CARING CENTER FOR WOMEN PA

Please help us know more about you and your pregnancy. All information will be kept confidential.

Name: _____ Date: _____

Your Race: _____ Marital Status: _____ Occupation: _____

Your age at delivery: _____ Highest grade completed/degree: _____

Spouse/Partner's/Father of Baby's Name: _____ Age: ____ Race: _____

Occupation: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Total Number of Pregnancies (including this one): _____ Full term: _____ Preterm: _____

Elective Abortions: ____ Miscarriages: _____ Ectopic: _____ Number of living children: _____

First day of last menstrual period: _____

Is this date definite?	Yes	No
Was it normal in amount of flow and number of days?	Yes	No
Do your periods come every 28 days?	Yes	No
Were you using any birth control method when you conceived?	Yes	No

When did you last use birth control (pills, ring, shot): _____

When did you have a positive pregnancy test? _____

How old were you when you had your first period? _____

Height: _____ Pre-pregnancy weight: _____

Medical History Do you or YOUR family members (immediate, parents/siblings only) have any of the following? If yes, give details.

	Self	Immediate family
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Seizures		
Autoimmune Disease		
Psychiatric Disease (depression/postpartum depression		
Liver Disease		
Varicose Veins		

	Self	Immediate family
Blood Clotting problems		
Cancer		
Thyroid Disease		
Lung Problems (including asthma)		
Breast Disease		
Abnormalities of uterus or cervix		
Other		

Have **YOU** ever had any of the following? (Give details)

Trauma: _____ Blood Transfusion: _____

Gynecologic surgery: _____

Other surgeries or hospitalizations: _____

Problems with anesthesia: _____ Infertility treatment: _____

When was your last pap smear? _____ Have you ever had an abnormal pap smear? _____

(Give details of when and how it was treated) _____

When was your last tetanus shot? _____

	No	Yes (please give details)
Are you allergic to medications? If Yes, please list medication and reaction		
Are you allergic to latex?		
Do **YOU** smoke? If yes, please list how much and how long Are you willing to quit?		
Do **OTHERS** in your household smoke?		
Do YOU drink alcohol? If yes, please list how much you drink at one time How often do you drink? Have you quit?		
Do YOU use recreational/illicit drugs? If yes, how often? IV Drug use? Have you quit?		
Do you have any inside pets?		

Does the Father of the baby have any medical problems? (Give details)

_____

_____

_____

_____

List all pregnancies (including miscarriages and abortions)

Date M/D/YY	Birth Weight	Name	Length of labor	Vaginal or C -Section	Anesthesia	City, State	Complications with Pregnancy, Delivery, or Infant

Genetic Screening: Please include self, Father of baby, or any family members (yours or Father of baby's). If yes, please give details.

	NO	Yes (please give details)
Will you be age 35 or older as of delivery date?		
Are you or baby's father's family from an Italian, Greek, Mediterranean, or Asian Background?		
Any infants with an open spine (spina bifida), brain defect, or anencephaly?		
Any infants with heart defects?		
Any infants with Down syndrome?		
Are you or baby's father's family Jewish, Cajun, French – Canadian?		
Are you or baby's father African/Black? Any history of sickle cell disease/trait?		
Do you, baby's father, or family members have hemophilia or other blood disorders?		
Have you, baby's father, or family members had a child with muscular dystrophy or other muscular, neurological disorders?		
Do you, baby's father, or family members have cystic fibrosis?		
Have you, baby's father, or family members had a child with mental retardation or Autism (if yes, was person tested for Fragile X)		
Have you, baby's father, or family members had a child with other inherited genetic or chromosomal disorders?		
Have you, baby's father, or family members had a child with a birth defect not listed above?		
Do you have diabetes?		
Do you have PKU?		

	NO	Yes (please give details)
Have you or the baby's father had 2 or more pregnancies that ended in miscarriage?		
Have you taken any of the following drugs during your pregnancy or around the time the pregnancy began? • Seizure medications (epilepsy) • Anti-cancer drugs • Heart or blood pressure drugs • Anti-coagulants (blood thinners) • Lithium • Accutane • Medications for depression		
Since your last period, have you had drinks containing alcohol (beer, wine, liquor) almost each day or frequently?		
Since your last period have you used cocaine, marijuana, methamphetamines or any street drugs?		
Is there anything that you think could be a birth defect, genetic problem (inherited or one that runs in your of the father's family) that is not listed here:		

Medications: Please list any medications (prescriptions, over the counter, vitamins, herbs, supplements) you are currently taking, or have taken since you have been pregnant

Name of Medication	Dose (amount) and How Often Do You Take the Medication	Date Started	Why Do You Take The Medication	If Prescription, Doctor's Name, City, and State

Infection History: Have you or the baby's father had any of the following? (If yes, give details)

	NO	Yes (please give details)
Lived with Someone with TB or exposed to TB		
Genital herpes		
Experienced a rash or viral illness since your last menstrual period		
Hepatitis B or C		
History of Gonorrhea		
History of Chlamydia		

	NO	Yes (please give details)
History of HPV		
History of HIV		
History of Syphilis		
Other infection		

Please list any current or recent problems

	NO	Yes (please give details)
High fever (greater than 100.4 degrees) since your pregnancy began		
Eye pain or trouble with your vision		
Ear pain/ringing in your ears or trouble hearing		
Fainting or "passing out" since your pregnancy began		
Easy bleeding or bruising		
Significant or consistent pain in your back or extremities		
A cough that won't go away		
Seasonal allergies		
Chest pain		
Shortness of breath at rest or minimal exertion		
Swelling of hands or feet		
Consistent vomiting		
Consistent diarrhea or constipation		
Pain with urination		
Depression or anxiety		

Please list any questions or concerns that you may have or problems not listed elsewhere on this form.

_____

_____

_____

_____

_____

_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Height: _____ **Weight:** _____ **Age of First Period:** _____ **Age of First Child (if applicable):** _____
Are You Menopausal: Yes or No **Have you ever used Hormone Replacement Therapy?** Yes or No
Has anyone in your family had genetic testing for a hereditary cancer syndrome (Ex: BRCA or Lynch)? Yes or No

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis) *Ex: Grandfather 65 yrs*
Y	N	Breast cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer				
Y	N	Male breast cancer				
Y	N	Are you of Jewish descent?				

COLON AND UTERINE CANCER (Colaris)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	N	Prostate Cancer (BRCA)				
Y	N	Pancreatic Cancer (Col/BRCA)				
Y	N	Melanoma (BRCA)				

Patient's Signature: _____ **Date:** _____

For Office Use Only:

BRCA/Lynch Testing Indicated?: YES NO
Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED
Follow-up appointment scheduled: YES NO Date of Appointment: _____

MD Signature: _____ Date: _____

BRCA – Personal or Fam. History	BRCA – Personal or Fam. History	Lynch Syndrome (Colon/Endo)
One person with (out to 2nd degree) • Breast Cancer at 45 or younger • Ovarian Cancer at any age • Male breast cancer any age • Breast Cancer + Jewish Heritage • Bilateral Breast at 50 or younger • Triple Neg Br.Ca. at 60 or younger	Two persons with (out to 3rd Degree) • 2 Breast Cancers at 50 or younger • Breast & Ovarian (any age) Three Persons with (out to 3rd degree) • Breast and/or Ovarian and/or Pancreatic (any age)	Personally affected with. • Colon or Endometrial at ≤ 50 or younger Family History of Colon, Endometrial, + another Lynch Cancer (gastric, ovarian, brain, kidney, small bowel) • 2 or more Lynch cancers, 1 dx ≤ 50

Natera Billing Acknowledgement

This office uses Natera to do Panorama non-invasive prenatal testing (NIPT) and Horizon Genetic Carrier Screening for Cystic Fibrosis and other genetic diseases.

Natera is in-network with Cigna, Aetna, United Healthcare, and Blue Cross Blue Shield of Texas. Testing with these in-network plans goes toward the deductible. Patient responsibility for deductibles and co-payments/co-insurance will apply toward billing with in-network plans. Once deductible is met, most patients typically pay $100-$200.

You can request to apply for the Natera Cares plan either before or after testing is completed. Approval is based on household size and income. If you qualify, your out of pocket will be $149 for Panorama and $95 for Horizon. To apply for Natera Cares, send an email to mgoertz@natera.com and ask for the Natera Cares form. Allow about a week for the application process.

Out-of-network plans will have an out of pocket amount between $100-$200. When you receive your explanation of benefits (EOB), call the Natera Billing Department to settle your out of pocket amount. The EOB will not reflect your out of pocket amount, but will show a higher amount that is billed out.

For billing questions, you may contact our representative for Natera, Meghan Goertz 210-352-0098

I have read and understand the information regarding billing for Panorama (NIPT) and Horizon Carrier Screening, I understand that billing takes place by Natera which is separate from Caring Center for Women.

_____ _____

Patient Name Patient Signature

_____

Date

CARING CENTER FOR WOMEN PA

705 Generations Drive, Ste #101
New Braunfels, TX 78130
office: 830.387.4790
fax: 512.396.7555

1305 Wonder World Drive, Ste #203
San Marcos, TX 78666

NEW BRAUNFELS SAN MARCOS www.caringcenterforwomen.com

Urine Drug Screen in Pregnancy Acknowledgement

Patient Name: _____ Date of Birth: _____

It is the policy of Caring Center For Women to perform a urine drug screen on all pregnant patients at the initial prenatal visit. The urine drug screen is a tool to help your physician provide the best prenatal care to you and your baby, both during and after pregnancy.

I understand that if my initial screen is positive, I may be asked to seek counseling for drug use, treatment for dependency, or be asked to undergo further testing as my pregnancy continues depending on my results and situation.

The purpose of the urine drug screen is not meant to be punitive or for criminal charges. It is to identify those at risk.

Positive test results will only be shared with essential medical professionals who are caring for you and your baby unless you give written consent or by court order.

The testing done by this office is a basic urine drug screen and is not one done for criminal or custody cases as there is no chain of custody involved.

I have been informed of Caring Center For Women's Urine Drug Screen Policy and understand the benefits and potential adverse consequences related to urine toxicology screening.

_____ _____

Patient Signature Date

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OPTIONAL NON-INVASIVE PRENATAL SCREENING TEST

We offer a non-invasive blood test that can detect chromosomal abnormalities and fetal gender as early as 10 weeks. It is especially recommended for high risk pregnancies including the following situations:

Advanced maternal age — If you are going to be age 35 or older at the time of delivery

Personal/family history of chromosomal abnormalities -- (parents, children, siblings, aunts, uncles, first cousins)

Abnormalities of the fetus seen on ultrasound, or other positive screening test

This test can be performed any time after 10 weeks into the pregnancy. A patient with a positive test result will be referred for genetic counseling and offered further testing.

Not all chromosomal abnormalities may be detected and therefore this test does not eliminate the possibility that other chromosomal abnormalities may exist in this pregnancy.

This office uses Natera to do non-invasive prenatal testing (NIPT). Natera offers billing options to help you even if the test is not covered by your insurance or if your cost with insurance it too expensive. Please read the Natera Billing Acknowledgement form for more information regarding billing for this test. Please carefully read the enclosed Panorama brochure for more information about the test and for Natera's phone number.

_____ I want this non-invasive prenatal screening test, and I understand the results may not be finalized for up to 3 weeks after the sample is collected.

_____ I do not want this non-invasive prenatal screening test.

_____ _____
PRINTED NAME DATE

_____
SIGNATURE

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CONSENT TO PERFORM HIV TESTING

Given the enormous advances in the prevention of perinatal transmission of human immunodeficiency virus (HIV), early identification and treatment of all pregnant women with HIV is the best way to prevent neonatal infection and improve women's health. This office follows ACOG and Texas state guidelines for HIV testing at the initial OB visit. Insurance companies are aware of ACOG and state guidelines for HIV testing and routinely cover this testing as part of your initial OB care with each pregnancy.

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:

- HIV is the virus that causes AIDS.
- The only way to know whether you have HIV is to be tested for it.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. You can withdraw consent at any time.
- Several testing options are available, including anonymous and confidential testing.
- State law may protect the confidentiality of test results and protects test subjects from discrimination based on their HIV status.
- If you test positive, your health care provider will talk with you about notifying your sex or needle-sharing partners of possible exposure.

I agree to a test for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing, which may occur on the sample I provide today, to determine the best treatment for me. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____
(Or signature of legally authorized representative)

If legal representative, indicate relationship to patient _____

Printed Name of representative _____

Certification

I certify that the named person above has been given an opportunity to read written information about HIV and to ask questions, that he or she understands the issues presented, that his or her decision to undergo HIV testing is an informed and voluntary one, and that I have witnessed his or her signature.

Witness Name _____

Witness Signature _____ Date _____

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Optional Genetic Carrier Screening

Carrier screening helps you better understand your risk of passing on certain inherited diseases. Carrier screening and counseling enables you to learn about possible reproductive risks and consider the most complete range of reproductive options depending on your carrier screening results. There is no genetic screening test that is 100% predictive or accurate.

If through carrier screening you are found to be a carrier of an autosomal recessive genetic condition, then your partner will need to be tested for the same condition to clearly understand your reproductive risks. If you are a carrier of an X-linked condition, each of your pregnancies has a risk of having an affected child.

Carrier screening requires a simple blood draw and a referral form completed by your Physician. This office offers single option carrier screening, or screening for multiple options. The American College of Obstetrics and Gynecology's current recommendation is to offer pregnant patients carrier screening for Cystic Fibrosis and Spinal Muscular Atrophy.

Currently this office uses Natera for Genetic Carrier Screening. The four most frequently requested carrier screening tests are offered as a panel by Natera for the same price as single option testing. We have included informational brochures for all four options in your initial OB packet for your review and have included a brief explanation for each below.

- **Cystic Fibrosis**
  - Cystic Fibrosis is a condition that causes problems with how the lungs, digestive system, and other parts of the body function. People with CF have delayed growth because of difficulties in digestion and recurrent lung infections that lead to permanent lung damage. Complications of CF can lead to early death. There are treatments for CF that can help lessen the severity of symptoms, but at this time, there is no cure. CF does not affect intelligence.
  - CF is inherited in an autosomal recessive manner, meaning both parents must be carriers of CF for their children to be affected. People who are carriers are typically healthy and do not have CF.

- **Spinal Muscular Atrophy**
  - SMA is a serious childhood condition that causes worsening muscle weakness, decreased ability to breathe, and loss of motor skills. Most children with SMA show symptoms in infancy and many die before the age of 2 years. Some children with SMA develop muscle weakness and other symptoms later in childhood. SMA is a leading inherited disease of infant death.
  - SMA is inherited in an autosomal recessive manner. This means that in most cases, both parents must be carriers of an SMN1 gene mutation to have a child with SMA. People who are carriers are generally healthy and do not have SMA, but have an increased risk of having a child with SMA.

- **Duchenne Muscular Dystrophy**
  - DMD is a condition that causes progressive skeletal muscle degeneration. The muscle weakness usually begins around 3-5 years of age and worsens to eventually involve the muscles of the lungs and heart in teenage years. DMD is an X-linked disorder, therefore it is more common for boys to be affected than girls. Children with DMD need lifelong medical treatment and most will be wheelchair bound by their mid to late teenage years. Survival into the 20s and 30s is common with current medical treatments.
  - DMD is an X-linked condition, meaning it is caused by a mutation in a gene on the X chromosome. DMD can be inherited from a mother who is a carrier of a mutation in the DMD gene, however some children born with DMD have a new mutation that is not inherited, but happened by chance.

- **Fragile X**
  - Fragile X syndrome is a common cause of intellectual disability. Boys with Fragile X are usually more severely affected than girls. Symptoms may include behavior problems and symptoms of autism. There is no cure for Fragile X currently. Children with Fragile X often need early intervention and special education, speech therapy, and behavioral therapy.
  - Fragile X is an X-linked condition, meaning it is caused by a mutation in a gene on the X chromosome. Premutation carriers are often healthy and have no symptoms but have an increased risk to have a child with Fragile X. Some premutation carriers are at risk for certain health problems including fertility issues.

This office uses Natera to do genetic carrier screening. Natera offers billing options to help you even if the test is not covered by your insurance or if your cost with insurance is too expensive. Please read the Natera Billing Acknowledgement form for more information regarding billing for carrier screening.

Please initial your choice below:

_____ I would like genetic carrier screening for Cystic Fibrosis only.

_____ I would like genetic carrier screening for Cystic Fibrosis and Spinal Muscular Atrophy.

_____ I would like genetic carrier screening for Cystic Fibrosis, Spinal Muscular Atrophy, Duchenne Muscular Dystrophy, and Fragile X.

_____ I do not want genetic carrier screening at this time.

Print Name: _____

Patient Signature: _____ Date: _____

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Transfusion Consent

I ____ do or ____ do not consent to the use of blood or blood products as deemed necessary if the event of an emergency or significant need.

Possible complications of a transfusion include:

1. Fever
2. Transfusion reaction which may include kidney failure or anemia
3. Heart failure
4. Hepatitis
5. AIDS (acquired immune deficiency syndrome)
6. Other infections

_____ Printed Name

_____ Signature

_____ Date

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OPTIONAL SCREENING TESTS FOR GENETIC OR BIRTH DEFECTS

Two or three of every one hundred babies born will have a birth defect. There are several screening tests which can identify women who will have a greater chance of having a baby with a birth defect. These tests do not tell us that the baby has a problem, but they do tell us what other tests, such as ultrasound and amniocentesis, can be offered to see which babies really have a problem. Even when a **screening** test shows the baby to be at risk, many babies will be normal. You will always be offered additional counseling and evaluation if there is an abnormal screening test.

The options listed below range from the simplest to the most complex tests. Please remember that if your test result does not fall within the normal range, it only means that further testing may be indicated. You will receive counseling about the options available from your physician.

Option 1: Non-Invasive Prenatal Test – A non-invasive blood test that can detect chromosomal abnormalities, such as Down Syndrome or Trisomy 18 and fetal gender as early as 10 weeks. (This office offers Panorama NIPT through Natera.)

Option 2: Genetic Carrier Screening – this is a blood test to see if a mother is a carrier for certain genetic conditions. (This office offers Horizon Genetic Carrier Screening through Natera.)

a) Cystic Fibrosis Carrier Screening – a blood test to see if a mother is a carrier for Cystic Fibrosis.
b) Horizon 4 Carrier Screening Panel – a blood test to see if the mother is a carrier for Cystic Fibrosis, Spinal Muscular Atrophy, Fragile X and Duchenne Muscular Dystrophy.
c) Other genetic carrier screening tests are also available and may be recommended if there is a family history or for other certain high-risk populations based on ethnic background).

Option 4: Ultra Screen – A test for Down syndrome or similar genetic abnormalities. This is a screening test consisting of a combination of ultrasound exam and blood test. This is a screening test which determines how likely it is that your baby has Down Syndrome or Trisomy 18. This test is performed with a maternal fetal medicine specialist between 11-13 weeks of pregnancy.

Option 5: Quadruple Screening – A blood test for Down syndrome and/or nervous system defects. This blood test detects a high proportion of the most common birth defects. This test can be performed using a blood sample from the mother between 15-20 weeks of pregnancy.

Option 6: Chorionic Villus Sampling (CVS) – Tests for birth defects caused by abnormal chromosomes. This test involves taking a tiny tissue sample from outside the gestational sac where the fetus develops. The tissue is tested to diagnose or rule out certain birth defects. This test is usually offered when there is an increased risk of birth defect. It is performed between 9-11 weeks of pregnancy.

Option 7: Amniocentesis.
This test is usually offered when there is an increased risk of chromosomal or genetic birth defects or certain malformations. A small sample of the amniotic fluid surrounding the fetus is removed and examined. It is performed between 15-18 weeks of pregnancy.

(over)

Tests are optional

These tests are not required as part of your prenatal care. Some families choose to have the testing because they want to know if there is a problem. Some families choose NOT to be tested because they do not want to know if there is a problem or feel that they would not do anything differently even if a problem was found.

Cost of Tests

This office uses Natera to do Panorama non-invasive prenatal testing (NIPT) and Horizon Genetic Carrier Screening for Cystic Fibrosis, Spinal Muscular Atrophy, or other genetic carrier screening tests. Some insurance companies do not cover these screening tests unless you are either over age 35 or have a family history of these problems. Natera offers billing options to help you even if the test(s) are not covered by your insurance or if your cost with insurance it too expensive. Please read the Natera Billing Acknowledgement form for more information about billing for Panorama and Horizon Carrier Screening. Please carefully read the enclosed Panorama NIPT and Cystic Fibrosis brochures for more information about the test and for **Natera's** phone number.

For Ultra Screen and Quadruple Screen, we recommend that you speak with your insurance company PRIOR to having the tests done to ask if those tests are covered. Some insurance companies do not cover these screening tests unless you are either over age 35 or have a family history of these problems.

Chorionic Villus Sampling and Amniocentesis are done with a Maternal Fetal Medicine Specialist and they will assist you in determining coverage for those tests.

Decision About Testing

Your doctor or his/her associates would like to know your decision about having these tests. Since some of the tests can only be done between 9 and 19 weeks of pregnancy, please tell your physician or other provider what you would like to do as soon as possible. This form will be kept in your chart. There will be a more detailed consent form for the tests you indicate you would like to do.

[ ] I want screening testing. (Circle options below)
- Option 1: NIPT
- Option 2: Cystic Fibrosis Alone CF and SMA Horizon 4 Other Genetic Carrier Screening
- Option 3: Ultra Screen
- Option 4: Quad Screen for Down Syndrome and ONTD Quad Screen for ONTD alone
- Option 5: Chorionic Villus Sampling
- Option 6: Amniocentesis

[ ] I **DO NOT** want screening testing.

[ ] I want genetic counseling.

[ ] I **DO NOT** want genetic counseling.

Print Name: _____

Signature: _____ Date: _____

SURGICAL FIRST ASSISTANTS

GREATER AUSTIN SURGICAL ASSISTANTS, LLC
201 SOUTH LAKE LINE BLVD, STE 405
CEDAR PARK, TX 78613
OFFICE (512) 381-GASA(4272) FAX (512) 381-4275
sascheduling@gasapc.com

ASSISTING SURGEONS IN YOUR CARE

DELFINO LORENZO, JR., LSA

DARISSA NORDMEYER, LSA **TODD NIESKES, LSA**

SALLY WALTER, LSA **ANDREW MUNDY, LSA**

LAJUNE WILLIAMS, LSA **ESTHER RIDGE, LSA**

CONSENT FORM

I, _____ (PRINT PATIENT'S NAME), HAVE BEEN INFORMED BY MY DOCTOR OR THEIR REPRESENTATIVE, _____ (PRINT DOCTOR'S OR REPRESENTATIVE'S NAME), THAT A SURGICAL FIRST ASSISTANT (LSA) WAS REQUESTED AND WILL BE PRESENT TO ASSIST MY DOCTOR WITH MY SURGICAL PROCEDURE ON _____(DATE OF SURGERY, SUBJECT TO CHANGE).

I UNDERSTAND THE SURGICAL FIRST ASSISTANT HELPS THE DOCTOR CARRY OUT THE PROCEDURE IN A SAFE AND EFFICIENT MANNER AND IS AN INDEPENDENT PRACTITIONER NOT EMPLOYED BY EITHER MY DOCTOR OR THE FACILITY.

I FURTHER UNDERSTAND I AM RESPONSIBLE FOR THE ASSISTANT'S FEE OF $300.00 MAXIMUM IN THE EVENT:

- -I HAVE NO INSURANCE.
- -I HAVE A GOVERNMENT RELATED INSURANCE SUCH AS, BUT NOT LIMITED TO, MEDICARE, MEDICAID, ALL MILITARY INSURANCES, INDIGENT HEALTHCARE PROGRAMS, ETC.
- -MY INSURANCE DOES NOT COVER THE USE OF THE SURGICAL FIRST ASSISTANT.
- -THE SURGICAL FIRST ASSISTANT IS OUT-OF-NETWORK.
- -MY OUT OF POCKET HAS NOT BEEN MET AT THE IN-NETWORK OR OUT-OF-NETWORK LEVEL.

I READ AND UNDERSTAND THE INFORMATION ABOVE REGARDING THE SURGICAL FIRST ASSISTANT AND I UNDERSTAND THAT I AM RESPONSIBLE FOR THEIR FEE AS OUTLINED ABOVE.

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
PHYSICIAN'S OR REPRESENTATIVE'S SIGNATURE DATE

MEDICARE/SUPPLEMENTS, MEDICAID, ALL MILITARY INSURANCES AND INDIGENT PROGRAMS ARE NOT ACCEPTED.
PLEASE CONTACT THE OFFICE TO MAKE PAYMENT ARRANGEMENTS.
AMERICAN EXPRESS, DISCOVER, MASTERCARD & VISA ARE ACCEPTED.