Mid-South Perinatal
ASSOCIATES, PC

Maternal Fetal Medicine is the sub-specialty of obstetrics and gynecology that focuses on the medical management of high risk pregnancies and assessment of fetus abnormalities.

To help provide our patients with the highest quality care, please review our clinic policies below to enhance our ability to stay patient focused.

- Please arrive 30 minutes prior to your scheduled appointment time to complete all necessary paperwork.
- Please bring your driver's license/identification card and current insurance card/information, be prepared to pay your co-pay and/or patient responsibility at the time of your visit.
- Only ONE support person is allowed with you during the ultrasound, for all scheduled appointments.
- NO CHILDREN are allowed into ultrasound, please make prior arrangements for childcare.
- Video cameras, cameras and/or media devices are not allowed, ultrasound pictures will be provided.
- We kindly request that cell phones be turned off during your appointment.
- Please notify our clinic 24 hours in advance to cancel or reschedule appointment.
- If you are late for your scheduled appointment, we will do our best to work you in however we must see patients at their scheduled time.

If you have questions concerning these policies, please contact our office prior to your appointment. We appreciate your doctor's referral and welcome the opportunity to take part in your healthcare.

Jackson Madison County General Hospital • 620 Skyline Drive, Jackson TN 38301 • Phone 731-541-6939 •Fax 731-541-4570

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

SSN: _____ Date of Birth: _____ Race: _____ Language: _____

Marital Status: ____S ___M ____D ____W Student: ____FT ____PT ____Not a Student

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Employment Status: FT ____ PT ____ Self Employed ____ Unemployed ____ Disabled ____

Employer: _____ Occupation: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relation: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relation: _____

Emergency Contact: _____

Phone Number: _____ Relation: _____

Patient Signature: _____ **Date:** _____

CONSENT TO COMMUNICATE MEDICAL INFORMATION

Communication with Friends, Family Members and/or Signification Others

Some patients would like us to discuss their medical care with a spouse, friend and/or family member. To assure privacy, we require patient permission. Please list below any other persons other than your referring provider.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Voicemail Communication

Many times during the course of your care our providers will want to provide information to you about your laboratory results, other medical information and appointment reminders. Sometimes it is difficult to connect with patients by phone which delays our ability to relay important information. We cannot use this method of communication unless we have patient's permission.

☐ Yes, you may leave a voicemail ☐ No, you may not leave voicemail

Home Phone: _____ Cell Phone: _____

Cell Phone Carrier: _____

Email Communication

Unencrypted email is not a secure form of communication. There is risk involved such as emails may be misdirected, disclosed to or intercepted by unauthorized third party. However, you may consent to receive emails regarding your treatment and appointment reminders.

☐ Yes, I consent to Email Communication

☐ No, I do not consent to Email Communication

Email Address: _____

Text Communication

I give permission to receive only appointment reminders by text message with cell phone number(s) provided.

☐ Yes, you may send Text Message

☐ No, you may not send Text Message

Patient Signature: _____ **Date:** _____

PATIENT AUTHORIZATION FORM

Patient Name: _____SSN: _____ DOB: _____

I consent to receive treatment from my physician and other employees at Mid-South Perinatal Associates, PC. I authorize my physician and the other employees at Mid-South Perinatal Associates, PC. involved in my care to provide the medical and surgical services, tests, procedures, drugs, supplies and other care in ways they deem advisable. I understand that these services may include for example, special tests or procedures ordered by my doctor. I acknowledge that no one has guaranteed, nor can anyone guarantee, the results of the care provided at Mid-South Perinatal Associates, PC. I understand that I may refuse to receive any medical or surgical service provided by Mid-South Perinatal Associates, PC at any time.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Mid-South Perinatal Associates, PC. I acknowledge that Mid-South Perinatal Associates, PC may use and disclose my personal health information as needed for the purposes of treatment, payment and healthcare operations. I have been given the opportunity to review Mid-South Perinatal Associates, PC Notice of Privacy Practices and understand I am entitled to receive a copy of this document upon request at any time.

I hereby give acknowledge authorization of benefits and financial agreement to Mid-South Perinatal Associates, PC. I authorize payment of insurance benefits to be made directly to Mid-South Perinatal Associates, PC for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize Mid-South Perinatal Associates, PC to release all information necessary to secure payment of benefit and authorization signature on all insurance submissions whether manual or electronic. I understand that certain test(s) ordered by my physician at Mid-South Perinatal Associates, PC may be considered "non-covered" or "not medically necessary" indicated by my insurance company and take full responsibility for services non payable.

I have received and reviewed the Mid-South Perinatal Associates, PC office policies and agree to abide by them.

Patient Signature: _____ **Date:** _____

Mid-South Perinatal Associates, PC
Review of Systems

Name: _____ DOB: _____ Date: _____

Allergies ☐ No ☐ Yes
If yes indicate:
_____
_____

Medications (Name and Dosage)
_____
_____
_____
_____

Pharmacy Name/Location/Phone Number
_____
_____
_____

General
Weight Gain ☐ No ☐ Yes
Weight Loss ☐ No ☐ Yes

Skin
Hair Loss ☐ No ☐ Yes
Rash ☐ No ☐ Yes

HEENT
Headache ☐ No ☐ Yes
Bleeding Gums ☐ No ☐ Yes

Respiratory
Chronic Cough ☐ No ☐ Yes
Difficulty Breathing ☐ No ☐ Yes

Breast
Breast Mass ☐ No ☐ Yes
Breast Pain ☐ No ☐ Yes
Breast Swelling ☐ No ☐ Yes
Nipple Discharge ☐ No ☐ Yes
Nipple Pain ☐ No ☐ Yes
Recent Breast Size Changes ☐ No ☐ Yes
Skin Changes ☐ No ☐ Yes

Gastrointestinal
Bloody Stool ☐ No ☐ Yes
Incontinence of Stool ☐ No ☐ Yes
Rectal Bleeding ☐ No ☐ Yes

Female Genitourinary
Absence of Menstruation ☐ No ☐ Yes
Discharge ☐ No ☐ Yes
Excessive Menstrual Bleeding ☐ No ☐ Yes
Incontinence ☐ No ☐ Yes
Menstrual Irregularities ☐ No ☐ Yes
Painful Intercourse ☐ No ☐ Yes
Painful Menstruation ☐ No ☐ Yes
Painful Urination ☐ No ☐ Yes
Urgency ☐ No ☐ Yes
Urinary Retention ☐ No ☐ Yes
Vaginal Discharge ☐ No ☐ Yes
Vaginal Dryness ☐ No ☐ Yes
Vaginal itching/burning ☐ No ☐ Yes
Urine Leakage ☐ No ☐ Yes
Have you had an STD? ☐ No ☐ Yes
(If yes, which disease?) _____
Do you wish STD testing? ☐ No ☐ Yes

Psychiatric
Anxiety ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Suicidal Ideation ☐ No ☐ Yes

Endocrine
Hot Flashes ☐ No ☐ Yes
Libido Change ☐ No ☐ Yes
Sexual Dysfunction ☐ No ☐ Yes

Hematology
Abnormal Bleeding ☐ No ☐ Yes
Excessive Bleeding ☐ No ☐ Yes

LMP: _____
(Last Menstrual Period)

FAMILY MEDICAL HISTORY

Please check any of the following that applies to your family and/or the father of the baby's family.
Please consider: parents, brothers, sisters, aunts, uncles, cousins and grandparents

_____ Anencephaly (Open Skull)

_____ Anemia

_____ Blindness

_____ Cancer

_____ Chromosome Abnormalities

_____ Cleft Lip/Palate

_____ Cystic Fibrosis

_____ Deafness

_____ Down Syndrome

_____ Epilepsy or Seizures

_____ Heart Defect

_____ Hemophilia (bleeding disorder)

_____ Huntington's chorea

_____ Hydrocephalus (water on the brain)

_____ Kidney Disease (i.e. Polycystic Kidney)

_____ Limb Defects (arms, legs)

_____ Mental Illness

_____ Mental Retardation

_____ Muscular/Myotonic Dystrophy

_____ Neurofibromatosis

_____ Neurologic or Degenerative Disorder

_____ Phenylketonuria (PKU)

_____ Sickle Cell Anemia

_____ Skeletal Problems (easily broken bones, dwarfism

_____ Skin Disease (dark or light patches)

_____ Spina Bifida (open spine)

_____ Thalassemia (Alpha or Beta)

_____ Urinary Tract Disease

_____ Birth Defects or inherited disorders NOT listed above _____

_____ NONE OF THE ABOVE

DO YOU OR THE FATHER OF THE BABY

Please mark YES or NO to all questions to complete questionnaire, continued on next page

YES	NO	
____	____	Have any birth defects, handicapping condition or disorder that might be hereditary?
____	____	Have any previous children with birth defects, handicaps, or genetic diseases?
____	____	Have any children who died (other than accident)?
____	____	Have a brother, sister, or parent with a handicap, birth defect or genetic disease?
____	____	Have any uncles, aunts, cousins, grandparents, nephews, or nieces with a handicap, birth defects or genetic diseases?
____	____	Know of any family members with mental retardation (even mild) or learning disabilities?
____	____	Have any family members who have had multiple miscarriages (two or more) or stillbirth?

YES	NO	
____	____	Are you 34 years old or older?
____	____	Is the father of your baby 55 years or older?
____	____	Are you and the father of your baby blood relatives?
____	____	Have you had a stillbirth or two or more miscarriages? _____
____	____	Do you have diabetes? If, yes what age diagnosed? _____
____	____	If you are diabetic, are you taking insulin? _____
____	____	Do you have any other medical conditions? _____
____	____	What is the father of your baby's race? _____
____	____	What countries are your ancestors from originally? Mother _____ Father _____ (Be specific – England, Africa, Vietnam, ETC.)
____	____	Are either you or the father of the baby Jewish, French Canadian, or Cajun? _____
____	____	Have you had the alpha-fetoprotein (AFP) blood test or the triple screen blood test? If yes, When? _____

ENVIRONMENTAL EXPOSURES HISTORY

Please mark YES or NO to all questions to complete questionnaire.

YES	NO	
____	____	Taken any prescription drugs or over the counter medications since becoming pregnant? List: _____ Circle any that may apply: Accutane, Epilepsy Medicines, Lithium, Blood Thinner (anti-clot), etc.
____	____	Had any illness or infection during pregnancy? List: _____
____	____	Had a fever over 101 degrees or taken sauna/whirlpool baths during pregnancy?
____	____	Had X-Rays or surgery since becoming pregnant? Specify: _____ When: _____
____	____	Had alcohol during your pregnancy? Specify when & how much: _____
____	____	Smoked during your pregnancy? Specify when & how much: _____
____	____	Used any other drugs during your pregnancy? Specify when & how much: _____
____	____	Taken vitamins, supplements, or herbal preparations this pregnancy? List: _____

Patient Signature: _____ **Date:** _____

Mid-South Perinatal Associates, PC

HIPAA NOTICE OF PRIVACY PRACTICE

Notice of Privacy Practices Effective June 24, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

If you have any questions about this Notice of Privacy Practices, please ask a member of the staff where you receive health care services. You may also contact our Privacy Officer (the Practice Manager) at 731-541-6939, contact information provided at the end of this Notice.

MID-SOUTH PERINATAL ASSOCIATES, PLC IS COMMITTED TO YOUR PRIVACY

At Mid-South Perinatal Associates, PC, we keep medical information about you to help us provide your care and to meet legal requirements. We also understand that your medical information is private.

The law requires us to...

- protect your medical information
- give you this Notice
- follow the terms of the Notice.

DEFINITION OF TERMS

In this document we will use words that will have the following meaning:

- "Notice" is used to refer to this Notice of Privacy Practices
- "MID-SOUTH PERINATAL ASSOCIATES" means Mid-South Perinatal Associates, PC, together with its medical staff and affiliated organizations listed at the end of this Notice
- "we," "our" or "us," means one or more of MID-SOUTH PERINATAL ASSOCIATES' licensed providers and staff
- "you" means the patient who is the subject of the medical information
- "medical information" includes all paper and electronic records of your care that identify you and relate to your past, present or future physical or mental health or condition including information about payment and billing for your health care services
- "use" means sharing or using your medical information within MID-SOUTH PERINATAL ASSOCIATES
- "share" or "disclose" means to release, give access to, or provide your medical information to someone outside MID-SOUTH PERINATAL ASSOCIATES.

HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

MID-SOUTH PERINATAL ASSOCIATES and its medical staff; employed healthcare professionals including physicians, nurses, care partners, other employees; trainees and students; volunteers; and business associates follow the terms of this Notice. MID-SOUTH PERINATAL ASSOCIATES uses electronic record systems to more efficiently and safely coordinate your care across many individuals and locations. Physical and technical safeguards are used to protect the information in these systems, and MID-SOUTH PERINATAL ASSOCIATES also uses policies and training to restrict use of your information to only those who need it to do their job.

Doctors and other people who are not employed by MID-SOUTH PERINATAL ASSOCIATES may share information about you with MID-SOUTH PERINATAL ASSOCIATES employees in order to provide your health care. These non-MID-SOUTH PERINATAL ASSOCIATES caregivers may also give you their notices that describe their privacy practices for information they maintain outside of MID-SOUTH PERINATAL ASSOCIATES.

All of these hospitals, clinics, doctors, and other caregivers, programs and services may share your medical information with each other for treatment, payment, and health care operations purposes. The general ways that we can use and share your information are described below.

Treatment: We may use and share your medical information to provide you with health care services. *For example, your medical information may be provided to your ob/gyn to further your treatment.* We may also share medical information about you in order to provide you with items and services such as medicine, lab tests and x-rays, and to make arrangements for transportation, home care, medical device or equipment experts, or with community agencies and family members. This medical information may be shared when needed in order to plan or provide your care.

Payment: We may use and share your information so that MID-SOUTH PERINATAL ASSOCIATES or other health care providers that have provided services to you, such as an ambulance company, may bill and collect payment for those services. *For*

example, we may share your medical information with your health plan so your health plan will pay for care you received at MID-SOUTH PERINATAL ASSOCIATES, or to obtain prior approval for a procedure, or to allow your health plan to review your records to make sure they have paid the correct amount to MID-SOUTH PERINATAL ASSOCIATES. We may also share your information with a collection agency when needed in order to collect an overdue payment.

Health Care Operations: We may use and share information about you for business tasks necessary to operate MID-SOUTH PERINATAL ASSOCIATES. Whenever practical we may remove information that identifies you. *For example we may use or share your medical information:*

- *to comply with laws and regulations*
- *for health care training and education*
- *to perform credentialing, licensure, certification, and accreditation functions*
- *to improve our care and service*
- *for our budgeting and planning*
- *for legal services and compliance programs*
- *to conduct audits*
- *to maintain computer systems*
- *to evaluate the performance of our staff in caring for you*
- *to make decisions about additional services MID-SOUTH PERINATAL ASSOCIATES should offer*
- *to do patient satisfaction surveys*
- *to bill and collect payment.*

When information is shared with outside parties (called "business associates") who perform these tasks on behalf of MID-SOUTH PERINATAL ASSOCIATES, the business associates are also required to protect and restrict use of your medical information.

Contacting You about Appointments, Insurance and Other Matters: We may contact you by mail, phone, or email about appointments, registration questions, insurance updates, billing or payment matters, test results, to follow up about care received, or to ask about the quality of the services we have provided to you. We may leave voice messages at the telephone number you give to us.

Treatment Alternatives or Health News and Services: We may use or share your information to inform you about treatment options or health-related products or services that may interest you.

Family Members and Friends Involved in Your Care or Payment for Your Care: We may share information about you with family members and friends who are involved in your care or payment for your care. Whenever possible, we will allow you to tell us who you would like to be involved in your care. However, in emergencies or other situations in which you are unable to tell us who to share information with, we will use our best judgment and share only information that others need to know. We may also share information about you with a public or private agency during a disaster so the agency can help contact your family or friends about your location and tell them how you are doing.

To Stop a Serious Threat to Health or Safety: When necessary to prevent a serious and urgent threat to the health and safety of you or someone else, we may share your medical information.

Military and Veterans: If you are a member of the armed forces, we may share your medical information with the military as authorized or required by law. We may also release information about foreign military personnel to the proper foreign military authority.

Workers' Compensation: We may share medical information about you with those who need it in order to provide benefits for work-related injuries or illness.

Health Oversight Activities and Public Health Reporting: We may share information with health oversight agencies for activities like audits, investigations, inspections, and review of requirements to obtain a license. We may also share your medical information to file reports with state public health authorities

Some examples of the reasons for these reports are:

- *to prevent or control disease and injuries*
- *to report events such as births and deaths*
- *to report reactions to medications or problems with products*

- *to notify people of recalls of products they may be using*
- *to notify a person who may have been exposed to a disease or may spread a disease*
- *to notify the appropriate authority if we believe a patient has been the victim of abuse, neglect or domestic violence.*

Lawsuits and Disputes: We may share your medical information as directed by a court order, subpoena, discovery request, warrant, summons or other lawful instructions from a court or public body when needed for a legal or administrative proceeding.

Law Enforcement: We may release your medical information to a law enforcement official, as authorized or required by law:

- in response to a court order, subpoena, warrant, summons or similar process
- to identify or locate a suspect, fugitive, material witness, or missing person
- if you are suspected to be a victim of a crime, generally with your permission
- about a death we believe may be the result of a crime
- about criminal conduct at the clinic
- in an emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

We May Share Your Information With:

- coroners, medical examiners and funeral directors so they can carry out their duties
- federal officials for national security and intelligence activities
- federal officials who provide protective services for the President and others such as foreign heads of state, or to conduct special investigations
- a correctional institution if you are an inmate
- a law enforcement official if you are under the custody of the police or other law enforcement official.

OTHER USES OF YOUR MEDICAL INFORMATION

We will not use or share your medical information for reasons other than those described above without your written consent. *For example, you may want us to give medical information to your employer or to your child's school.* We will share your medical information for purposes like this only if you give your written approval. You may revoke the approval, in writing, at any time, but we cannot take back any medical information that has already been shared with your approval.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

The records we create and maintain using your medical information belong to MID-SOUTH PERINATAL ASSOCIATES, but you have the following rights:

Right to Review and Get a Copy of Your Medical Information: You have the right to look at and get a copy of your medical information, including billing records. You must first make your request in writing to the address provided at the end of this Notice. We may charge a fee to cover copying, mailing, and other costs and supplies used to respond to your request. We may deny your request for certain information in very limited cases. If we deny your request, we will give you the reason for the denial in writing. In some cases, you may request that the denial be reviewed by a licensed health care professional chosen by MID-SOUTH PERINATAL ASSOCIATES.

Right to Ask for a Change of Your Medical Information: If you think our information about you is not correct or not complete, you may ask us to correct the record by writing to the address listed at the end of this Notice. Your written request must give the reason you ask for a correction. If we accept your request, we will tell you we agree and add the correction. We cannot take anything out of the record. We can add new information to complete or correct the existing information. With your help, we will notify others who have the incorrect or incomplete medical information. If we deny your request, we will tell you in writing the reasons. If we deny your request, you have the right to submit a written statement that tells what you believe is not correct or is missing. We will add your written statement to your records and include it whenever we share the part of your medical record that your written statement relates to.

Right to Ask for an Accounting of Disclosures: You have the right to request a list of when your medical information was shared without your written consent.
This list will not include uses or disclosures:

- to carry out treatment, payment, or health care operations
- to you or your personal representative
- to your family members or friends who are involved in your care

- as required or permitted by law as described above
- as part of a limited data set with direct identifiers removed

Any request for this list must be made in writing to the Privacy Officer (the Practice Manager), at the address listed below. Your request must state the time period for which you want the list. The time period may not be longer than six years and may not begin before April 14, 2003. The first list you request within a 12-month period will be free. We will charge you a fee for additional requests in that same period.

Right to Ask for Limits on the Use and Sharing of Your Medical Information: You have the right to ask that we limit our use or sharing of information about you for treatment, payment or health care operations. You also have the right to ask us to limit the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *For example, you could ask that we not share information about a procedure you had.* We reserve the right to accept or reject your request. Generally, we will not accept restrictions for treatment, payment, or health care operations. We will notify you if we do not agree to your request. If we do agree, our agreement must be in writing, and we will comply with the restriction unless the information is needed to provide emergency treatment for you. We are allowed to end the restriction if we tell you. If we end the restriction, it will only affect medical information that was created or received after we notify you.

You must submit your request to restrict the use and sharing of your medical information in writing to the Privacy Officer at the address listed at the end of this Notice. In your request, you must tell us (1) what information you want to limit (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

Right to Ask for Confidential Communications: You have the right to ask us to communicate with you in a certain way or at a certain location. *For example, you can ask that we contact you only at work or at a post office box.* You must make your request in writing to the Privacy Officer at the address given at the end of this Notice. You do not need to tell us the reason for your request. Your request must specify how or where you wish to be contacted. You will also be required to tell us what address to send bills to for payment. We will accept all reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information we have.

Right to Get a Paper Copy of This Notice: You have the right to get a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may get a copy at any of our facilities, by contacting the Privacy Officer at the number below.

CHANGES TO THIS NOTICE

We have the right to change this Notice at any time. Any change could apply to medical information we already have about you as well as any information we receive in the future. The effective date of this Notice is on the first page.

HOW TO ASK A QUESTION OR REPORT A COMPLAINT

If you have questions about this Notice or want to talk about a problem without filing a formal complaint, please contact the Privacy Officer at 731-541-6939. The Privacy Officer is the Practice Manager, Shawn f you believe your privacy rights have been violated, you may file a written complaint with us. Please send it to the MID-SOUTH PERINATAL ASSOCIATES Privacy Officer at the address listed below. You may also file a complaint the Secretary of the Department of Health and Human Services.

You will not be treated differently for filing a complaint.

HOW TO CONTACT US:

Privacy Officer: Shawn Lewis
Practice Manager
Mid-South Perinatal Associates, PC
620 Skyline Dr.
Jackson, TN 38301-3923

Phone: 731-541-6939
Fax: 731-541-7346

Revision Date: 6/24/13