PROVIDENCE
Medical Group
OB-Gyn Health Center

PMG OB-GYN HEALTH CENTER

940 Royal Avenue, Ste 350
Medford, OR 97504
541.732.7460
541.732.7461

Care Team Green
Phone Option 2
Maria Cordeiro, MD
Jennifer Hall, MD
Andrew Galffy, MD
Nancy Seulean, CNM
Betty Kay Taylor, CNM

Care Team Blue
Phone Option 3
Shannon Fife, DO
Jon Freeman, MD
Donna Niemela, CNM
Nancy Seulean, CNM
Betty Kay Taylor, CNM

Congratulations on your pregnancy and thank you for choosing the Providence Medical Group / OBGYN Health Center for your medical care. We look forward to working with you to ensure a safe, healthy outcome for you and your baby.

We have enclosed forms asking for information about you and your family.
This will help us to provide you with the best prenatal care.
We want you to be able to spend as much time with your provider as possible, so please take a few moments to fill out the forms and bring them with you to your first appointment.

We provide complete prenatal care using a team approach. You will see your physician for many of your visits. Other times, one of the other physicians or a Certified Nurse Midwife will see you. You may also be seen at the Asante Maternal Fetal Medicine Clinic for ultrasounds.

As our valued patient, we want to be sure you understand how our group's Hospital "call" coverage is arranged to give you complete medical coverage for your pregnancy and delivery. We feel truly privileged to have the opportunity to be with you during the delivery of your baby. The chance to share in this special experience is one of the best aspects of our work. Since each of us cannot be available at all times, we rotate call responsibility to provide a dedicated physician or Certified Nurse Midwife to the obstetric service each day and night. This allows us to provide consistent coverage to our laboring patients, avoid canceling scheduled appointments in the office, and allow appropriate rest for physicians between call responsibilities.

The obstetricians at PMG OB/Gyn Health Center rotate call equally. At times, we participate in the care of patients with other obstetricians in the Rogue Valley. We feel this collaborative call sharing approach is beneficial to you in ensuring that we are able to give high quality medical care no matter when you need it. It is important for you to establish care with a primary care provider for non-OB related illnesses. Please see enclosed PMG brochure.

We encourage members of your family and friends to be involved in your pregnancy. Please bring another adult to help supervise young children to your first 2 visits and to scheduled ultrasound appointments. We thank you for choosing our practice, and look forward to sharing in this exciting event in your life.

Your Dating Ultrasound and education appointment is with

_____ on _____at _____am/pm *(Disc available for $5 cash only)*

Your New OB Patient appointment is with

_____ on _____at _____am/pm

Your First Meet appointment with your OB provider is with

_____ on _____at _____am/pm

General Information

You will be provided with a detailed packet of pregnancy information at your first office visit.

Prenatal Vitamins: If you are not already taking prenatal vitamins, please start now. You will need folic acid, 0.8mg daily. We recommend over the counter vitamins. We also recommend DHA supplements (omega fatty acid), 200 mg daily. Do not take fish oil.
Calcium: Your daily calcium intake should be 1500mg, either by diet or supplements. Do not take calcium supplements and prenatal vitamins at the same time of day.
Medications and supplements: Medications and supplements should be avoided in pregnancy, especially during the first 12 weeks. We will provide a list of safe medications and supplements at your first visit.
Diet: We recommend a healthy, balanced diet. Most pregnant women need only an additional 300 calories a day.
Avoid: Alcohol, smoking and drug use.
Eliminate caffeine: Consume no more than one cup of coffee or 12 oz of soda daily.

Exercise: Exercise is very beneficial for pregnant women. Remember you should be able to carry on a conversation while exercising, avoid overheating and stay well hydrated.
Do not use hot tubs or saunas while you are pregnant.
Interior painting, hair coloring, perms and manicures are fine with proper ventilation.
Toxoplasmosis: Toxoplasmosis is an infection carried in cat feces, raw meat and unpasteurized milk. Because there is a risk of exposure to toxoplasmosis from cat litter, we recommend that you not clean the litter box. If your cat is strictly an indoor cat, you are probably not at risk. We also recommend you not consume raw meat or unpasteurized milk.

Please feel free to call us with questions. 541-732-7460

For answers to many of your questions, may we suggest a visit to our website: www.providence.org/pregnancy
Other websites that you may find helpful: www.webmd.com www.storknet.com www.pregnancyguideonline.com

Your First Prenatal Visits:

Dating Ultrasound appointment

We ask that you arrive at this appointment with all the enclosed forms filled out. You may purchase a disc of your ultrasound showing photos of your new baby for $5.00 cash when you check in for your appointment.

If you bring children to an ultrasound appointment, please bring an adult to supervise them during your visit.

The baby's heartbeat is visible on ultrasound 7 weeks from the first day of your last menstrual period. The dating ultrasound appointment can be scheduled anytime after the end of week six. At this appointment, an ultrasound will be done to confirm your pregnancy and determine your due date. Lab work will be drawn; please review the list of labs included. You will receive a packet of important pregnancy-related information. Your provider will review previous pregnancies, surgeries, medical conditions and exposure to contagious diseases. She will record medications or supplements you have taken or are currently taking. Let your provider know about unusual activities, work conditions or stress you are experiencing.

New OB Patient appointment

Soon after your dating ultrasound appointment, you will have your "New OB" appointment. This 45-minute visit is usually scheduled with one of our Certified Nurse Midwives. During this visit she will determine your general health, find out your health history, explore the medical history of your family members, determine if you have any pregnancy risk factors. Your provider will perform a physical including breast and pelvic exam.
Your height, weight and blood pressure will be checked.
During the pelvic exam, a Pap smear is done to screen for cervical cancer.

Cultures will be taken to detect sexually transmitted diseases.
An internal exam will be performed to determine the size of your uterus and pelvis.
Your provider may listen for the baby's heartbeat with a Doppler.

Nuchal Translucency Ultrasound Appointment

Nuchal Translucency ultrasound performed during weeks 11-14 at our OBGYN Health Center or at Maternal Fetal medicine.

OB Lab Tests

Complete Blood Count (CBC): This test screens for blood problems such as anemia.

HIV test: This test is routinely ordered; please let us know if you want to decline the HIV test.

RPR: This test screens for syphilis (a sexually transmitted disease) that can be transmitted to your unborn child. If left untreated, it can cause a dangerous condition called congenital syphilis in the baby that leads to bone and tooth deformity, nerve damage, or brain damage.

Rubella: This test screens for immunity (protection) against German measles. Most Americans received vaccinations against rubella as children and are immune. If you aren't immune, you will need to avoid people with the disease (which is rare in the U.S.) as it can have serious consequences for your developing baby.

Hep B and Hep C: These tests screen for hepatitis, a viral infection that affects the liver. It is transmitted through contaminated needles, or blood, or through saliva, semen, or vaginal fluid. Infected mothers can transmit this disease to their baby during childbirth. You could have this disease and not know it.

Urinalysis: During this test you will urinate in a cup and the urine will be tested for kidney disease or bladder infections and high levels of sugar that might indicate diabetes. Bladder infections are very common in pregnant women and are easily treated. If left untreated, bladder infections can quickly progress to kidney infections, which can cause problems for the baby or premature labor.

UDS: Urine Drug Screen

Type and screen blood test: This test determines your blood type and Rh factor. Everyone is either Rh negative or Rh positive (85% of us are Rh positive). If your blood is Rh negative and your partner's blood is Rh positive, your baby's Rh factor may not match yours. This can be a problem for future pregnancies.
If your blood type is Rh-, you will be given an injection of Rhogam during the 28th week of your pregnancy. You will also receive this injection if you have any significant bleeding during your pregnancy. Additionally, an injection of Rhogam is given after delivery if your baby has Rh+ blood.

Genetic Tests: Depending on your ethnic background and medical history, you may also be tested for **sickle-cell anemia, Tay-Sachs disease, and thalassemia**. Blacks, Jews, French Canadians, and people of Mediterranean descent are most at risk for these illnesses. All of these diseases can be passed onto the baby because of defective genes that the parents may carry (even if they don't have the disease.)

Cystic fibrosis is an inherited disease that can affect breathing and digestion in your baby if you and your partner are carriers.

First Trimester Screening is a series of tests to see if you are at increased risk of having a baby with a chromosome anomaly such as Down Syndrome, Trisomy 13, or Trisomy 18. The following information is to help you decide if that testing is something you would like to do.

What are Down Syndrome, Trisomy 13, and Trisomy 18?
These are all genetic disorders where babies are born with too many chromosomes, which cause mental retardation and birth defects. Babies with Down Syndrome have an extra chromosome 21, which results in mental retardation and problems in the formation of the heart and digestive tract. Many babies with Down Syndrome are able to live an almost normal life, although they need extra help with learning and may have health problems. Babies with Trisomy 13 and 18 have very severe birth defects and almost never survive more than 2 years of life, and many of them die before they are born.

Who can have a baby with these conditions?
Anyone can have a baby with these conditions, but the chances increase as the mother gets older. Women over age 35 at the time their baby is due may be offered different testing because of this increasing risk.

What can this testing tell me?
The test can only tell you if you have an increased *risk* of having a baby with one of these conditions. Additional testing is required to confirm the diagnosis.

Why should I have a test to find out if I am at risk of having a baby with these conditions?
The testing is optional. Some people would want to know if they might have a baby with these conditions so they can be prepared for the extra work that is required to care for these children. Other people may choose not to continue a pregnancy affected with one of these conditions. Some people may decide not to have the testing because they would not change anything about how they would handle their pregnancy.

How is the testing performed?
The testing is done between 11 and 14 weeks of gestation. There are two parts to the test, an ultrasound to look at the fluid collection in back of the baby's neck (nuchal translucency or NT) and a blood collection from the mother. Together, the results of these tests give a number that describes your risk.

What happens if my test is positive?
If the test is positive, it means there is an increased risk for Down Syndrome, Trisomy 13, or Trisomy 18. You will have the choice to have another test done to confirm the diagnosis. The testing involves taking a sample of fluid from around the baby, or a sample of the placenta, which allows a way to count the chromosomes directly.

If my test is negative, will my baby definitely be normal?
The test is specific for the three conditions listed. As with any test, there is a chance that the result is a "false negative", or that the results are wrong. This chance is very small, but not zero. There are also lots of other problems that can occur during a pregnancy. Another ultrasound will be done around 20 weeks to check on how the baby is developing.

What if I am too far along to have First Trimester Screening?
There is a blood test that can be done in the second trimester, called a Quad Screen that can give a similar evaluation of risk. This can be done up to 22 weeks of gestation. Please let us know if you would like to do this test instead. It is not recommended that you do both first and second trimester screening, unless it is part of the same test (called "Sequential Screening").

Will my insurance company pay for this test?
Most insurance companies do cover First Trimester Screening. Our office will obtain authorization for the ultrasound visit. If you have concerns, you should contact your insurance company directly and ask if they cover the test. If they do not, you may be eligible for a discount on the cost of the test if it is something you would still like to do.

OB Patient History

Patient Name: _____ **Date:** _____ **Primary Care Provider**: _____

Date of Birth:_____

Phone: Home:_____ **Work:**_____ **Cell:**_____

Marital Status: _____**Partner:**_____ **Ethnicity/Race:** _____**Religion:** _____**Occupation**:_____

Father of Baby: _____ **Father of Baby Contact Number:** _____

Prescriptions, over the counter, medications, supplements, and vitamins: _____

_____

Allergies: _____

_____

Medical History: Have you ever been **diagnosed with or treated for** problems related to:

Abnormal pap	☐Yes ☐No	Kidney disease	☐Yes ☐No
Anemia	☐Yes ☐No	Liver disease	☐Yes ☐No
Anesthetic complications	☐Yes ☐No	Lupus	☐Yes ☐No
Asthma	☐Yes ☐No	Mental disorder	☐Yes ☐No
Blood dyscrasia (disorder)	☐Yes ☐No	Post partum depression	☐Yes ☐No
Breast problems	☐Yes ☐No	Rh incompatibility	☐Yes ☐No
Diabetes mellitus	☐Yes ☐No	Seizures	☐Yes ☐No
Herpes	☐Yes ☐No	Sickle cell anemia	☐Yes ☐No
HIV/AIDS	☐Yes ☐No	Thyroid disease	☐Yes ☐No
Hypertension	☐Yes ☐No	Trauma/violence	☐Yes ☐No
Infertility	☐Yes ☐No	Varicosities/phlebitis (blood clots)	☐Yes ☐No
Other: _____	☐Yes ☐No		

Please explain:

_____

Surgical /Hospitalization History: **(Please explain)** ☐**Yes** ☐**No**

Description including dates: _____

Family History: (Include your Grandparents, parents, siblings and children). Please include your family member's age at onset of illness and Maternal (M) or Paternal (P) relationship.

Breast cancer	☐**Yes** ☐**No** _____	Hypertension	☐**Yes** ☐**No** _____
Cancer	☐**Yes** ☐**No** _____	Ovarian Cancer	☐**Yes** ☐**No** _____
Colon Cancer	☐**Yes** ☐**No** _____	Preterm Labor	☐**Yes** ☐**No** _____
Diabetes	☐**Yes** ☐**No** _____	Spontaneous abortions (miscarriages)	☐**Yes** ☐**No** _____
Eclampsia	☐**Yes** ☐**No** _____	Other:	_____

Patient Name: _____ Date of Birth: _____

Social History:

Do you drink alcohol? ☐Yes ☐No
If Yes: ____ glasses of wine, ____ beers ____shots of hard liquor___ drinks with .5 oz alcohol
Are you currently using drugs? ☐Yes ☐No Please share the types you are currently using: _____
Are you currently a smoker? ☐Yes ☐No Smokeless tobacco? ☐Yes ☐No
If YES: _____ packs a day. **Ready to quit?** ☐Yes ☐No
If NO: Were you ever a smoker? ☐Yes ☐No Year you quit? **_____.**

Social Risk:

1. Do you feel you are at risk for HIV? You may be at risk if you engage in or have a history of high risk sexual practices, or a history of or currently use IV drugs. ☐Yes ☐No
2. Do you feel you are at risk for Hep C (Hepatitis C)? You may be at risk if you engage in or have a history of high risk sexual practices, a history of drug use/IV drug use, exposure to household members with Hep C, obtain frequent body piercings and/ or tattoos, are a dialysis patient, or have had a blood transfusion prior to 1990. ☐Yes ☐No
3. Do you feel safe in your current relationship? ☐Yes ☐No
4. Have you ever been hit, slapped, physically hurt or threatened by your current partner? ☐Yes ☐No
5. Are you concerned that anyone in your life is misusing your money or property? ☐Yes ☐No

Obstetrical History: LMP: _____ Was this period normal: ☐Yes ☐No Explain _____.

Total Pregnancies: _____ Full Term (37-40 weeks): _____ Premature (less than 37 weeks):_____

Miscarriages: _____ Abortions: _____ Ectopic: _____ Multiples: _____ Living:_____

(List All Pregnancies)	First	Second	Third	Fourth	Fifth
Date					
Weeks Pregnant					
Vaginal or c-section					
Length (hours)of Labor					
Weight					
Sex/Name of baby					
Anesthesia					
Preterm labor					
Living?					
Location of Delivery					

(If more than five pregnancies please complete on a separate sheet)

Infection History: Do you…

Live with someone with TB (Tuberculosis) or have you been exposed to TB? ☐**Yes** ☐**No** _____
Have a partner with a history of Genital Herpes? ☐**Yes** ☐**No** _____
Have a rash or viral illness since your last menstrual period? ☐**Yes** ☐**No** _____
Have Hepatitis B or C? ☐**Yes** ☐**No** _____
Have a history of STDs, Gonorrhea, Chlamydia, HPV, HIV, or Syphilis? ☐**Yes** ☐**No** _____
Other: _____

Patient Name: _____ Date of Birth: _____

Genetic Screening/Teratology Counseling: Please circle, and explain.

Do you, does the baby's father, or does <u>anyone</u> in <u>either family</u> have a history of:

1. Patient's age 35 yrs or older at Estimated Date of Delivery? ☐Yes ☐No

2. Thalassemia (Italian, Greek, Mediterranean, or Asian Background) ☐Yes ☐No

3. Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly?) ☐Yes ☐No

4. Congenital heart defect ☐Yes ☐No

5. Down Syndrome ☐Yes ☐No

6. Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian) ☐Yes ☐No

7. Canavan Disease (Ashkenazi Jewish) ☐Yes ☐No

8. Familial Dysautonomia (Ashkenazi Jewish)

9. Sickle Cell Disease or Trait (African) ☐Yes ☐No

10. Hemophilia or other blood disorders

11. Muscular Dystrophy ☐Yes ☐No

12. Cystic Fibrosis ☐Yes ☐No

13. Huntington's chorea ☐Yes ☐No

14. Mental Retardation ☐Yes ☐No

If yes, was person tested for Fragile X? ☐Yes ☐No

15. Other inherited Genetic or Chromosomal disorder ☐Yes ☐No

16. Maternal Metabolic Disorder (EG, Type 1 diabetes, PKU) ☐Yes ☐No ☐Yes ☐No

17. Patient or baby's father with birth defects not listed above ☐Yes ☐No ☐Yes ☐No

18. Recurrent pregnancy loss ☐Yes ☐No

19. Medications (including supplements, vitamins, herbs, or OTC drugs)/illicit/recreational drugs/ alcohol since Last Menstrual Period (If yes please list agents, strength, dose**)** ☐Yes ☐No

Mood Disorder Screening: Please rate your feelings in the past two weeks,

Feeling nervous, anxious, or on edge:
☐ Never ☐ Sometimes ☐Usually ☐Always

Not able to stop worrying:
☐ Never ☐ Sometimes ☐Usually ☐Always

Feeling down, depressed, or hopeless?
☐ Never ☐ Sometimes ☐Usually ☐Always

Little interest or pleasure in doing things?
☐ Never ☐ Sometimes ☐Usually ☐Always

Risk factors for suicide: Please check and share with us:

☐Past suicide attempt ☐Mental Health or Substance Use Disorder diagnosis ☐Agitation ☐Suicidal Ideation ☐Deteriorating physical health ☐ Feelings of hopelessness, overwhelmed, can't go on ☐Pain ☐Deliberate harm of self, intending to cause pain or self injury, but not death ☐Anxiety

Thoughts of Harming Yourself? Please select:

☐No ☐Yes, recently, but not now ☐Yes, currently

- *Thank you for taking the time to share how you are feeling.*

Patient Name: _____ Date of Birth: _____

Review of systems: Are you **currently** experiencing problems with:

General Well Being: ☐Activity change ☐Appetite change☐ Fever/Chills ☐Fatigue ☐ Weight changes

Endocrine: ☐ Heat/Cold Intolerance ☐Thirst ☐ Hair Loss/Growth ☐Hot flashes ☐ Excessive sweating

HENT: ☐Facial swelling ☐Neck pain/stiffness ☐Ear discharge/pain, hearing loss/tinnitus ☐ Nose bleeds ☐Vision Loss, Discharge or Pain ☐ Nose bleeds/Runny Nose/Congestion/ Post nasal drip, Sneezing ☐Sinus Pressure ☐Dental Problems ☐Drooling ☐Sore mouth or throat ☐Trouble swallowing ☐Voice changes

Eyes: ☐Discharge ☐Itching ☐Pain ☐Redness ☐ Light sensitivity ☐Visual disturbances

Respiratory: ☐Apnea ☐Chest tightness ☐Choking ☐Cough ☐Shortness of Breath ☐Wheeze

Cardiovascular: ☐Chest Pain ☐Swelling of Lower Legs ☐Irregular Heartbeat (palpitations)

Gastrointestinal: ☐ Abdominal Bloating ☐Anal bleeding ☐Blood in stool ☐Constipation ☐Diarrhea ☐Nausea ☐Rectal Pain ☐Vomiting ☐Reflux

Genitourinary: ☐Urinary Problems: Painful, frequent, sense of urgency, difficulty urinating, blood in urine ☐Urinary Incontinence ☐Flank pain ☐Genital sore ☐Pain or Bleeding with Intercourse ☐Vaginal Discharge, Odor, Itching or pain ☐Abnormal Vaginal Bleeding or Spotting ☐Breast Lumps, Pain or Discharge ☐Concerns about sexual life or functioning

Musculoskeletal: ☐Back Pain ☐Joint Pain/swelling ☐Arthritis ☐Difficulty walking

Skin: ☐Color changes ☐Rash ☐Itching ☐Dryness ☐New Moles ☐Sores

Neurological: ☐Dizziness/Vertigo ☐Facial asymmetry ☐Headaches ☐ Numbness ☐Seizures ☐Speech Difficulty ☐Fainting ☐Tremors ☐Weakness

Hematology/Lymphatic: ☐Severe Bruising ☐Easy Bruising ☐Enlarged Lymph Glands

Psychiatric: ☐Agitation/nervous/ anxious ☐Behavior problems ☐Confusion ☐Decrease concentration ☐Mood changes ☐Hallucinations ☐Hyperactive ☐Self injury ☐Insomnia ☐Suicidal ideations

Allergic/Immunological: ☐Seasonal Allergies ☐Persistent Infections

Other _____

Would you like an escort present during your exam? ☐Yes ☐No

Please bring these completed forms with you to your appointment.

OBGYN Health Center - 940 Royal Ave - Suite 350 - Medford OR - 97504-6193 Tele (541) 732-7460

OB/GYN Health Center
940 Royal Avenue, Suite 350
Medford, OR 97504
Tele: 541.732.7460
Fax: 541.732.7461

This letter will outline how your OB services will be billed.

The doctor's fee for your OB care will be billed as a "global" service upon delivery.
This fee includes:

- **13 Routine OB office visits**
- **Normal vaginal delivery**
- **A six-week postpartum checkup**

The 2014 global fee for this service is $ 6888.00 If your delivery is anticipated the following calendar year, please note that there will be an annual increase that has not yet been determined. Also, should a Cesarean Delivery be necessary, the fee would be adjusted.

You may need more services or care during your pregnancy. These services may include:

- Laboratory work
- Diagnostic tests (including ultrasounds and fetal non-stress test)
- Additional office visits
- Hospital services

These particular services are not part of the global service and will be billed as a separate charge. Please note, our ultrasounds are read by Maternal Fetal Medicine. They are affiliated with Asante' so you may receive a bill from Asante'.

If you have insurance, we will confirm your eligibility and OB benefits with your insurance carrier. Based on the information they provide, an "anticipated patient balance" will be calculated for you. Please see attached sample OB Payment Plan.

The "anticipated patient balance" is to be paid 1 month before your delivery date. **The Payment Plan Agreement outlines the global fee for OB care, your quoted insurance benefits, and the amount you are expected to pay.** You are expected to pay any additional fees that are not covered by your insurance plan. **You will be asked to meet with someone in the OB-Gyn Business Office before your NOB appointment, or before one of your subsequent visits shortly thereafter to discuss and sign an OB Payment Plan.** You will be given an opportunity to ask questions at this time. Even if you will not have an anticipated balance for the Global Fee, you will be asked to sign a statement affirming that the billing process has been explained to you, and that you understand it.

After you have signed the agreement, if you need to discuss your payment arrangements, or if you have any questions, please speak to an OB Representative at Providence Physicians Business Office; toll free: 1-800-433-9001, between 8 a.m. and 3:30 p.m., Monday through Friday.

Should your insurance coverage change during the course of your OB care, please let us know immediately as this may affect your payment plan.

We look forward to providing you with excellent service.

The PMG OB-Gyn Business Office

SAMPLE ONLY

Providence Physicians Business Office
Attn: OB Department
1235 NE 47th Ste 129, Portland, OR 97213-0994
Phone: (503) 215-6494 or (800) 433-9001

OB PAYMENT PLAN AGREEMENT

Patient Name:_____ **Account #** _____

- *Anticipated* Patient Charge (Vag. Delivery) $ 6888.00 <cont. Adj. - > = $_____
  (*Global Service fee for current calendar year)
- Anticipated _____Insurance Reimbursement…….._____%……..$_____

  Deductible $_____ Out of Pocket $_____ (info only, not calculated in anticipated patient balance)

- Co-pay Per Pregnancy/Office Visit ……..$_____

- *Anticipated* Patient Balance ……$_____
  (Based on today's current "Global" fee, insurance contract, (if applicable), and your carrier's quoted current plan benefits)

Payment(s) of $_____due on the____of each month for_____month(s), with first payment due ____/_____/_____

I understand that any "non-routine" or unrelated OB Office Visits, and/or Labs, Diagnostic tests, (including, but not limited to, ultrasounds and fetal non-stress test), and hospital services are separate from the OB Global Service Fee. Should a Cesarean delivery be necessary, charges will be adjusted. I also understand the the "*anticipated*" insurance reimbursement and the "*anticipated*" patient balance noted above are based on the current calendar year fee and the quotes provided by my insurance carrier (s), (if applicable). Should I deliver the following calendar year, the new, increased fee will apply. I further understand if there is a change to my insurance carrier the "Global" fee may be subject to "prorated" fees (separate antepartum and delivery) as appropriate, and that my payment plan agreement may need to be updated.
Patient initials_____ Date ____/____/_____

The total *anticipated* patient balance noted above should be paid prior to your anticipated delivery date of ____/____/____. I agree to the terms of this payment plan for the *anticipated* patient balance. Any balance remaining after any insurance payment would remain due and payable. I understand that in order to keep my account in good standing, the payments listed above must be received by Providence Physician's Business Office on or before the dates indicated.

*Global Service Fee=*Routine* Prenatal Office Visits, Normal *Vaginal* delivery and *Routine* Post Partum follow-up care.

Signed:_____ Date:_____
Patient/Guarantor

Signed:_____ Date:_____
Clinic Business Office Representative

Signed:_____ Date:_____
Clinic Business Office Supervisor

PROVIDENCE
Medical Group
OB-Gyn Health Center

Clinic Family and Friends Authorization Form

Patient Name: _____ Date of Birth: _____

As a patient of Providence Health & Services, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved I your health care. This information can be changed or revoked with your permission at any time.

I give permission for information related to my current health status to be discussed with:

Name	Relationship	Telephone

I understand that this might include such information as: diagnosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance and any other medical information relevant to my care.

Signature: _____ today's Date _____

☐ **I Decline to have my medical information discussed with family or friends.**