years or older as of EDD			
Thalassemia (Italian, Greek, Mediteraanean or Asian Background)			
Neural tube defects (Spina Bifida, Meningomyelocele, or Anencephaly)			
Congenital Heart Disease			
Down Syndrome			
Tay-Sachs (Ashkenazi Jewish)			
Familial Dysautonomia (ashkenazi Jewish)			
Sickle Cell Disease or Trait (African American)			
Hemophilia or Other Blood Disorders			
Muscular Dystrophy			
Cystic Fibrosis			
Huntington's Chorea			
Mental Retardation/Autism			
Other Genetic/Chromosomal Disorder			
Maternal Metabolic Disorder (Diabetes, PKU)			
Patient or Baby's Father had a child with birth defects (not listed above)			
Recurrent Pregnancy loss or stillbirth			

Any other NOT listed above:_____

_____

_____

_____

_____

Effective as of July 1, 2018

Eastwind Women's Health will be charging for any FMLA and Disability forms to be completed.

- The Charge for completing the first form is $30

-Any additional forms after will be $10 each.

Please bring ALL forms FILLED out with your information. (Any forms not filled out when turned in will be returned back to the patient and will not be completed.)

We require 7-14 Business days (Monday through Friday) to complete the forms. Payment of forms are due the day they are dropped off. (Cash, Card, or Check) If forms are not paid for, we will not fax, or give them back to the patient once they are complete. If you decide to have them faxed to our office, please be aware that sometimes faxes do not go through. Please be sure to call our office to verify we have received the forms.

Eastwind Women's Health

★ **Patient Information:** (Please print and complete fully)

Legal Name: _____
(Last) (First) (Middle)

Address: _____
(Street Address) (City) (State) (Zip)

SS # (required): _____ Birth Date: _____ Age: _____

Marital Status (circle one): Single Married Widowed Divorced Partner

Phone: Home:_____ Cell: _____ Work: _____

Do we have your permission to leave a message (circle one): Yes No

Email: _____

Employer: _____ Occupation: _____

★ **Emergency Contact:**

Name:_____ Relationship:_____

Emergency Contact Phone:_____

★ **Primary Care Physician:** _____ Phone: _____

★ **Medical Insurance Information: (Must present insurance card at each visit)**
(It is the patient's responsibility to determine coverage/ benefits at the time of service)

Do you have insurance?(circle one): Yes No

Primary Insurance:_____
Subscriber Name: _____ Subscribers D.O.B: _____
Relationship to patient: _____

Secondary Insurance:
Subscriber Name: _____ Subscribers D.O.B: _____
Relationship to patient: _____

Consent to Medical Care and Treatment: While at Eastwind Women's Health I Give consent for all medical care, any tests and examinations needed. I will not hold Eastwind Women's Health or any person responsible for the results if I refuse medical treatment or advice. This consent will be valid for one year unless otherwise indicated in writing by either party.

Patient Signature:_____ Date:_____

★ Release of Information:

I understand that Eastwind Women's Health may use or release my medical/ health information for the following reasons as needed:

- Insurance information, billing and payment
- Release to other healthcare providers for billing, payment, referrals and discharge planning
- Quality improvement reviews
- Medicare, Medicaid and other government programs
- Employer, if injured
- Public health reporting
- Legal, regulatory and accreditation agencies
- Eastwind Women's Health may receive or release my health information, whether written, verbal, fax, or electronic using secured internet websites.

★ Acknowledgement of Privacy Practices:

Option 1:
_____ I was offered a copy of the Notice of Privacy Practices, but did not want it.

Option 2:
_____ I have received a copy of Eastwind Women's Health Notice of Privacy Practices.

I understand I have a right to keep my medical information private.
If you would like someone (spouse, sister, brother, son, daughter, etc.) to have access to your medical information please fill in the blanks below:

I, _____, hereby allow Eastwind Women's Health, to discuss my medical

information with _____.
Name Relationship

★ Payment and Financial Responsibility:

I hereby authorize and/ or assign my Medicare and/or my insurance benefits to be paid directly to Eastwind Women's Health. I realize I am responsible to pay non- covered services as well as any deductibles, copays or coinsurance. I am aware that all unpaid balances and copays are due at the time of my visit. I certify that the information given to me by the practice, in applying for under Medicare and/ or insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me to release to Medicare and/ or the insurance company or its agents, any information needed to determine the benefits payable to related services. I consent to any request for review or appeal by Eastwind Women's Health, to challenge a determination of benefits made by a third party payer/ insurer. This assignment will remain in effect until revoked by me if writing. A photocopy of this assignment is considered to be as valid as the original. If you are a self pay patient any quotes provided are strictly estimates.

Print Name: _____ Date of Birth:_____

Signature: _____ Date:_____

Eastwind Women's Health

Eastwind Women's Health Financial Policy

Welcome to Eastwind Women's Health. In order for our medical staff to able able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary to continue to provide high- quality care and make your visit as pleasant as possible.

Please read ALL information and acknowledge by signing below:

1. If you have a change of address, name, telephone number or insurance, please notify the receptionist.
2. We ask that you present a copy of your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
3. We will collect your co-payment at the time of your visit. If you have a balance after an insurance payment from a previous visit, we will also ask for that payment. We accept checks, cash and all major credit cards.
4. If we do not participate within network of your insurance company, you will be expected to make payment in full at the time the service is rendered.
5. If your insurance denies our charges, does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to a collection agency and report your account to the credit bureau.
6. HMO-PPO: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of the visit. If insurance requires a referral from your PCP. It is your responsibility to obtain it day of the visit.
7. SELF-PAY: Patients with no insurance will be expected to pay in full at the time of the visit.
8. Your insurance is a contract between you, your employer, and the insurance company. It's very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company only pays a portion of the bill or rejects your claim, any contract or explanation should be made to you, their policy holder. Reduction of rejection of your claim by your insurance does not relieve you of your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for your payment of the charges. If you have any questions regarding our financial policy, please contact our billing department at 614-890-1914, ext 3.

I have read and have a full understanding of the financial policy of Eastwind Women's Health.

Print Name_____ Date of Birth: _____

Signature: _____ Date: _____