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Clinton Women's Healthcare, PC

Obstetrics and Gynecology
clintonwomenshealthcare.com

Obstetrical Care Policy

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 billing directly to your insurance carrier. We will do all that we can to process insurance claims, but please remember that your coverage is 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: _____

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

48801 Romeo Plank, Suite 103A
Macomb, Michigan 48044
Phone: 586-726-6556
Fax: 586-726-4917

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

Corewell Medical Staff Members

Beaumont

Reproductive Genetics Program/Fetal Imaging
3601 West 13 Mile Road, South Tower
Royal Oak, MI 48073
248-551-0395

REPRODUCTIVE GENETIC HISTORY QUESTIONNAIRE

NAME _____

MEDICAL HISTORY

YES	NO	DO YOU . . .	COMMENTS
☐	☐	1. Have diabetes?	
☐	☐	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?	
☐	☐	6. Have rheumatoid arthritis or systemic lupus erythematosus (SLE)?	
☐	☐	7. 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 impairment (even mild) or learning disabilities?	

(continued on other side)

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)

- ☐ Anencephaly (open skull)
- ☐ Blindness or eye problem
- ☐ Bone disorder
- ☐ Cerebral palsy
- ☐ Chromosome abnormality
- ☐ Cleft lip/palate
- ☐ Cystic fibrosis
- ☐ Deafness
- ☐ Down syndrome (mongolism)
- ☐ Epilepsy or seizures
- ☐ Heart defect
- ☐ Hemophilia (bleeding tendency)
- ☐ Hydrocephalus (water on the brain)
- ☐ Kidney disease
- ☐ Limb defects
- ☐ Malformations or birth defects
- ☐ Mental illness
- ☐ Mental impairment
- ☐ Muscular dystrophy
- ☐ Neurologic or degenerative disorder
- ☐ Neurofibromatosis
- ☐ Short stature (under 5 ft.)
- ☐ Sickle cell anemia
- ☐ Skeletal problems (like easily broken bones or curvature of the spine)
- ☐ Skin disease (including dark or light patches of skin)
- ☐ Spina bifida (open spine)
- ☐ Tay-Sachs disease
- ☐ 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 medications
- ☐ Antibiotics
- ☐ Anticoagulants (blood thinners to prevent blood clots)
- ☐ Antithyroid drugs
- ☐ Birth control pills
- ☐ Chemotherapeutic drugs (anti-cancer drugs)
- ☐ Medical Marijuana
- ☐ Diet pills
- ☐ Female hormones
- ☐ Male hormones
- ☐ Medications for epilepsy (seizures)
- ☐ Multi-vitamins
- ☐ Steroids
- ☐ Tranquilizers
- ☐ Vitamin A supplements
- ☐ Other high dose vitamins

☐ Other_____

YES NO

☐ ☐ 23. Have you had any illness or infection recently or do you have any chronic disease not covered on the other side?

☐ ☐ 24. Have you had frequent or high fevers or do you take saunas or hot whirlpool baths?

☐ ☐ 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?

☐ ☐ 28. Do you drink more than one glass of alcohol per week (including beer)?

☐ ☐ Have you consumed alcohol during your pregnancy? When & how much?_____.

☐ ☐ 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? _____

☐ ☐ Have you smoked during your pregnancy? How many packs of cigarettes per day?_____.

☐ ☐ 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?