

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? <input type="radio"/> Yes <input type="radio"/> No 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	Communication Preference: <input type="radio"/> Mail <input type="radio"/> Phone <input type="radio"/> No Preference	
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:** _____



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

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

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

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

Pregnancy History

- 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: _____
- Have you had Non-invasive Prenatal Testing (NIPT)? If yes, when? _____
- During *this* pregnancy, have you had any of the following? (If "yes", please describe, including dates, if known):

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

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: _____

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	<ul style="list-style-type: none"> 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>I would like more information regarding this testing:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spinal Muscular Atrophy (SMA)	<ul style="list-style-type: none"> 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>I would like more information regarding this testing:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Recommended Prenatal Genetic Screening Tests

Continued from previous page

Fragile X syndrome	<ul style="list-style-type: none"> 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>I would like more information regarding this testing:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

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. *

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)

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 authorization and 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 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)



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

We feel that our patient's time is valuable. When your appointment is made, time is reserved, your records are prepared, and certain staff is assigned to serve you. Please remember that your appointment is reserved exclusively for you.

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. Please be courteous and call our office promptly if you are unable to keep your appointment.

- **Patients who fail to show to their scheduled appointment or do not notify the office of cancellation more than 24 hours of their scheduled appointment shall be subject to a "No Show/Cancellation" fee of \$50. In the event of an emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.**
- As a courtesy, we make text message and/or 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.

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

Patient Name: _____

Patient Signature: _____ Date: _____