THE MIDWIFE GROUP
Women's Health & Birth Center

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ MARITAL STATUS_____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE: HOME _____ CELL _____ WORK _____
EMAIL ADDRESS (for patient portal access): _____
EMPLOYER _____ OCCUPATION _____
RACE:

o White	o Asian	o Other
o Black/African American	o Hispanic or Latino (no race info available)	o Decline to Report
o American Indian or Alaskan Native	o Native Hawaiian or Pacific Islander	

ETHNICITY:

o No, not Spanish/Hispanic/Latino	o Decline to Answer	o Unknown
o Yes/Cuban o Yes/Puerto Rican	o Yes, Mexican, American, Chicano	o Yes, Other Hispanic o (Specify)_____

PREFERRED LANGUAGE:

o English	o Spanish	o Japanese	o Chinese	o Italian	o Hindi
o Portuguese	o Russian	o French	o Guatemalan	o Tagalog	o Arabic
o Bosnian	o Vietnamese	o Laotian	o German	o Gujarati	

INSURANCE INFORMATION

please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section
NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER_____PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY_____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____
_____

SECONDARY INSURANCE INFORMATION (if applicable)

please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section
NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER_____PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY_____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____
_____

1692 CHATHAM PARKWAY
SAVANNAH, GA 31405
WWW.THEMIDWIFEGROUP.COM
PH: 912-629-6262
FAX: 912-226-3268

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PATIENT NAME (please print)_____ DATE OF BIRTH _____

SPOUSE/SIGNIFICANT OTHER

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ MARITAL STAUS_____ SOCIAL SECURITY NUMBER _____
PHONE: HOME _____ CELL _____ WORK _____
EMPLOYER _____ OCCUPATION _____

PARENT/GUARDIAN (if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE_____ RELATIONSHIP TO PATIENT _____

ALTERNATIVE CONTACT (other than spouse/significant other – if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE_____ RELATIONSHIP TO PATIENT _____

PREFERRED PHARMACY

NAME_____ LOCATION _____

PREFERRED LAB

We send all lab work to LabCorp. Your insurance provider may require the use of a different lab. Please select:

○ LabCorp	○ Other (specify):_____

LIVING WILL

Do you have a living will?

○ Yes	○ No	○ I'd like information about establishing a living will

PATIENT SIGNATURE _____**DATE**_____

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PRIVACY NOTICE

This privacy notice describes how your medical information may be disclosed and used by this practice. This notice also discusses your rights to access your medical information.
The HIPAA Privacy Rule allows your health information to be disclosed to carry out treatment, payment, and other healthcare operations. We are required to abide by the information outlined in this privacy notice. We reserve the right to update this policy as changes occur in the HIPAA Privacy Rule. HIPAA grants you the right to access and control your health information.

USES AND DISCLOSURES

Treatment: Your health information will be disclosed to provide, coordinate, and manage your healthcare. All of the providers in our practice may have access to your medical records. Additionally, our medical consultants and ultrasonographer review some records to assist us with your care. Your health information may be disclosed to any other physician or healthcare provider that may become involved in your care.
Healthcare Operations: Your health information will be used to support the business activities of the practice. Examples include, but are not limited to: quality assessment, employee reviews, nursing and midwifery student training, licensing, and other business activities. Health information may be shared in our group prenatal sessions.
Payment: Your health information will be used to obtain payment for services provided by this practice. Disclosures may be given to health plans, insurance providers, and collection agencies.
Business Associates: Your health information may be shared with third party business associates. Examples include billing and legal services. We have established written contracts that contain the terms that will protect your health information with all third party business associates. All business associates must comply with HIPAA guidelines.
Disclosures Requires by Law and Workers Compensation: We are permitted to disclose your health information to comply with workers compensation laws and legal proceedings. If required, you will be notified of disclosure. The protected health information of members of the armed forces may be disclosed to authorized federal officials, under certain circumstances.
Abuse or Neglect: We may disclose your protected health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.
Emergencies: If you are incapacitated, we may use our best judgement to disclose information that is only directly relevant to your care.
Research and Health Oversight: We are permitted to disclose your information to researchers with an institutional review board has reviewed a research proposal and established protocols to ensure your health information will be kept confidential. We are permitted to disclose your health information to a health oversight agency for activities authorized by law. Examples include: audits, investigations, and inspections.
Written Authorization: Unless not required by law, your written authorization will be required for all disclosures of your protected health information. You can revoke authorization at any time via written request. It is important to note that we are unable to undo any disclosures previously made with your authorization.
Voicemail: Employees may only leave detailed voicemail messages if the greeting appropriately identifies the patient or another person who is authorized to receive information regarding the patient. If there is not appropriate identification, only the minimum necessary information will be left. This includes the caller's name, practice name, and a contact number. Patients have the right to opt out of voicemail messages.

PATIENT RIGHTS

You have the right to inspect and copy your protected health information. You may obtain your medical record that contains medical and billing information. As permitted by federal or state law, we may charge you a reasonable copy fee to provide a copy of your records. You may request an amendment of your protected health information. We reserve the right to deny your request. If we deny your request for amendment, you have the right to file a statement of disagreement. We may provide you with a copy of any rebuttal. Federal law prohibits you from inspecting or copying psychotherapy notes and information compiled in reasonable anticipation of, or use of, civil or criminal proceedings, or administrative actions or proceedings.

PRIVACY COMPLAINTS/ CLIENT GRIEVANCES

Should you believe that your privacy rights have been violated, and wish to file a complaint, you may contact us by calling our office at (912)629-6262 and asking to speak with our privacy officer. . The director or her designee will personally respond within 10 business days to any complaint registered by a client about any aspect of Family Health and Birth Center. You may also contact our accrediting organization, The Commission for the Accreditation of Birth Centers at 240 Independence Drive, Hamburg, PA 19526, phone number 1-877-241-0262. Unresolved complaints may be directed to the Georgia Department of Community Health, Health Facilities Regulation Division, Attention: Complaints, 2 Peachtree Street NW, Atlanta, GA 30303-3142, phone: 1-800-878-6442.

THE MIDWIFE GROUP
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OUR FINANCIAL POLICY / RELEASE AND ASSIGNMENT

Full payment is due at the time of service. We accept cash, checks, and credit cards. Our practice is committed to providing the best treatment for our clients, and our charges are reasonable and customary for our area.

I am responsible for payment regardless of the insurance company's arbitrary determination of reasonable and customary rates or decisions regarding non-covered services. I agree to pay collection fees associated with any outstanding balance on my account.

I hereby authorize The Midwife Group and Birth Center/Family Health and Birth Center, Inc. to release any of my medical records deemed necessary to process my insurance claim. I authorize payment of medical benefits to The Midwife Group/Family Health and Birth Center Inc., or its providers for services rendered to me. I fully understand that I am responsible for all charges incurred as a result of services rendered to me and any balance remaining after my insurance pays. I, the undersigned, a patient at this facility, hereby authorize the providers (and whomever they may designate as their assistants) to administer treatment as necessary. I hereby certify that I have read and fully understand this authorization for medical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

PATIENT SIGNATURE _____ **DATE**_____

OR SIGNED FOR PATIENT BY _____ **RELATIONSHIP** _____

DISCLOSURE OF CONFIDENTIAL INFORMATION (select one)

○ I choose to have voicemail left with minimally necessary information. In the event that I am not available, you may leave a message	○ I choose to opt-out of voicemail messages.

You also have my permission to disclose information about my care to the following individual(s): _____

_____

PATIENT SIGNATURE _____ **DATE**_____

CONFIDENTIALITY AGREEMENT FOR PARTICIPATION IN GROUP PRENATAL CARE (for pregnant patients only)

You have the right to expect what is said in class to remain private and confidential. Along with our commitment to maintain your privacy, you also have a responsibility to respect and protect each other's privacy. If you have any questions about this policy, you may ask our HIPAA compliance officer.

I have read the Privacy Notice and understand these policies.

PATIENT SIGNATURE _____ **DATE**_____

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HIV TESTING IN PREGNANCY (for pregnant patients only)

The HIV test is a routine screening in pregnancy. While I do have the right to refuse HIV testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to HIV testing, and understand that the result will become a part of my medical record.

PATIENT SIGNATURE _____ **DATE** _____

DRUG TESTING IN PREGNANCY (for pregnant patients only)

Because the use of illegal drugs/substances is potentially harmful for me and my fetus, drug screening is a routine screening in pregnancy. While I do have the right to refuse drug testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to drug testing, and understand that the results will become a part of my medical record.

PATIENT SIGNATURE _____ **DATE** _____

NO SHOW FEE

We understand that there are times when you may miss an appointment due to emergency or unexpected obligations for work or family, however, when you do not call to cancel your appointment in a timely manner, you may be preventing another patient from getting an appointment. If an appointment is not cancelled at least 24 hours in advance, you may be charged a $25 fee. This fee will not be covered by your insurance company.

PATIENT SIGNATURE _____ **DATE** _____

PARTICIPATION IN EDUCATION

I hereby give my permission for the participation of students in my care. Students will always be supervised by a Certified Nurse Midwife, Nurse Practitioner, Medical Doctor, Radiologic Technologist, or Registered Diagnostic Medical Sonographer. I may refuse student involvement at any time.

PATIENT SIGNATURE _____ **DATE** _____

AABC PERINATAL DATA REGISTRY (for pregnant patients only)

The purpose of this data registry is to help improve and maintain quality of care of childbearing families, provide for ongoing and systematic collection of data on normal birth, and facilitate research on maternity care practices that support optimal birth. By consenting to participate in this registry I understand that all information about me and my pregnancy will be kept confidential. As required by HIPAA, no identifying information will be seen by those conducting the project except for my date of birth and zip code. Statistical data will be kept on file and may be used later by other researchers who are studying specific parts of birth center or midwifery care. I freely consent to participate, and also give permission for data about my newborn to be used.

PATIENT SIGNATURE _____ **DATE** _____

PRINTED PATIENT NAME _____

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GYN HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. Please complete ***ENTIRE*** form.

Name *(Last, First, M.I.):*				**DOB:**		
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Significant other name:						
Highest level of education:				**Employed:**		
Who do you live with?						
What are your living arrangements? ☐ **House** ☐ **Apartment** ☐ **Mobile Home** ☐**Other**						

PERSONAL MEDICAL, SURGICAL HISTORY AND SOCIAL HISTORIES:
Please complete this portion of your health history in the ***patient portal PRIOR*** to your appointment. This is a very important part of your care and we want to make the most of your visit with the midwife by having the most updated and complete information. ***If the patient portal is not completed, we may be required to reschedule or have you return for an additional visit to complete the appointment***.

Have you had any recent hospitalizations? ☐ Yes ☐ No If yes, when why?_____
_____

Do you have any allergies to medications? ☐ Yes ☐ No If yes, list allergies:_____
_____

FAMILY HEALTH HISTORY:
Your family history is very important for certain health screening as well as anticipating your health care needs. Please ensure you complete this section in the patient portal PRIOR to your appointment.

OB/GYN HEALTH HISTORY

Pregnancy History: Total # pregnancy: ____ # Premature births _____ #miscarriages/ abortions: _____# term births?_____

Please answer all the questions below and write in any explanations or comments in the space provided

Last Menstrual Period:			
Last pap test:	Have you ever had an abnormal Pap test?		
Age period began?	Length of periods?	#days between periods?	
Are you sexually Active?	☐ Yes ☐ No	☐ One partner ☐ more than one partner ☐ Heterosexual ☐ Homosexual ☐ Bisexual	
Any history of Sexually Transmitted infection	☐ Yes ☐ No	☐ Gonorrhea ☐ Chlamydia ☐Trichomonas ☐ HPV ☐ Syphilis ☐ HIV	
Do you or your partner have a history of herpes?	☐ Yes ☐ No		
Any recent changes in your periods?	☐ Yes ☐ No		

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Do you use birth control?	☐ Yes	☐ No	
Any history of pelvic or vaginal infections?	☐ Yes	☐ No	
Any problems with intercourse?	☐ Yes	☐ No	
Any abnormal vaginal bleeding or vaginal discharge?	☐ Yes	☐ No	
Any uterine abnormality?	☐ Yes	☐ No	
Any history of endometriosis?	☐ Yes	☐ No	
Any history of infertility?	☐ Yes	☐ No	
LAST NAME: **DOB:**			
Any history of polycystic ovarian syndrome?	☐ Yes	☐ No	
Any menopause symptoms?	☐ Yes	☐ No	
Do you do regular self-breast exams?	☐ Yes	☐ No	
Do you have any history of physical or sexual abuse?	☐ Yes	☐ No	

Exercise	Do you exercise? Yes ☐ No ☐ What type of exercise do you enjoy? How often?			
Diet	Are you on any special diet or have dietary restrictions? If so what?		☐ Yes	☐ No
	Do you eat three meals a day?		☐ Yes	☐ No
	Do you have a working stove?		☐ Yes	☐ No
	Do you have running hot and cold water?		☐ Yes	☐ No
	Do you receive WIC?		☐ Yes	☐ No
	#meals you eat in an average day?	How much water a day?	How much caffeine a day?	
	How many servings of grain food do you eat each day? (cereal, rice, pasta, bread)			
	How many servings of vegetables do you eat each day?			
	How many servings of fruits do you eat each day?			
	How many servings of dairy products do you eat each day?			

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DEFINITION OF A WELL-CARE VISIT

The focus of a well-care visit is preventive care. **If tests or services beyond the scope of a well-care visit are provided, then additional charges may be incurred for those services**. The choice to address both well-care and medical issues may be offered during the same visit for convenience, if the provider's schedule will allow. This is up to your provider so that they may stay on schedule and keep other scheduled patients from waiting. Although our office will assist you with your insurance processing, it is the patient's responsibility to understand their insurance benefits.

What is a Well-Care Visit?	
YES	NO
A review of your current health and medical history	Treatment or consultation for a specific medical condition
Counseling about ways to improve your health	Any service not considered part of a well-care visit
A physical exam tailored to your preventive care needs	
Referral or performance of screening tests, if needed (billed separately by providers who perform the service)	

Your scheduled appointment day is for an Annual Exam which is a well-care visit. Each insurance company has different contracts regarding group and individual coverage for well-care (preventive care) benefits. We do not know your contract so we cannot tell you if your insurance company is going to cover the charge for a well exam. Insurance plans typically do not pay for this service twice in less than one year regardless of where you have it done. If there is any question about when your last well-woman exam was, please contact the office where you last had one to ensure you have been scheduled appropriately with us. If your last well-woman exam was at our office, we can find the date of your last exam for you. If tests or services beyond the scope of a well-care visit are provided, then you may be required to pay a co-pay and may incur additional charges.

PATIENT SIGNATURE: _____ **DATE:** _____

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Hurt, Insulted, Threatened with Harm and Screaming (HITS)

Domestic Violence Screening Tool

Name:_____ Date:_____

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you?					
2. Insult or talk down to you					
3. Threaten you with harm?					
4. Scream or curse at you					
	1	2	3	4	5
Total Score:					

Reviewed by:_____

Each item is score from 1-5. Range between 4-20. A score greater than 10 signifies that you are at risk of domestic violence abuse and should seek counseling or help from a domestic violence resource center.

Sherin, K. et.al. *HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting,* Family Medicine 1998;30(7):508-12.)

National Hotlines can connect clients to local resources and provide support.

For Free help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233) TTY: 1-800-787-3224

Teen Dating Abuse Hotline
1-866-331-9474

Rape, Abuse, Incest, National Networks (RAINN)
1-800-656-HOPE (1-800-656-4673)

Georgia 24 Hour Statewide Domestic Violence Hotline
1-800-33HAVEN (1-800-334-2836) https://gcadv.org/get-help/

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