Perinatology or 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 of care, please review our clinic polices 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 drivers' license/identification card and current insurance card/information, be prepared to make your co-pay/patient responsibility at the time of your visit.
- Only ONE support person is allowed during the ultrasound, for all scheduled appointments.
- NO CHILDREN are allowed into ultrasound, please make prior arrangements for childcare.
- Food and drinks are not allowed in the clinic in consideration of other patients, but, may be in waiting area.
- Video cameras, cameras, and media drives are not allowed, you will be provided with ultrasound pictures.
- We kindly request that cell phones be turned off during your appointment
- If, you need to cancel or reschedule an appointment please notify our clinic 24 hours in advance, however, we do understand emergencies happen.
- 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 times.

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

RICHARD K. WAGNER, MD, FACOG • NATHAN J. HOELDTKE, MD, FACOG
BOARD CERTIFIED IN MATERNAL-FETAL MEDICINE
620 SKYLINE DR., JACKSON, TN 38301-3923 • PHONE: 731-541-6939 • FAX: 731-541-7346
www.midsouthperinatal.com

PATIENT INFORMATION

Last Name: ______________________ **First Name:** ______________________ **MI:** ______

Address: ____

City: ______________________ **State:** ______________ **Zip:** ____________

Home Phone: ______________**Cell Phone:** ______________ **Work Phone:** ____________

SSN: ______________________**Date of Birth:** ______________________ **Age:** ______

Marital Status: ___ S ___ M ___ D ___W **Spouse Name:** ________________**Phone:** ____________

Student: ___Full Time ___Part Time ___Not a Student **Race:** ____________ **Language:** ____________

Employment Status: ___Full Time ___Part Time ___Self Employed ___Unemployed ___Military ___Disabled

Employer's Name: ____________________________ Occupation: ______________________

Address: ______________________ City: __________ State: ________Zip: __________

Referring Physician: ______________________________ **Phone:** ______________

Primary Care Physician: ___________________________ **Phone:** ______________

Pharmacy: ____________________________________ **Phone:** ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Primary Insurance Name: ____

Policy Number: ____________________________ Group: ______________________

Policy Holder Name: _________________________ DOB: ____________Relation: ____________

Secondary Insurance Name: ____

Policy Number: ____________________________ Group: ______________________

Policy Holder Name: _________________________ DOB: ____________Relation: ____________

Patient Signature/Authorized Representative: ________________________ **Date:** ____________

Patient Consent to Share Personal Health Information

I hereby authorize Mid-South Perinatal Associates, PC to share my personal health information with named person(s) below until further written notice from me:

Return Appointments:	YES	NO	Ultrasound Results:	YES	NO
Out-Patient Testing:	YES	NO	Return Calls:	YES	NO
Lab Results:	YES	NO	Amino Results:	YES	NO

Name: ______________________ Relation: ______________________ Phone: ______________

Name: ______________________ Relation: ______________________ Phone: ______________

Name: ______________________ Relation: ______________________ Phone: ______________

Emergency Contact: ______________________ Phone: ______________ Relation: __________

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review Mid-South Perinatal Associates, PC; Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Authorization for Voicemail/Text Message Usage for PHI

I hereby give permission to leave a message on my voicemail to any phone numbers given to Mid-South Perinatal Associates, PC concerning my personal health information. ☐ Decline Option

I hereby give permission to receive appointment reminders by text message via Televox with cell phone number(s) provided on behalf of Mid-South Perinatal Associates, PC. ☐ Decline Option

Assignment and Authorization of Benefits/Financial Agreement

I hereby give authorization for 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 this healthcare provider to release all information necessary to secure payment of benefit and authorize signature on all insurance submissions whether manual or electronic. I understand that certain test(s) ordered by doctor(s) of Mid-South Perinatal Associates, PC may be considered "non-covered" or "not medically necessary" indicated by insurance company and take full responsibility for services non payable. I further agree that a photocopy of this agreement is valid as the original.

Patient Signature: ______________________________ **Date:** ______________

CHILD ATTENDANCE POLICY
IMPORTANT REMINDER – EFFECTIVE IMMEDIATELY

Dear Patient,

Mid-South Perinatal Associates, PC has a long standing policy of not allowing children in the ultrasound room while a scan is being performed. The reason for this policy is to create a quiet environment where our sonographers are able to perform an accurate and comprehensive ultrasound scan. Our policy ensures the integrity of the ultrasound procedure as well as the safety of your child/children.

We must, therefore, enforce our policy and not allow children into the ultrasound room. Children can remain in waiting area with appropriate adult supervision during the scan.

We reserve the right to cancel appointments if patients arrive with child/children who will be unattended during procedures, testing, and/or counseling sessions.

Thank you for your understanding and cooperation in this matter. Our goal is to continue to strive to provide our patients and their families with a positive experience that is patient focused and quality driven. If you have questions or concerns, please contact Jenna Britt, Practice Manager, at 731-541-6939.

The Mid-South Perinatal Staff

Patient Signature: ______________________________ **Date:** ________________

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Patient Consent for Physician(s) to Use or Disclose Health Care Information
For Treatment, Payment and Health Care Operations

Patient Name: ______________________________ Date of Birth: __________________ SSN: ______________

I understand that my health information is private and confidential. I understand that Mid-South Perinatal Associates, PC works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that Mid-South Perinatal Associates, PC may use and/or disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health operations. Failure to sign this consent may result in the physician declining to treat me.

Mid-South Perinatal Associates, PC has a detailed document called "Notice of Privacy Practice." It contains more information about policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement. Mid-South Perinatal Associates, PC may update this "Notice of Privacy Practices." Upon request Mid-South Perinatal Associates, PC will provide me with most current document.

Under the terms of this consent, I can request Mid-South Perinatal Associates, PC to restrict how my personal health information is used or disclosed to carry out treatment, payment and/or health care operations. I understand Mid-South Perinatal Associates, PC does not have to agree to my request. If Mid-South Perinatal Associates, PC does not agree to my request, I understand that Mid-South Perinatal Associates, PC would follow the agreed limits.

I understand that I have the right to cancel this consent in writing at any time. If I do cancel the consent, I understand that Mid-South Perinatal Associates, PC may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that Mid-South Perinatal Associates, PC can give me called "Revocation of Consent for Use and Disclosure of Health Care Information," or
2. Writing, signing and dating a letter to Mid-South Perinatal Associates, PC. If I write a letter, is must say that I want to revoke my consent to authorize the use and disclosure of patient's personal health information for treatment, payment and health care operations.

I understand that if I cancel this consent, Mid-South Perinatal Associates, PC does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Mid-South Perinatal Associates, PC "Notice of Privacy Practices."

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 informotion 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 os births and deaths*
- *to report reactions to medications or problems with products*

- 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, Jenna Britt.** If 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: Jenna Britt
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