



Thank you for trusting us with your health care!

It is important to find a clinic that is both compassionate and professional while still maintaining a relaxing environment. Our philosophy is “**Tenderness with Technology**” and we strive to deliver individualized care with state-of-the-art equipment. If this is your first time with us, welcome and thank you for choosing us! If you are an established patient, thank you for your continued loyalty!

We are staffed by eleven providers: six Board Certified Obstetricians/Gynecologists, one Certified Nurse Midwife, three Certified Family Nurse Practitioners, & one Certified Women’s Health Nurse Practitioner. While each of our providers strives to be available to their patients as needed, please be aware there may be times when you will need to see or be delivered by one of our other providers. All of our exam rooms are equipped with a state-of-the-art ultrasound machine to ensure the highest quality of care.

We encourage you to follow our social media sites below and to look at our website, www.colwc.com, for additional clinic and health information. We recommend looking through the Stages of Development section under the Obstetrics link.

Due to the nature of our practice, there can be daily situations that require schedule changes and/or a delay in your appointment time. Because our providers can be called out for a delivery at a moment’s notice, please be prepared for a wait.

***In order to ensure accurate records, we require paperwork to be updated frequently for all of our patients. If you have completed these forms in the past, we ask that you please complete them again simply to ensure we have your health history correct. Therefore, please fill out the enclosed forms (**both front & back of each page**) in either blue or black ink and bring them to your appointment along with the following:**

- Your insurance card(s)
- A picture ID
- Your insurance copay
- A list of all of your current medications including the name, strength, and dosage of each. Please ensure the spelling of your medications.

This will help with the registration and check-in process. Please arrive at least 15 minutes early for your appointment.

Your appointment is on _____ at _____ am/pm with _____.



Jed Naisbitt MD | David Bierer MD | Julia Johansson MD | Jeffery Brown DO
Brett Larson MD | Azadeh Poursaid, MD, PhD | Karen McBride CNM
Jessica Hess FNP | Shannon Brennan FNP | Sierra Mayzsak FNP | Kaitlin Ellison, WHNP



Patient Information			
Name (Last, First Middle)		SSN #	Birthdate
Mailing Address		City, State, Zip	
Primary Phone & Type (ex. Cell)		Secondary Phone & Type (ex. Work)	Primary Care Provider
Marital Status	Smoker Yes / No	Race	Email Address
Employer		Emergency Contact (person not living with you)	
Occupation		Name	
Address		Relationship	
		Address (City/State Only)	
Work Phone		Phone Number	
Spouse (for patients who are married) or Guarantor Information (for patients under 18)			
Name (Last, First Middle)		SSN #	Birthdate
Mailing Address		City, State, Zip	
Primary Phone & Type (ex. Cell)		Secondary Phone & Type (ex. Work)	Race
Employer		Email Address	
Occupation			
Relationship to Patient			
Primary Insurance			
Name of Insurance Company		Policy #	
Name of Policy Holder		Group #	
Policy Holder Date of Birth			
Claim Address of Insurance Company		Copoly Amount	
City, State, Zip		Phone	
Relationship to Patient		Effective Date	
Secondary Insurance (if applicable)			
Name of Insurance Company		Policy #	
Name of Policy Holder		Group #	
Policy Holder Date of Birth			
Address of Insurance Company		Copoly Amount	
City, State, Zip		Phone	
Relationship to Patient		Effective Date	

{ } I have current insurance but I choose not to have my insurance billed or use my insurance benefits at this time. I understand that due to certain filing time constraints and pre-authorization requirements, I will be responsible for payment in full for the services rendered. I further release my provider of any obligations under my healthcare plan.

Patient's Initials (only if this option applies):

I agree that all of the information above is accurate and current. I realize my information may be shared with outside entities to assist with treatment, research, and/or collection of payment. I have read & agree to fully comply with the clinic's Financial Agreement.

My signature indicates I fully understand and agree to the above terms. I further grant authorization for treatment for all evaluations & procedures performed and allow the release of information as indicated above.

Signature

Date

Prenatal History

Please complete all sections below and bring this form to your first prenatal appointment.

Please complete both the front & back of each page

***Before being taken to our Registration area, this document will need to be completed in its entirety.**

PATIENT INFORMATION

Hospital for delivery: McKay Dee Hospital Ogden Regional Medical Center

Pediatrician: _____

Mother of Baby:

Name: _____ Age: _____ Race: _____

Primary Language: _____ Religion: _____

Occupation: _____

Father of Baby:

Name: _____ Age: _____ Race: _____

Primary Language: _____ Religion: _____

Occupation: _____

PREGNANCY HISTORY

Total Pregnancies: _____ Full Term: _____ Premature: _____ Abortions: _____

Miscarriages: _____ Ectopics: _____ Multiple Births: _____ Living: _____

	Birth Year	Place of Birth	Sex	Birth Weight	Gestational Age (in weeks)	Delivery Type: Vaginal C-Section VBAC	Anesthesia Type: Epidural Cervical Block None Other	Length of Labor (in hours)
1								
2								
3								
4								
5								
6								
7								
8								

If you had any complications and/or would like to list any additional comments, please list which pregnancy & explain details below:

Is this pregnancy a surrogacy agreement? Yes No

MEDICAL RISK FACTORS

Do you have a personal history of:

	<u>Yes</u>	<u>No</u>	Details/Comments
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes (if yes, Type 1 or Type 2)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Venous Thromb/Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disease/Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prior Abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>	_____

GENETIC RISK FACTORS

	<u>Yes</u>	<u>No</u>	Details/Comments
Drug, med, radiation exposure in 1 st trimester	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family history of birth defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous fetus/infant with birth defect	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a personal or family history of:			
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Disease/Trait	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Huntington Chorea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spina Bifida/Anencephaly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hydroencephaly	<input type="checkbox"/>	<input type="checkbox"/>	_____

ALLERGIES

Please list all of your current allergies:

MEDICATIONS

Please list all of your current medications (prescribed & over the counter). Many medications have similar spelling so please confirm the list below with your actual medication bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name <i>(check spelling on bottle)</i>	Dosage <i>(strength)</i>	Frequency <i>(how often you take)</i>	Route of Administration <i>(ex. oral, injectable, etc.)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREFERRED PHARMACY

Which pharmacy do you prefer we use for any prescriptions/medications we may prescribe?

Name: _____

Address: _____

SUPPLEMENTS

Please list all of your current supplements. Many supplements have similar spelling so please confirm the list below with your actual supplement bottles to ensure we update your records accurately. If you need additional space, please attach a separate sheet.

Name <i>(check spelling on bottle)</i>	Dosage <i>(strength)</i>	Frequency <i>(how often you take)</i>	Route of Administration <i>(ex. oral, injectable, etc.)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OBSTETRIC RISK FACTORS

	<u>Yes</u>	<u>No</u>	Details/Comments
Previous stillbirth/neonatal death	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous infant admitted to NICU	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous infant with IUGR	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abruption in prior pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Placenta previa in prior pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous cesarean section	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous infant > 9 pounds	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of fetal distress in labor	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of preeclampsia	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of poly/oligohydramnios	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of recurrent UTI	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antibody sensitization	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple gestation	<input type="checkbox"/>	<input type="checkbox"/>	_____

RISK FACTORS FOR PRETERM BIRTH

Do you have a personal history of:

	<u>Yes</u>	<u>No</u>	Details/Comments
Age < 18 or > 35	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight < 121 pounds (or < 55 kg)	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of STD's	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous uterine surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Known uterine malformation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prior preterm birth (37 weeks or less)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Incompetent cervix	<input type="checkbox"/>	<input type="checkbox"/>	_____
DES exposure	<input type="checkbox"/>	<input type="checkbox"/>	_____
2 or more miscarriages requiring D&C	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug abuse (including alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychosocial/Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____



Prenatal Testing

In trying to keep all our patients up to date with standard recommendations in pregnancy & changes in technology, Circle of Life Women's Center would like you to understand the following:

During your prenatal care, multiple tests will be performed. We are providing this summarized document to help familiarize you with both the routine & optional testing as well as when to expect such tests.

***BEFORE your first prenatal appointment, we ask that you review the following information (both the front & back side of this document) and BRING this completed form with you to your first appointment. If you have additional questions, please ask your provider at your first prenatal appointment before completing & submitting this form.**

Required Testing

Prenatal Panel Blood Work (drawn at first prenatal appointment):

CBC, Blood Type, RH, HIV, Hepatitis B and C, Antibody Screen, RPR, TSH, Rubella

Urine Culture (collected at first prenatal appointment)

Chlamydia/Gonorrhea (collected at first prenatal appointment)

1 Hour Glucose Screening (26 - 28 weeks gestation)

3 Hour Glucose Screening (only done if 1 Hour Glucose Screening is failed)

Group B Strep Culture (35 - 37 weeks gestation)

PIH panel (if needed for Pregnancy Induced Hypertension)

Pap Smear (if needed)

*For detailed information on the above routine testing, please visit: www.acog.org & search routine tests during pregnancy.

Approximate Cost: If billed to insurance up to \$1,200.00 & Self-Pay up to \$800.00

Optional Testing (Fetal and Maternal Genetic Testing)

*Please select one or more tests if you would like them to be performed OR select the opt-out box and bring this form to your next appointment.

The following tests screen for **fetal genetic chromosomal abnormalities**. These test for Trisomy 21, Trisomy 18, & Open Neural Tube Defects (ex. Spina Bifida).

- Labcorp: A-Fetoprotein (AFP) Tetra Profile (15 - 20 weeks gestation). CPT Code = 82105. www.labcorp.com/tests. Approximate Cost: If billed to insurance up to \$200.00 & Self-Pay up to \$160.00.
- Natera Panorama: Non-Invasive Prenatal Testing (>= 10 weeks gestation). CPT Code = 81420. www.natera.com. Approximate Cost: If billed to insurance up to \$2,500.00 & Self-Pay up to \$249.00.
- Natera Panorama Extended Panel: Non-Invasive Prenatal Testing plus 5 additional microdeletions (>= 10 weeks gestation). CPT Code = 81422. www.natera.com. Approximate Cost: If billed to insurance up to \$2,500.00 & Self-Pay up to \$349.00. (**not available for twins or egg donors*)

***Natera Panorama: Non-Invasive Prenatal Testing is recommended for Advanced Maternal Age (35 yrs. or older at time of delivery) and/or history of genetic abnormalities.**



The following test is a **maternal screening for carrier genes of inherited diseases – specifically Cystic Fibrosis, Spinal Muscular Atrophy (SMA), & Fragile X**. This test can be done any time prior to conception and/or at any time during pregnancy.

- Natera: Carrier Screen. CPT Codes: (Cystic Fibrosis = 81220), (SMA = 81401), (Fragile X = 81243), & (BRCA1 & BRCA2 = 81162). www.natera.com. Approximate Cost: If billed to insurance up to \$2,500.00 & Self-Pay up to \$249.00.

I will review the different testing offered with my provider and have my questions answered before services are rendered. I recognize that while these tests are useful in determining possible abnormalities, they are not intended to detect all birth defects and detectable birth defects can be and are missed. The optional tests are screenings only and I understand that these optional tests cannot detect all abnormalities that can occur in pregnancy. I also realize that a positive result is not a 100% guarantee of an abnormality related to my unborn baby. In the instance of a positive result, additional measures will be taken to ensure proper care of myself and my unborn baby.

- I voluntarily am opting out of all optional testing.

I realize that I could be responsible for more lab bills than what it costs for my pregnancy when considering all the new lab options that are available. All blood work, cultures, and pathology are billed through outside labs. I am aware that my information will be shared with outside entities to assist with treatment, care, and/or collection of payment. I realize that even though these are the companies that Circle of Life Women's Center uses, they may not be in-network with my insurance company. I understand that these charges are separate from Circle of Life Women's Center and are not included in clinic prices. I agree that prices quoted to me are an estimate only and may not reflect the amount that I am responsible for. I understand that it is my responsibility to check benefits with my insurance company (applicable CPT Codes for each test are listed above) and that I am responsible for any balances left to me by my insurance company. Please contact the lab companies above directly for additional billing and/or insurance benefit questions. Circle of Life Women's Center's providers and office staff cannot guarantee insurance coverage on any type of service and therefore it is strongly recommended that insurance benefits are verified by the patient before services are rendered. This is the reason we are providing this document before your first prenatal appointment.

My signature indicates I fully understand and agree to the above terms. I authorize payment of my insurance benefits directly to the laboratory facility used for services and understand that all billing matters will be handled with the servicing company. I am aware that if any problems occur with the billing of these services, I will need to contact the outside companies directly as Circle of Life Women's Center is not affiliated with these companies.

Print Patient Name

Patient Signature

Today's Date

Maternity Care Benefits

The process of coordinating benefits between you, your insurance company, and your doctor's office can be confusing. Maternity charges are typically billed out as "Global". This "Global" charge includes the doctor's portion of your prenatal visits and your delivery. Lab work, tests, ultrasounds, and procedures are charged out separately. We suggest you contact your insurance company as soon as possible to inquire about your maternity benefits. To help you feel prepared before calling them, we have provided a list of suggested questions below. If you do not have insurance, or if your insurance company will leave you owing some portion of the charges, please contact our billing department immediately to make payment arrangements. You will be asked to divide your financial responsibility throughout the course of your pregnancy care so please plan accordingly.

All payments and billing questions should be directed to:

1525 E. 6000 S. Suite A

South Ogden, UT 84405

Phone: (801) 337-5800

Payments can also be made on our website: www.colwc.com

- Do I need my doctor's office to contact you for a maternity authorization?
*If so, please contact our billing department immediately.
- Where should I go to have any LAB work done (LabCorp, McKay-Dee, or Ogden Regional)?
***We typically use LabCorp – if your insurance requires a different lab, please inform your doctor/midwife.**
- At which hospital should I deliver (McKay-Dee or Ogden Regional)?
- What is my deductible? How does this work if I am pregnant this year but won't deliver until next year?
- After I meet my deductible, how much will I be responsible for?
- My doctor's office generally charges a minimum of two ultrasounds but depending upon my course of treatment, more ultrasounds may be needed. What is my coverage for ultrasounds?
- What are my contraceptive benefits after I deliver?

****PLEASE REMEMBER: IF YOU CHANGE INSURANCE COVERAGE DURING YOUR PREGNANCY IT IS VERY IMPORTANT THAT YOU NOTIFY US IMMEDIATELY.****

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