Circle of Life
Women's Center

1525 E. 6000 S. Suite A
South Ogden, UT 84405
Phone: (801) 337-5800
Fax: (801) 337-5809
www.colwc.com

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!

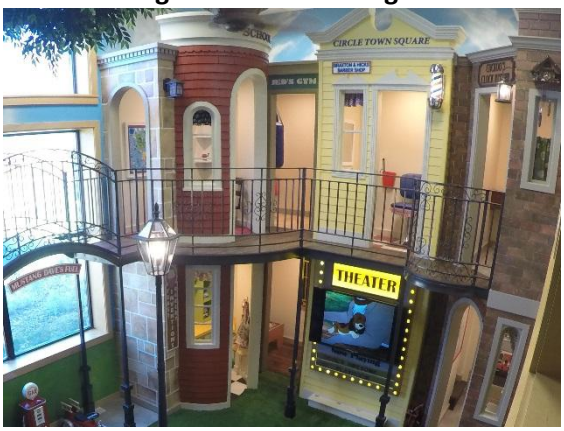
We are staffed by ten providers: five Board Certified Obstetricians/Gynecologists, one Certified Nurse Midwife, three Certified Family Nurse Practitioners, & one Certified Women's Health Nurse Practitioner. While each of our providers strives to be available to their patients as needed, please be aware 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 | Karen McBride CNM | Shannon Brennan FNP
Sierra Mayzsak FNP | Kaitlin Ellison WHNP | Laura Blackett FNP

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Patient Information			
Name (Last, First Middle)	SSN #	Birthdate	Sex
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 Occupation	Emergency Contact (person not living with you) 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	Sex
Mailing Address	City, State, Zip		
Primary Phone & Type (ex. Cell)	Secondary Phone & Type (ex. Work)	Race	
Employer Occupation	Email Address		
Relationship to Patient			

Primary Insurance	
Name of Insurance Company	Policy #
Name of Policy Holder Policy Holder Date of Birth	Group #
Claim Address of Insurance Company	Copay Amount
City, State, Zip	Phone
Relationship to Patient	Effective Date

Secondary Insurance (if applicable)	
Name of Insurance Company	Policy #
Name of Policy Holder Policy Holder Date of Birth	Group #
Address of Insurance Company	Copay 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**

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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:

_____

_____

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Is this pregnancy a surrogacy agreement? Yes No

MEDICAL RISK FACTORS

Do you have a personal history of:

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

GENETIC RISK FACTORS

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

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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 *(check spelling on bottle)*	**Dosage** *(strength)*	**Frequency** *(how often you take)*	**Route of Administration** *(ex. oral, injectable, etc.)*

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 *(check spelling on bottle)*	**Dosage** *(strength)*	**Frequency** *(how often you take)*	**Route of Administration** *(ex. oral, injectable, etc.)*

Please complete both the front & back sides of each page

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OBSTETRIC RISK FACTORS

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

RISK FACTORS FOR PRETERM BIRTH

Do you have a personal history of:

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

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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.**

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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*

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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
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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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