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Obstetrics and Gynecology clintonwomenshealthcare.com

11051 Hall Road, Suite 110 Utica, Michigan 48317 Phone: 586-726-6556 Fax: 586-726-4917

Clinton Women's Healthcare, P.C. <u>Obstetrical Care Policy</u>

6483 Citation Drive, Suite A Clarkston, Michigan 48346 Phone: 248-922-0856 Fax: 248-922-9368

Thank you for selecting Clinton Women's Healthcare for your obstetrical needs. We look forward to partnering with you and providing the highest quality of care you deserve. Your clear understanding of this policy is an essential element of your care and treatment.

Clinton Women's Healthcare, P.C. will submit your bill directly to your insurance carrier. We will do all that we can to process insurance claims, but please remember that your coverage is a contract between you and your insurance company. Any balance that your insurance company does not pay, or is considered a non-covered service, is due from you or your responsible party. Many insurance companies require a deductible to be satisfied each year by the patient or responsible party before insurance benefits begin. We will verify insurance coverage before your visit. During the verification process we may find that your deductible has not been satisfied, in which case we will have to collect a reasonable amount before each office visit. Please contact your insurance company if you have any questions about your coverage.

If at any time there is a change in your insurance coverage or should you lose coverage entirely, please know: it is your responsibility to inform us immediately.

We do not participate with any state-funded insurance plans.

Global Fees

A "Global" fee includes all **routine** prenatal office visits, the delivery of your baby, and your postpartum visit.

59400

Prenatal Care and Vaginal Delivery

59510

Prenatal Care and Cesarean Section

Miscellaneous Fees

58611

Tubal Ligation w/ Cesarean Section*

54150

Circumcision*

Additional care may be needed for the well-being of you and your baby. This may result in charges which are not part of the "Global" fee. Any such charge(s) will be submitted to your insurance carrier at the time of service, not at the time of delivery. The following are some examples:

- Ultrasound
- Fetal Non-Stress test
- Amniocentesis
- Consults with other physicians such as Maternal Fetal Medicine Specialists
- Venipuncture for prenatal blood tests

It may be necessary for you to be seen for a problem that is unrelated to your OB care or even be admitted to the hospital prior to your delivery. There is always a charge for all unrelated office visits and hospital visits, such as a copayment or deductible.

| *Not covered by some insurance carriers | Patient Signature: |
|---|--------------------|
| | Date: |



William Beaumont Hospital Royal Oak Reproductive Genetics Program 3535 W. Thirteen Mile Road Suite #329 Royal Oak, Michigan 48073 (248) 551-0395

REPRODUCTIVE GENETIC HISTORY QUESTIONNAIRE

| | | | NAME |
|-------|--------|--|--|
| MEDIC | AL HIS | TORY | |
| YES | NO | DO YOU | COMMENTS |
| | | 1. Have diabetes? | The state of the s |
| | | 2. Have seizures or epilepsy? | |
| | | 3. Have kidney disease? | |
| | | 4. Or your husband/partner have a history of cancer treatment? | |
| | | 5. Have any skin disorders including moles, acne, light or dark patches of skin? | |
| | | Have rheumatoid arthritis or systemic lupus erythematosus (SLE)? | |
| | | Have a history of being on a special diet as a baby or small child? (You may need to ask your parents about this.) | |
| | | 8. Know the results of routine prenatal blood test for rubella (German measles) susceptibility and if yes, check below: | |
| | | ☐ Immune ☐ Susceptible (not immune) | |
| | | 9. Have any other medical condition not mentioned | ? |
| | | FAMILY HISTORY | (|
| YES | NO | | COMMENTS |
| | | 10. Are you 34 years old or older? | |
| | | 11. Is your husband/partner 55 years old or older? | |
| | | 12. Are you and your husband/partner blood relatives (e.g. cousins)? | |
| | | 13. Are you or your husband/partner of ☐ Jewish, ☐ Black, ☐ Mediterranean descent? | |
| | | 14. Have you had a stillbirth or miscarriage? | |
| | | do you or your husband/partner | |
| | | 15. Have any birth defects, handicapping condition, or disorder that might be hereditary? | |
| | | 16. Have any previous children with birth defects, handicaps, or genetic disease? | |
| | | 17. Have any children who died (other than in an accident)? | |
| | | 18. Have any relatives who have had a stillborn infant or multiple miscarriages? | |
| | | 19. Have a brother, sister or parent with a handicap, birth defects, or genetic disease? | |
| | | 20. Have uncles, cousins, nieces, nephews, grandparents, or grandchildren with birth defects or genetic disease? | |
| | | 21. Know of any family member with mental retardation (even mild) or learning disabilities? | |

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SOME EXAMPLES OF BIRTH DEFECTS AND GENETIC DISEASES THAT MIGHT BE IN YOUR FAMILY (Please check any of the following that might be in your family)

☐ Malformations or birth defects ☐ Anencephaly (open skull) ☐ Mental illness ☐ Blindness or eye problem ☐ Mental retardation ☐ Bone disorder ☐ Muscular dystrophy ☐ Cerebral palsy ☐ Chromosome abnormality ☐ Neurologic or degenerative disorder ☐ Cleft lip/palate ☐ Neurofibromatosis ☐ Cystic fibrosis ☐ Short stature (under 5 ft.) ☐ Sickle cell anemia Deafness ☐ Down syndrome (mongolism) ☐ Skeletal problems (like easily broken bones or ☐ Epilepsy or seizures curvature of the spine) ☐ Heart defect ☐ Skin disease (including dark or light patches ☐ Hemophilia (bleeding tendency) of skin) ☐ Hydrocephalus (water on the brain) ☐ Spina bifida (open spine) ☐ Tay-Sachs disease ☐ Kidney disease ☐ Limb defects ☐ Urinary tract abnormality ☐ Other MEDICATION/DRUG EXPOSURES YES NO 22. Do you take any prescription drugs or over-the-counter medications? If you are pregnant, have you taken any medications since your last period? Examples: Please check those you have taken during this pregnancy. ☐ Accutane or other dermatologic or acne ☐ Diet pills medications ☐ Female hormones ☐ Male hormones Anticoagulants (blood thinners to prevent ☐ Medications for epilepsy (seizures) blood clots) ☐ Multi-vitamins ☐ Antithyroid drugs ☐ Steroids ☐ Birth control pills ☐ Tranquilizers ☐ Chemotherapeutic drugs (anti-cancer drugs) ☐ Vitamin A supplements ☐ Other high dose vitamins Other___ 23. Have you had any illness or infection recently or do you have any chronic disease not covered on the YES NO other side? 24. Have you had frequent or high fevers or do you take saunas or hot whirlpool baths? П 25. Have you recently had x-rays or surgery or are you planning to do so soon? 26. Are you exposed to anesthetic gases, lead, other heavy metals or radiation in your occupation? 27. Have you been exposed to pesticides or potentially toxic chemicals at home or elsewhere? П 28. Do you drink more than one glass of alcohol per week (including beer)? 29. Do you have a household cat or clean a cat litter box? 30. Do you eat raw or very rare meat? 31. Do you smoke? How many packs of cigarettes per day? ____ \Box 32. Do you use any other drugs or medications not previously listed? 33. Do you have any other questions or concerns regarding your ability to have a healthy baby?