

## INSURANCE AND PAYMENT INFORMATION

### PATIENT INFORMATION

<b>Patient Name (Last, First, Middle):</b>	<b>Maiden Name:</b>	<b>Date of Birth (MM-DD-YYYY):</b>
_____	_____	_____
<b>Social Security #:</b>	<b>Driver's License #:</b>	<b>Phone Number:</b>
_____	_____	_____
<b>Home Address:</b>	<b>City:</b>	<b>State:</b> <b>ZIP Code:</b>
_____	_____	_____
First time here? <input type="radio"/> Yes <input type="radio"/> No	Communication Preference: <input type="radio"/> Mail <input type="radio"/> Phone <input type="radio"/> No Preference	
Smoking Status: <input type="checkbox"/> Current Everyday Smoker <input type="checkbox"/> Current Some Day Smoker <input type="checkbox"/> Former Smoker	<input type="checkbox"/> Heavy Tobacco Smoker <input type="checkbox"/> Light Tobacco Smoker <input type="checkbox"/> Never Smoker	
<b>Employer:</b>	<b>Work Address:</b>	<b>Work Phone:</b>
_____	_____	_____
<b>Name of Nearest Relative (other than spouse/partner):</b>	<b>Relationship to Patient:</b>	<b>Phone Number:</b>
_____	_____	_____

### SPOUSE/PARTNER INFORMATION

<b>Spouse/Partner Name (Last, First, Middle):</b>	<b>Date of Birth (MM-DD-YYYY):</b>	
_____	_____	
<b>Social Security #:</b>	<b>Driver's License #:</b>	<b>Work Phone:</b>
_____	_____	_____
<b>Employer:</b>	<b>Work Address:</b>	
_____	_____	

### INSURANCE INFORMATION

<b>Primary Insurance:</b>	_____		
Address:	_____		
Policy Number:	_____	Subscriber Name:	_____
<b>Secondary Insurance:</b>	_____		
Address:	_____		
Policy Number:	_____	Subscriber Name:	_____

Your signature below confirms that the information submitted above is true and correct to your knowledge and that you have read, understood, and accept our Insurance, Payment, and Other Terms on a separate page.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# GENETICS CENTER

## GENETIC SCREENING QUESTIONNAIRE

Name: \_\_\_\_\_ Pronouns (circle one)  She/her  He/him  They/them  Other: \_\_\_\_\_ DOB: \_\_\_\_\_

Partner's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Due Date: \_\_\_\_\_

### Family and Patient History

1. Is your family or your partner's family...
 

	<input type="checkbox"/> No	<input type="checkbox"/> Maternal Yes	<input type="checkbox"/> Paternal Yes
a. Southeast Asian, Taiwanese, Chinese, or Filipino? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Italian, Greek, Middle Eastern, Indian Subcontinent .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. African or African-American (Black)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Jewish? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Cajun or French Canadian? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. White? If yes, what countries are your ancestors from? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Hispanic? If yes, what countries are your ancestors from? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
  
2. Have you, your partner, or anyone in either of your families ever had any of the following disorders?
 

	<b>No</b>	<b>Yes</b>		<b>No</b>	<b>Yes</b>
a. Chromosomal abnormalities (such as Down syndrome) .....	<input type="checkbox"/>	<input type="checkbox"/>	h. Polycystic kidney disease/kidney abnormalities.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Neural tube defect (such as spina bifida, anencephaly) .....	<input type="checkbox"/>	<input type="checkbox"/>	i. Heart defect (at birth) .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Cystic fibrosis (a lung disease) .....	<input type="checkbox"/>	<input type="checkbox"/>	j. Cleft lip/palate .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Blood disorder (such as hemophilia, sickle cell, thalassemia, clotting disorder) .....	<input type="checkbox"/>	<input type="checkbox"/>	k. Developmental delay, intellectual disability, or autism .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Tay-Sachs/Canavan .....	<input type="checkbox"/>	<input type="checkbox"/>	l. Any birth defect or genetic condition not listed above .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Nerve or muscle disorder (such as neurofibromatosis, muscular dystrophy) .....	<input type="checkbox"/>	<input type="checkbox"/>	m. Needed surgery before age 1 year.....	<input type="checkbox"/>	<input type="checkbox"/>
g. Bone or skeletal disorder (e.g. dwarfism).....	<input type="checkbox"/>	<input type="checkbox"/>	n. Cancer in childhood or young adulthood.....	<input type="checkbox"/>	<input type="checkbox"/>
			o. Non-age-related blindness or deafness.....	<input type="checkbox"/>	<input type="checkbox"/>
  
3. Are you and your partner related by blood (such as cousins)? .....  No  Yes
4. Have you, your partner, or anyone in either of your families had a baby who died shortly after birth or in childhood? .....  No  Yes
5. Have you, your partner, or anyone in either of your families had a stillbirth or two or more pregnancy losses? .....  No  Yes
6. Have you or your partner had any genetic tests (such as chromosomes, cystic fibrosis, Tay-Sachs, or sickle cell screening)? Other: \_\_\_\_\_ .....  No  Yes
7. Have you ever been diagnosed with diabetes, cancer, seizures, another serious medical condition, or genetic condition? .....  No  Yes
8. Do you or your partner have a history of infertility? .....  No  Yes  
 If so, specify the cause, if known: \_\_\_\_\_

My signature below indicates that the above family and pregnancy history information provided is complete and correct.

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

### Insurance, Payment, and Other Terms

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(MM-DD-YYYY)

<b>AUTHORIZATION TO RELEASE INFORMATION FOR BILLING</b>
I authorize the Genetics Center and its medical affiliates to release any information acquired in the course of my examination and treatment to my insurance company for billing purposes.
<b>AUTHORIZATION TO RELEASE PAYMENT(S) TO GENETICS CENTER</b>
I irrevocably assign and transfer insurance payment(s) directly to the Genetics Center.
<b>INSURANCE ELIGIBILITY</b>
I certify that I am eligible with my insurance company. I understand that if this is not true or if I am not eligible for some or all of the Genetics Center services under the terms of my insurance contract, I am liable for any and all charges for services rendered. Also, if I am not eligible, I agree to pay in full for all services rendered within thirty days of receiving a bill from the Genetics Center.
<b>INSURANCE AND PAYMENT TERMS</b>
I acknowledge that all medical bills are due and payable at the time services are rendered. However, as a courtesy to me the patient, Genetics Center will submit my claim to my insurance company for me. I understand that my insurance coverage is a contract between me and my insurance carrier. If it is my desire to have Genetics Center bill my insurance carrier for these services, I will present my insurance card.  I also acknowledge that <b>all co-pays and unmet deductibles are due and must be paid at the time of service</b> . In certain cases, Genetics Center may also require some deposit in advance. If my insurance company pays more than was collected, Genetics Center will promptly reimburse me that amount of the deposit. In some cases, my insurance will only cover a portion of the fees. If I have made an initial payment, it will then be applied to my balance. <b>If Genetics Center does not receive payment from my insurance carrier within 60 days from the date of my service, Genetics Center may look to me for payment in full.</b> A monthly 1.5% service charge will be added to balances over 30 days old, and a \$10 statement fee will be added to balances over 60 days old. <b>The charges for Genetics Center services are ultimately my responsibility.</b>
<b>BENEFITS AND COVERAGE CHECK IS SUBJECT TO CHANGE</b>
<b>Genetics Center cannot accept responsibility for any differences between what was quoted to them by my insurance during their courtesy benefits and coverage check (copay, deductible, etc), and the final benefit determination performed by my insurance when my claim is processed. Therefore, I may owe a different amount than what was quoted to me prior to services.</b>
<b>ACKNOWLEDGEMENT OF INDEPENDENT CONTRACTORS</b>
I acknowledge that some providers involved here are not employees, but are independent contractors, specifically including the NT practitioners, sonographers, and perinatologists.
<b>ACKNOWLEDGEMENT OF POTENTIAL BILLING BY OTHER PROVIDERS</b>
I acknowledge that there could be other providers involved, such as ultrasound, hospital, perinatologist, etc., which will have their own billing.
<b>AUTHORIZATION TO RECEIVE VOICE MESSAGES</b>
I authorize the doctor and/or facility and/or staff to identify themselves as being from Genetics Center when calling to leave a message regarding my appointment, results, or other medical information on any answering device or with another person answering the phone
<b>ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES</b>
I acknowledge that I was offered a copy of the Genetics Center's Notice of Privacy Practices.

*My signature confirms that I have read, understand, and accept these terms.*

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(or parent if minor)