

Hello!

Thank you for choosing Women's Care Group for your pregnancy care. This letter is to share some information with you that will help you prepare for your initial obstetric visit to our office.

Patient Information Sheets:

Please take a few moments to fill out the enclosed information sheets in **black ink only and bring them, completed**, to our office the day of your appointment.

What to expect on your first visit:

Plan on being in our office for approximately two (2) hours. During this time, we will complete necessary paperwork, take a careful history, perform a complete physical exam, initiate various types of lab work, and perhaps do an ultrasound exam, if indicated.

Enclosed Information:

Enclosed are several information sheets, which may be useful to you. They outline many medications you can take while pregnant, a number of foods to avoid, and a sample menu that, if followed, may help reduce nausea.

Office Information:

Our office hours are Monday – Friday 8:00 AM to 5:00 PM and we are closed weekends and holidays. Our practice is affiliated with UT Medical Center and Baptist West Hospital.

Information to bring on your first visit:

Please bring your current insurance card, a detailed list of current medications, and this notice. These three items will expedite your office encounter.

Blood Transfusion:

In case of emergency if you are not willing to accept a blood transfusion please call our office before your appointment.

We would appreciate a 24-hour notice of cancellation if you find you are unable to come for your appointment. To cancel, please call (865) 546-1642.

WOMEN'S CARE GROUP

LISTENING TO YOU. CARING FOR YOU. CLOSE TO YOU.

Hello!

Thank you for choosing Women's Care Group for your prenatal care. In an effort to speed up the inevitable paper work, and better expedite your office encounter, please complete the enclosed information sheets and bring them with you when you come in for your first OB visit along with your current insurance card and the appointment reminder.

Please note this insurance-related requirement about your OB care.

If your insurance company is a managed care plan, we may be restricted from taking care of your colds, sore throats, or any other illness that is not specifically related to your pregnancy.

If you have any health concerns **not** related to your pregnancy, your insurance **might** require that you either see your primary care, family practice, or internal medicine physician; or get your physician to approve his/her referral to your obstetrician at Women's Care Group.

We apologize for any inconvenience that this may have imposed by your insurance payer. Thank you for understanding, and we look forward to seeing and caring for you.

If you have any questions, please do not hesitate to contact the office at (865) 546-1642.

Thank you.



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PATIENT AUTHORIZATION

Patient Name: _____

Account #: _____

Date: _____

Regardless of your insurance coverage, you as the patient are always responsible for the payment of your charges. Unless you have Medicare, or an HMO, or a PPO membership office charges are to be paid by cash, check or credit card at the time of service. Counselors are available to discuss large dollar charges and payment schedules.

Authorization & Assignment:

I authorize WCG to release any information acquired by my physician/or staff to my insurance carrier(s). I authorize payments directly to my physician. I recognize and accept responsibility for any balance or fees not covered by insurance and agree to pay the balance in a prompt manner. In any event this account is referred to an outside agency, credit reporting bureau or attorney for collection, I agree to pay all attorney fees, collection costs, court costs and/or any other expenses incurred in its collection, according to the 1989 statues of the State of Tennessee.

Signature: _____

WOMEN'S CARE GROUP

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Women's Care Group Knoxville / Maryville CONFIDENTIAL NEW PATIENT REGISTRATION

*Copies of your insurance cards must be presented and will be copied and verified
A copy of your driver's license is required*

PATIENT INFORMATION

Name: _____ Social Security#: _____

Address: _____ Race: _____

_____ Home Phone #: _____

City, State, Zip _____ Cell Phone#: _____

Referring MD: _____ Date of Birth: _____

Primary Care MD: _____ Age: _____

Marital Status [] Married [] Single [] Widowed

PATIENT EMPLOYMENT

Employer Name: _____ Phone: _____

SPOUSE'S INFORMATION

Name: _____ Social Security#: _____

Employer Name: _____ Date of Birth: _____

EMERGENCY CONTACT(S)

Name: _____ Phone#: _____

Name: _____ Phone#: _____

How did you hear about us? _____ Family _____ Friend _____ Church _____ Word of Mouth

_____ Yellow Pages Ad _____ MD Referral _____ Other

Would you like information regarding a living will or Power of Attorney? _____ Yes _____ No

Signature: _____ Date: _____

WOMEN'S CARE GROUP

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What is Cystic Fibrosis?

- Cystic Fibrosis (CF) causes the body to produce a large amount of thick mucus.
- If CF is in the lungs, the mucus leads to congestion and pneumonia.
- If present in the intestines, CF leads to diarrhea and poor growth.
- CF does not affect intelligence.
- Most people with CF have severe medical problems. Others are mildly affected and may be unaware that they have CF.
- In the past, people with CF died very young, but scientists are making progress in improving treatment and are searching for a cure. Now, many people with CF are living in their 20s and 30s.

Is there a chance that my baby could have Cystic Fibrosis?

- Both parents must be carriers in order to have a child with CF.
- You can be a carrier of CF even if there is no history in your family.
- Your chances of having a child with CF or being a CF carrier are dependent on your ethnic background.

Ethnic Background	Carrier Risk	General Risk of Child with CF
Caucasian	1 in 25	1 in 2,500
Hispanic	1 in 45	1 in 8,000
African-American	1 in 60	1 in 15,000
Asian-American	1 in 90	1 in 32,000

- If both parents are carriers, there is a 1/4 (25%) chance of having a child with CF.
- A family history of CF increases your risks beyond those mentioned above.

What testing is available?

- There is a blood test that can determine if you or your partner is a carrier.
- If both parents are carriers, their unborn child can be tested for CF.
- It is important to understand that CF carrier testing does not detect all carriers of CF.

How much does the test cost?

- Some insurance companies cover CF testing while others do not. It is your responsibility to contact your insurance company regarding coverage.
- If not covered by insurance, the cost is between \$300-500.

_____ **Yes, I would like to be tested for CF.** I understand the above information

_____ **No, I do not want more information about CF.** I understand the above information.

_____ I have already been tested for CF and my results are _____.

_____ I have several questions about CF and would like to talk with a genetic counselor at my next appointment.

Patient Name: _____ Signature: _____ Date: _____

Reviewed by: _____ Med Rec #: _____ Date: _____



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OBSTETRICAL CARE BILLING AND DEPOSITS

Women's Care Group will do all insurance filing for you during your pregnancy. We will resubmit any denied claims that are necessary. We will file any type of testing such as lab work or ultrasounds at the time of service. Your global delivery charge will be filed when you deliver.

The global delivery charge consists of antepartum care during your pregnancy. This includes monthly visits up to 28 weeks gestation; biweekly visits to 36 weeks gestation and weekly visits until delivery. The physician's delivery service is included in the global charge. Postpartum care until 45 days after delivery is also included in the global charge.

All other services will be an additional charge. These additional services would include such items as lab work, ultrasounds, amniocentesis, non-stress tests, fetal biophysical profiles, etc. Any office visits outside of the routine antepartum care listed above will be an additional charge. You may also receive statements from other sources such as Associated Pathologists or University Pathology. Any specimen sent out of our office for testing is an additional charge and is billed through that providers billing office.

You will receive statements during your pregnancy if you have a balance in the patient responsibility portion of your account. This would happen after we receive an explanation of benefits from your insurance company showing you are responsible for a portion of the billed service.

We do require an obstetrical deposit based on your insurance benefits. This deposit will cover any amounts that your insurance company deems to be your responsibility. This may include any deductible that is not met when services are filed to your insurance, copays/coinsurance amounts or non covered items under your insurance plan.

If you have any questions regarding your billing please feel free to contact our Financial Services Department at 865-544-6708.



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HIV CONSENT FORM

It is our policy and good medical practice that all obstetric patients have a routine screening for HIV (the virus associated with AIDS) on their initial obstetric visit. Should you have any questions concerning this, please discuss it with the provider you see today.

No attempt is being made to single out any individual patient, as all obstetrical patients who enter our practice will be screened. Results of this screen will be used in subsequent counseling concerning risk to you and your baby. The screening helps us provide better care for you and your baby.

According to the American College of Obstetrics and Gynecology, providing excellent medical care for a pregnant woman includes a HIV test. If HIV positive, steps can be taken to reduce the chance of a baby getting the virus. Through the use of medication, the risk for a baby would be lowered from about 3 in 12 to about 1 in 12.

All test results are kept confidential and, except in the event of an appropriate court order, will not be released without a patient's written consent.

I have read and understood the above information. I have had a chance to have my questions answered.

Print

Name: _____ **Signature:** _____ **Date:** _____

Please initial the appropriate response

_____ **I hereby give my consent to have the HIV test.**

_____ **I hereby refuse to allow the routine screen for HIV to be performed.**

Reviewed

by: _____ **Date:** _____

Medical Record # _____