



CHRISTINE EDWARDS, MD FACOG  
LAURA WALSH LAFFINEUSE MD FACOG  
Tracy Gordon FNP-BC

## WELCOME TO FLORIDA PERINATAL CENTER, LLC.

**We welcome you to our practice and look forward to providing you with the best possible care. Your physician has referred you for either routine obstetrical screening/consultation or for high risk perinatal services. We work in conjunction with your obstetrician who remains your primary medical provider. We provide ultrasound and consultation services, we do not offer delivery services. Florida Perinatal Center (FPC) is a separate entity from your physician's practice.**

**The information below will help to make the process smoother. If you are a new patient, please arrive 20 mins before your appointment to complete the paperwork if not previously completed (forms can be downloaded from our website [www.myfpcbaby.com](http://www.myfpcbaby.com))**

**If you are more than 15 mins late for your appointment, you may be asked to reschedule, in order to prevent long waits for our other patients.**

**We offer many different services, patients may be called out of order, depending on the type of the service they are scheduled for.**

**Please bring the following items for your visit:**

- **Completed new patient forms**
- **Current insurance card**
- **Photo ID**

**Please ensure we have your referral/authorization if your insurance requires one. Insurance- copay, coinsurance and/or other payment responsibilities are expected at the time of service.**

1. If you have insurance and you have a copay, payment is expected at the time of your visit (this is a contractual agreement with your insurance company and can only be modified by them).

2. Please make cancellations at least 24 hours before your scheduled appointment-this ensures that other patients who may need an appointment can get access.

3. Please advise the office BEFORE your next appointment if you change insurance companies, or we may have to reschedule you (some insurance companies require preauthorization prior to your visit).



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4. If your insurance requires an authorization, it is your responsibility to ensure it is in our office before your appointment.
  
5. Advise the office immediately of any change in address, or telephone number.
  
6. Should you change your obstetrician, please advise the front desk and sign the “Notice of Change of OB” form provided.
  
7. This office does work by appointments, however, due to the nature of our practice, we sometimes experience delays. Please be patient as we give every patient the same careful attention.
  
8. Prescription refills and insurance questions may only be addressed during regular office hours.
  
9. The doctors do not discuss financial matters. If you need special arrangements to be made, please speak with our Billing Coordinator or Office Manager.
  
10. Children under 6 years old are not allowed without an accompanying adult (in addition to the patient).

*We look forward to making your experience with us a pleasant one!*



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## ULTRASOUND CONSENT

Your physician has requested an ultrasound (sonogram), to evaluate your baby. There are presently no known risks to the fetus from ultrasound. However, we cannot predict any future developments in this area, thus we will only perform medically indicated studies.

### LIMITATIONS

Ultrasound technology has advanced significantly, and we are able to see more detailed structure. However, it is very important to understand that a fetus that appears to be “normal” on an ultrasound, may in fact have birth defects. These may include, but is not limited to mental retardation, or other abnormalities that cannot be detected by current technology.

The ability to diagnose many birth defects, particularly those involving the brain, spine, face, heart and extremities, is also limited by the gestational age at examination, the fetal position, the amount of amniotic fluid present, and the mother’s body type and composition. Additionally, some birth defects may not be apparent at early gestational ages, and may only become sonographically identifiable as the pregnancy progresses. This is especially true for brain, heart and gastrointestinal defects. Chromosomal abnormalities such as Down syndrome cannot be diagnosed or ruled out using ultrasound alone. Procedures such as CVS (chorionic villus sampling), done in the first trimester or amniocentesis (performed in the 2nd trimester), will more reliably make this diagnosis.

Ultrasound also does not guarantee the gender of your baby. The sex of your baby can only be confirmed after birth. A normal ultrasound does not guarantee a healthy baby and does not rule out some birth defects.

The ability to complete the ultrasound and see the anatomy that is necessary to complete the scan can also be limited by the fetal position, gestational age and maternal body habitus. It may become important to return to complete the rest of the anatomy scan.

This information is not meant to cause concern, it simply makes you aware of the limitations of ultrasound. If the sonogram appears to be normal, the baby will most likely not have a significant birth defect.

If you have any questions about the performance of the sonogram, please ask. We will be happy answer your questions. Please be advised that the sonographers are not able to discuss medical to issues or concerns.

We will be happy to provide ultrasound pictures of your baby. Per our practice policy, NO taking pictures or videotaping is allowed.

## PELVIC EXAMINATION CONSENT

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider’s gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I authorize the employed and/or contracted medical personnel of Florida Perinatal Center as deemed necessary by my treating physician to perform a pelvic examination, including vaginal sonography, as described above.

### ACKNOWLEDGEMENT

I have read the above information and I understand the limitations of ultrasound to diagnose birth defects and other abnormalities of my baby. I have had all my questions answered and agree to have the ultrasound and accept its limitations.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFO

With my consent, Florida Perinatal Center, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Florida Perinatal Center LLC, for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Florida Perinatal Center, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Florida Perinatal Center.

With my consent, Florida Perinatal Center, LLC may call my home or other designated location and leave a message on voice mail/answering machine or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Florida Perinatal Center, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential.

With my consent Florida Perinatal Center, LLC may email me (there is some risk that any protected health information contained in such email may be disclosed to, or intercepted by, unauthorized third parties), any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items and any item pertaining to my clinical care, including laboratory results among others.

With my consent Florida Perinatal Center, LLC may text me in reference to any items that assist the practice in carrying out TPO, such as appointment reminders.

I have the right to request that Florida Perinatal Center, LLC restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Florida Perinatal Center, LLC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent Florida Perinatal Center, LLC may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Print Name of Patient/Legal Guardian

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_



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## NEW PATIENT'S INFORMATION SHEET

Please print clearly. Please complete ALL information so that your claim can be processed quickly and efficiently. Thank you!

### Patient information:

Full Name: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_  
Last First

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Marital Status (circle): S M W D

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone # H: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_ Employer: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext: \_\_\_\_\_ Work Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Job Title: \_\_\_\_\_

Student (circle): Full time/Part time School Name: \_\_\_\_\_

### Responsible Party/Spouse Information:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_

Work Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Primary Insurance Information:

Do you have Medicare Insurance?: Y N

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Certificate, Policy or ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Relationship to Patient: Self Spouse Child / Other: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M F



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## NEW PATIENT'S INFORMATION SHEET

Please note Medicaid will not cover your claims if you have another active insurance. Patients are expected to pay their Specialist Office Copay at each visit. If your yearly deductible has not been met, you are expected to pay the fees that are due at each visit. If applicable, you will also receive a statement for co-insurances, balance on deductible and any unpaid procedures performed in the office, which amount will be due on receipt of statement.

If you need special arrangements to be made or have any questions regarding this, please speak to the Office Manager or Billing Co-ordinator.

We are Maternal Fetal Medicine Specialists and are not part of the Global Package. We bill and are reimbursed separately from your OB/GYN office.

Patient balances which exceed 60 days, are sent to our Collections Agency.

**I HEREBY ASSIGN, TRANSFER, AND SET OVER TO FLORIDA PERINATAL CENTER, LLC. ALL OF MY RIGHTS, TITLE, AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS. UNDER MY INSURANCE POLICY. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO DETERMINE THESE BENEFITS. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL WRITTEN NOTICE IS GIVEN BY ME REVOKING SAID AUTHORIZATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE.**

Patient's Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_



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## CO-INSURANCE AND DEDUCTIBLE RESPONSIBILITY

Date of Service: \_\_\_\_\_ Account # \_\_\_\_\_

Regarding: Co-Insurance, CoPay and Deductible Responsibility

I \_\_\_\_\_ am aware that I am responsible for any CoPay, Co-Insurance and Deductible due as determined by my insurance policy. (This information is obtained from my insurance company \_\_\_\_\_ when our office calls to verify eligibility and benefits). Payments are expected at the time of service.

Please note that once we submit the insurance claim to your insurance carrier for charges and they apply that amount towards your deductible, the amount applied will be your responsibility. If you have Medicaid as a secondary insurance, your deductible and/or Co-Insurance will not be covered by Medicaid.

Deductible \$ \_\_\_\_\_ Co-Insurance \$ \_\_\_\_\_, CoPay \$ \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

***Deductible: the amount you are contracted to pay for your healthcare before your insurance company will cover any cost. (eg: a \$1000 deductible means you must pay \$1000 to your provider before your insurance carrier will pay any charges).***

***Co-Insurance: the percent of the charges you are expected to pay (eg: 20% coinsurance means that your insurance will pay 80% of your bill and you are responsible for the remaining 20%).***

***CoPay: an amount determined by your insurance to be paid to the provider, often this varies depending on whether or not it is your primary care provider, a subspecialist, if you have an office visit , or for certain procedures.***

***Prior to your office visit we contact your insurance company to determine if any of the above applies.***



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### MEDICAL INFORMATION RELEASE

I, \_\_\_\_\_ agree to the doctors discussing my information/giving results of tests to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CONSENT FOR EMAIL COMMUNICATION

Email messaging allows Florida Perinatal Center's health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email messaging is not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage during transmission.

If you would like to exchange email messages that contain your health information, please complete and sign this Consent below. You are not required to authorize the use of email messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of your email, we will continue to use telephone, fax or US mail to communicate with you.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_