GENETICS CENTER

INSURANCE AND PAYMENT INFORMATION

PATIENT INFORMATION

Patient Name (Last, First, Middle): _____

Maiden Name: _____

Date of Birth (MM-DD-YYYY): _____

Last 4 Digits of Social Security #: _____

Driver's License #: _____

Phone Number: _____

Home Address: _____

City: _____

State: _____ **ZIP Code:** _____

First time here? ◯ Yes ◯ No

Communication Preference: ◯ Mail ◯ Phone ◯ No Preference

Smoking Status: ☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Former Smoker

☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Never Smoker

Employer: _____

Work Address: _____

Work Phone: _____

Emergency Contact _____

Relationship to Patient: _____

Phone Number: _____

SPOUSE/PARTNER INFORMATION

Spouse/Partner Name (Last, First, Middle): _____

Date of Birth (MM-DD-YYYY): _____

Last 4 Digits of Social Security #: _____

Driver's License #: _____

Phone Number: _____

Employer: _____

Work Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Address: _____

Policy Number: _____ Subscriber Name: _____

Secondary Insurance: _____

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…

		Maternal	Paternal
a. Southeast Asian, Taiwanese, Chinese, or Filipino?	☐ No	☐ Yes	☐ Yes
b. Italian, Greek, Middle Eastern, Indian Subcontinent	☐ No	☐ Yes	☐ Yes
c. African or African-American (Black)?	☐ No	☐ Yes	☐ Yes
d. Jewish?	☐ No	☐ Yes	☐ Yes
e. Cajun or French Canadian?	☐ No	☐ Yes	☐ Yes
f. White? If yes, what countries are your ancestors from? _____	☐ No	☐ Yes	☐ Yes
g. Hispanic? If yes, what countries are your ancestors from? _____	☐ No	☐ Yes	☐ Yes

2. Have you, your partner, or anyone in either of your families ever had any of the following disorders?

	No	Yes
a. Chromosomal abnormalities (such as Down syndrome)	☐	☐
b. Neural tube defect (such as spina bifida, anencephaly)	☐	☐
c. Cystic fibrosis (a lung disease)	☐	☐
d. Blood disorder (such as hemophilia, sickle cell, thalassemia, clotting disorder)	☐	☐
e. Tay-Sachs/Canavan	☐	☐
f. Nerve or muscle disorder (such as neurofibromatosis, muscular dystrophy)	☐	☐
g. Bone or skeletal disorder (e.g. dwarfism)	☐	☐
h. Polycystic kidney disease/kidney abnormalities.	☐	☐
i. Heart defect (at birth)	☐	☐
j. Cleft lip/palate	☐	☐
k. Developmental delay, intellectual disability, or autism	☐	☐
l. Any birth defect or genetic condition not listed above	☐	☐
m. Needed surgery before age 1 year	☐	☐
n. Cancer in childhood or young adulthood	☐	☐
o. Non-age-related blindness or deafness	☐	☐

	No	Yes
3. Are you and your partner related by blood (such as cousins)?	☐	☐
4. Have you, your partner, or anyone in either of your families had a baby who died shortly after birth or in childhood?	☐	☐
5. Have you, your partner, or anyone in either of your families had a stillbirth or two or more pregnancy losses?	☐	☐
6. Have you or your partner had any genetic tests (such as chromosomes, cystic fibrosis, Tay-Sachs, or sickle cell screening)? Other: _____	☐	☐
7. Have you ever been diagnosed with diabetes, cancer, seizures, another serious medical condition, or genetic condition?	☐	☐
8. Do you or your partner have a history of infertility?	☐	☐

If so, specify the cause, if known: _____

Pregnancy History

	No	Yes
1. Was this pregnancy achieved through in-vitro fertilization (IVF) or other assisted reproductive methods?	☐	☐

If yes, was there: ☐ Sperm donor ☐ Egg donor ☐ ICSI ☐ Preimplantation genetic diagnosis (PGD) ☐ Other: _____

2. Have you had the California Prenatal Screening Program blood test? If yes, when? _____	☐	☐
3. Have you had Non-invasive Prenatal Testing (NIPT)? If yes, when? _____	☐	☐

4. During *this* pregnancy, have you had any of the following? (If "yes", please describe, including dates, if known):

	No	Yes
a. Cramping, vaginal bleeding or vaginal leakage of fluid	☐	☐
b. Infections, rashes, or other illness, fever over 101°	☐	☐
c. X-rays, hospitalizations, or surgery	☐	☐
d. Cigarettes, alcoholic beverages, or "street" drugs	☐	☐
e. Ultrasound ("sonogram")	☐	☐
f. Occupational, chemical, or other exposures	☐	☐
g. Prescription or non-prescription medication	☐	☐
h. Prenatal vitamins	☐	☐

If yes to any question above, please explain:

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

Completed by: _____ Date: _____

Reviewed by: _____ Date: _____

GENETICS CENTER

Recommended Prenatal Genetic Screening Tests

Patient Name: _____ **Date of Birth:** _____
(MM-DD-YYYY)

The following tests are recommended to be offered to every patient who is planning a pregnancy or who is already pregnant. The testing can determine if the pregnancy is at a higher risk than the general population of having these conditions. Currently, there is not a cure for these conditions prior to or after birth. If the risk of these conditions is higher, you would be offered further diagnostic testing. The purpose of having this information about your developing baby is so that you can prepare yourself to care for a child with special health care needs or choose to not continue an affected pregnancy. Please review the basic information regarding these conditions. If you would like more information or have further questions, your genetic counselor can answer them for you. We can also verify insurance coverage for this testing.

Cystic Fibrosis	• CF is a life long illness that causes problems with digestion and breathing. CF does not affect intelligence or appearance. In California, all infants are tested for this condition at birth through the State Newborn Screening Program. • CF is most common in individuals of European, Caucasian, or Jewish descent. However, CF has been reported in other populations as well. • To have a child with CF, both parents must carry a genetic change or mutation. • CF carrier screening does not detect all CF carriers. The detection rate varies by specific ethnic group.
I would like more information regarding this testing: ☐ Yes ☐ No	
Spinal Muscular Atrophy (SMA)	• SMA is a serious condition that causes progressive muscle weakness and paralysis. Children with SMA type 1 usually die from respiratory failure by 2 years of age. Other types of SMA are less severe, but are also disabling. • SMA affects all ethnic groups equally. The chance of being a carrier is approximately 1/50 in the general population. • To have a child with SMA, both parents must carry a genetic change or mutation. • SMA carrier screening does not detect all SMA carriers. 6-9% of carriers of SMA are not detected by current technology. • The severity of SMA cannot be predicted by genetic testing.
I would like more information regarding this testing: ☐ Yes ☐ No	

Continued on next page

GENETICS CENTER

Recommended Prenatal Genetic Screening Tests

Continued from previous page

Fragile X syndrome	• This condition is the most common cause of inherited intellectual disabilities and developmental delay in males. Behavioral abnormalities, including autism spectrum disorder, are also common. • Only females can carry the genetic mutation that causes Fragile X syndrome. Males with Fragile X syndrome are more severely affected than females with this condition. • The incidence in the general population is approximately 1/2000 to 1/4000 live births.

I would like more information regarding this testing: ◯ Yes ◯ No

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

**I acknowledge that the values and limitations of DNA testing have been explained to me, and I give my consent for testing.*

FOR COUNSELOR USE ONLY

Patient understands the information on Cystic Fibrosis, Spinal Muscular Atrophy & Fragile X syndrome.

- ☐ Patient declines Cystic Fibrosis carrier testing.
- ☐ Patient elects Cystic Fibrosis carrier testing (*also complete separate CF consent form*)*
- ☐ Patient declines Fragile X carrier testing.
- ☐ Patient elects Fragile X carrier testing. *
- ☐ Patient declines Spinal Muscular Atrophy carrier testing.
- ☐ Patient elects Spinal Muscular Atrophy carrier testing. *

GENETICS CENTER

REQUEST FOR MEDICAL INFORMATION BY

GENETICS CENTER
211 SOUTH MAIN STREET, SUITE E, ORANGE, CALIFORNIA 92868
TEL. 714.288.3500 FAX 714.288.3510

GENETICS CENTER is currently treating the patient identified below, and we are requesting that medical information for that patient be released to **GENE**TICS CENTER and forwarded to us at the above address.

Patient's Full Name: _____
(Last, First, Middle)

Date of Birth: _____

Information Requested: **Screening Results from The California Prenatal Screening Program**

*I hereby authorize release of the above records to **GENE**TICS CENTER.*

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

OR

Signing for Patient: _____ **Date:** _____

Relationship to Patient: _____

Witness' Signature: _____ **Date:** _____

GENETICS CENTER'S **Signature:** _____

Date: _____

FOR OFFICE USE ONLY
Medical Information being requested from:

Physician or Facility: California Department of Public Health - Genetic Disease Screening Program

Address: _____

City, ZIP code: _____

Phone Number: _____

Fax Number: _____

Please return a copy of this form with the records. Thank you.

Notice of Separate Fee From the California Prenatal Screening Program

The California Prenatal Screening Program has the following ***separate fees*** for participation in its program for the two different screenings:

1) $344.00 for Cell-free DNA (cfDNA) screening.
2) $85.00 for Maternal serum alpha-fetoprotein (MSAFP) screening.

The fees cover the cost of the screening and any State authorized follow up services. Please see the California Prenatal Screening Patient Booklet for further details.

For any questions regarding the above fees or any potential bills received from the State, please directly call the State at 510-412-1613, as Genetics Center is not involved in this billing.

I acknowledge that I have read this form and am aware of the separate State fee:

Signature:_____ **Date:**_____

Acknowledgment of Separate Services

I understand for certain services such as first trimester ultrasounds, nuchal translucency ultrasounds, anatomy scans, etc, Genetics Center is only coordinating/facilitating these services to be performed at the Providence St. Joseph Hospital Center for Maternal-Fetal Health. (You may also select a different facility of your choice for these services). Therefore, Genetics Center has no involvement with the charge for my service(s) and is not responsible for any bills I may receive, potential lack of coverage from my insurance company, etc, regardless of authorization from my insurance company.

For any billing and coverage questions, please contact the Providence St. Joseph Hospital Center for Maternal-Fetal Health (363 S. Main St., Suite #420, Orange, CA 92868, 714-744-8713) or the facility performing the service(s).

Patient Name (Print) _____Date:_____

Responsible Party (Print) _____
(if Different Than Patient)

Signature _____
(Patient or Responsible Party)

GENETICS CENTER

Insurance, Payment, and Other Terms

AUTHORIZATION TO RELEASE INFORMATION FOR BILLING

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.

AUTHORIZATION TO RELEASE PAYMENT(S) TO GENETICS CENTER

I irrevocably assign and transfer insurance payment(s) directly to the Genetics Center.

INSURANCE ELIGIBILITY

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.

INSURANCE AND PAYMENT TERMS

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 **all co-pays and unmet deductibles are due and must be paid at the time of service.** 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.
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. 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. **The charges for Genetics Center services are ultimately my responsibility.**

California Senate Bill (SB) 1061 Notice: A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

BENEFITS AND COVERAGE CHECK IS SUBJECT TO CHANGE

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.

ACKNOWLEDGEMENT OF INDEPENDENT CONTRACTORS

I acknowledge that some providers involved here are not employees, but are independent contractors, specifically including the NT practitioners, sonographers, and perinatologists.

ACKNOWLEDGEMENT OF POTENTIAL BILLING BY OTHER PROVIDERS

I acknowledge that there could be other providers involved, such as ultrasound, hospital, perinatologist, etc., which will have their own billing.

AUTHORIZATION TO RECEIVE VOICE MESSAGES

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

NOTICE OF OPEN PAYMENTS DATABASE

To comply with Assembly Bill (AB) 1278, I acknowledge receiving the required notice: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.
It can be found at https://openpaymentsdata.cms.gov

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Genetics Center's Notice of Privacy Practices.

AUTHORIZATION TO RECEIVE TEXT MESSAGES

[Yes ☐ No ☐] I expressly consent and authorize receipt of text messages from Genetics Center at the telephone number you provide for appointment reminders and general information related to my health care treatment, and I understand that I can opt-out at anytime.

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

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____
(or parent if minor)

GENETICS CENTER
211 South Main Street, Orange, California 92868
Tel 714.288.3500 & 888.4.GENETIC Fax 714.288.3510
www.geneticscenter.com

No-Show and Cancellation Policy

An appointment cancellation or rescheduling made with less than 24 hours notice (one business day), or a no-show, significantly limits our ability to make the appointment available for another patient in need. We understand that unforeseen circumstances may cause you to cancel. We request that you contact us promptly to cancel your appointment.

- Appointments canceled or rescheduled without a 24 hours notice will be subject to a **$25.00** cancellation fee. Please provide our office a 24 hour notice to cancel or reschedule your appointment.
- If you cancel or reschedule late (less than 24 hours) or no-show for two appointments, we cannot schedule future appointments for you.
- If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled.
- As a courtesy, we make text message and/or make appointment reminder calls a day or two in advance. This policy still remains in effect if a text message, reminder call, or voicemail is not received.

We appreciate your help in keeping our office running efficiently.

Your signature below indicates that you have read and understand the above.

Patient Name:_____

Patient Signature:_____ Date:_____