Maternal Fetal Medicine of Arizona

Welcome to Maternal Fetal Medicine of Arizona.

This is the new patient packet that must be filled out. You can type in your information then print out the packet. Make sure you sign where appropriate. If you cannot type, print the packet out and fill in.

Come with the packet filled out 10 minutes before your appointment. If you choose to fill out the packet in our office, come 30 minutes before your appointment time.

If you have any questions please call the office at 480-467-3545.

Maternal-Fetal Medicine of Arizona

PATIENT INFORMATION

Date _____

Patient's Last Name _____ First Name _____ Middle Name _____

Social Security Number _____ Date of Birth _____ Marital Status _____

Mailing Address _____ Zip Code _____ City _____ State _____

Home Address _____ Zip Code _____ City _____ State _____

Home Phone(___) _____ Cell Phone (___) _____ Work Phone (___) _____ Email Address _____

Employer _____ Occupation _____

Referring Physician _____

Emergency Contact (Parent / Guardian if patient is a minor)

Name _____ Relationship _____

Home Phone(___) _____ Cell Phone (___) _____ Work Phone (___) _____

INSURANCE INFORMATION

Policy Holder's Name _____ Relationship to Patient _____

SSN _____ Date of Birth _____ Home Phone(___) _____ Cell Phone (___) _____ Work Phone (___) _____

Street Address _____ Zip Code _____ City _____ State _____

Employer _____ Occupation _____

Insurance Company _____ ID# _____ Group# _____

ADDITIONAL INSURANCE INFORMATION (if applicable)

Policy Holder's Name _____ Relationship to Patient _____

SSN _____ Date of Birth _____ Home Phone(___) _____ Cell Phone (___) _____ Work Phone (___) _____

Street Address _____ Zip Code _____ City _____ State _____

Employer _____ Occupation _____

Insurance Company _____ ID# _____ Group# _____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST.
PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

Maternal-Fetal Medicine of Arizona

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

_____ _____

(Signature of Patient or Legal Representative) Date

INSURANCE ASSIGNMENT

I hereby authorize Maternal Fetal Medicine of Arizona LLC to bill my insurance company and to receive payments on my behalf from them. I authorize the physician to release information required for filing the necessary insurance claim forms. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

(Signature of Patient or Legal Representative) Date

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ _____

(Signature of Patient or Legal Representative) Date

_____ _____

Medicare B # Date

Maternal Fetal Medicine of Arizona

FINANCIAL POLICY

The following is an explanation of our policy regarding patient accounts. Please take the time to read this policy as it describes your responsibilities for the handling of your account. If you feel that you need additional information or explanation regarding these policies, our manager will be glad to answer any questions.

Maternal Fetal Medicine of Arizona charges on a fee-for-service basis. We submit our services to your insurance company; however, you are responsible for the balance of the account and any portion not paid by your insurance. Co-payments and deductibles are due at the time of service. Please notify us of any changes in your insurance plan or coverage as soon as possible to help you in receiving benefits from your insurance.

If you are a self-paying patient, you will be required to pay for your office visits and procedures at the time of service. The front desk will be happy to provide you with an estimate of the charges.

Once your insurance has processed your claim and a remaining balance is your responsibility, you will receive a statement letting you know of the balance owed by you. The balance due from that statement is due and payable by you upon receipt and we would ask that you pay the amount due in full. Remember that your insurance coverage is between you and your insurance carrier, therefore you will need to contact your insurance carrier if you have any questions as to how your claim was processed leaving you with a balance due.

If you do not pay your account in full after 30 days for each outstanding date of service where a balance is due, a monthly billing charge of $50.00 will be applied to your account. A service charge of $35.00 will be added on all returned checks and payment will then be required by cash or credit card.

ACCEPTANCE OF TERMS

I certify that I have read and fully understand the policies of Maternal Fetal Medicine of Arizona. I realize that I am responsible for my charges and that any collection of attorney's fees will be charged to me in the event that my account is not paid in full as described in the terms and conditions above.

_____ _____

Signature (patient or legally responsible party) Date

ASSIGNMENT OF BENEFITS

I authorize Maternal Fetal Medicine of Arizona to bill my insurance company and to receive payments on my behalf from them. I authorize the physician to release information required for filing the necessary insurance claim forms.

_____ _____

Signature (patient or legally responsible party) Date

WAIVER OF ASSIGNMENT OF BENEFITS

I understand by not signing the above assignment of benefits, I will be responsible for 100% of all charges incurred at the time of service.

_____ _____

Signature (patient or legally responsible party) Date

Maternal Fetal Medicine of Arizona

PREGNANCY AND FAMILY HISTORY QUESTIONNAIRE

Patient's Name _____ **DOB**_____**Weight**_____**Height**_____

Father of the Baby's Name _____**DOB**_____

Please list any allergies to LATEX, medications or foods _____

Current Pregnancy History

What is the Date of your Last Menstrual Period? _____

What is your Expected Date of Delivery?_____

Did you have fertility treatment? (Check one) ☐Yes ☐No

If yes, what type?_____

If you used donor eggs, what was the age of the donor?_____

Have you had any prior ultrasounds (with this pregnancy)?_____

If yes, when was the ultrasound performed?_____

Have you had any screening for Down syndrome?_____

If yes, what kind?_____

Have you experienced any complications with this pregnancy (i.e. bleeding)? (Check one) ☐Yes ☐No

If yes, please explain_____

During this pregnancy have you used any medications? (Check one) ☐Yes ☐ No

If yes, please explain_____

_____

During this pregnancy have you used alcohol, cigarettes or recreational drugs? (Check one) ☐Yes ☐ No

If yes, please explain_____

Previous Pregnancy History

Total number of pregnancies (including this one) _____

Number of term deliveries (≥37 weeks) _____ Number of preterm deliveries (20-37 weeks) _____

Number of miscarriages _____ Number of terminations_____

Number of stillbirths_____ Number of ectopic pregnancies_____

Number of cesarean deliveries_____ Number of living children _____

Past pregnancies summary

#	Month/ Year	Birth/Miscarriage Termination/Ectopic	Delivery Type Vaginal/Cesarean	Birth Weight	Gender F/M	Complications before or after delivery, with you or your child
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Medical/Surgical/Family History

Do you or any member of your family (**not the father of the baby**) have any of the following conditions?

	please list who
Diabetes	
High Blood Pressure	
Heart disease	
Asthma	
Other lung disease	
Kidney disease	
Seizure disorder (epilepsy)	
Other neurological problems	
Thyroid dysfunction	
Liver disease	
Autoimmune disorder (i.e lupus)	

Have you had any surgeries? (Check one) ☐Yes ☐No

If yes please explain _____

Is there a history of any of the following conditions **in your family or the father of the baby's family**?

	please list who
Neural Tube Defect	
Congenital Heart Defect	
Other congenital defect	
Down Syndrome	
Other chromosomal abnormality	
Mental Retardation/ Fragile X	
Seizure disorder	
Sickle Cell disease	
Other blood disorder	
Tay Sachs	
Muscular Dystrophy	
Stillbirth/three or more miscarriages	
Other genetic condition	

Are you adopted? (Check one) ☐ Yes ☐ No
Is the father of the baby adopted? (Check one) ☐ Yes ☐ No
Are you and the father related by blood? (Check one) ☐ Yes ☐ No
Does the father of the baby have any children from a previous relationship? (Check one) ☐ Yes ☐ No
If yes, do they have any potential health concerns? _____
_____

Ethnic Background

What is your ethnicity (Check one):	What is the ethnicity of the father of the baby (Check one):
☐ African-American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Jewish ☐ Greek/Italian/Middle Eastern ☐ Asian	☐ African -American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Jewish ☐ Greek/Italian/Middle Eastern ☐ Asian

Patient Signature:_____ Date _____

Maternal Fetal Medicine of Arizona

HIPAA NOTICE OF PATIENT PRIVACY PRACTICES (NPP)

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

This Notice applies to all of the health records that identify you and the care you receive at Maternal Fetal Medicine of Arizona LLC.

If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

If you have any questions about this notice, please contact Ron Russell, Privacy Officer, Maternal Fetal Medicine of Arizona LLC at (480) 467-3545.

Section A: Who Will Follow This Notice

This notice describes Maternal Fetal Medicine of Arizona LLC practices and that of:

- Any health care professional authorized to enter information into your medical chart.
- All departments of Maternal Fetal Medicine of Arizona LLC.
- Any member of a volunteer group we allow to help you while you are at Maternal Fetal Medicine of Arizona LLC.
- All employees, staff and other personnel of Maternal Fetal Medicine of Arizona LLC.

All entities, sites, and locations Maternal Fetal Medicine of Arizona LLC follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or medical practice operations purposes described in this notice. This list may not reflect recent acquisitions or sales of entities, sites, or locations.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or maintained by Maternal Fetal Medicine of Arizona LLC, whether made by Maternal Fetal Medicine of Arizona LLC personnel or your personal doctor. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

• Use our best efforts to keep medical information that identifies you private;

• Give you this notice of our legal duties and privacy practices with respect to medical information about you; and

• Follow the terms of the notice that is currently in effect.

Section C: How We May use and Disclose Medical Information About You

We may share your medical information in any format we determine is appropriate to efficiently coordinate the treatment, payment, and health care operation aspects of your care. For example, we may share your information orally, via fax, on paper, or through electronic exchange.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Maternal Fetal Medicine of Arizona LLC personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of Maternal Fetal Medicine of Arizona LLC also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays. We also may disclose medical information about you to people outside Maternal Fetal Medicine of Arizona LLC who may be involved in your medical care after you leave Maternal Fetal Medicine of Arizona LLC, such as family members, clergy, or others we use to provide services that are part of your care.
- **Payment**. We may use and disclose medical information about you so that the treatment and services you receive at Maternal Fetal Medicine of Arizona LLC may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about surgery you received at Maternal Fetal Medicine of Arizona LLC, so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **Health Care Operations**. We may use and disclose medical information about you for Maternal Fetal Medicine of Arizona LLC operations. These uses and disclosures are necessary to run Maternal Fetal Medicine of Arizona LLC and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may give our your medical information to our business associates that help us with our administrative and other functions. These business associates may re-disclose your medical information as necessary for our health care operations functions. We may also combine medical information about many patients to decide what additional services Maternal Fetal Medicine of Arizona LLC should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Maternal Fetal Medicine of Arizona LLC personnel for review and learning purposes. We may also combine the medical information we have with medical information from other entities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at Maternal Fetal Medicine of Arizona LLC.
- **Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
- **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the hospital. We will generally ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at Maternal Fetal Medicine of Arizona LLC.
- **As Required by Law**. We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert A Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Section D: Special Situations

- **Organ and Tissue Donation**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the following:
  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - 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 be at risk for contracting or spreading a disease or condition;
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes**. If you or we are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement**. We may release medical information is asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at Maternal Fetal Medicine of Arizona LLC; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of Maternal Fetal Medicine of Arizona LLC to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.
- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy some of the medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. When your medical information is contained in an electronic health record, as that term is defined in federal laws and rules, you have the right to obtain a copy of such information in an electronic format and you may request that we transmit such copy directly to an entity or person designated by you, provided that any such choice is clear, conspicuous and specific. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

  We may deny your request to inspect and copy medical information in certain circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the hospital;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. The accounting will exclude certain disclosures as provided in applicable laws and rules such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, disclosures for notification purposes and certain other types of disclosures made to correctional institutions or law enforcement agencies. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on 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 use or disclose information about a surgery you had. 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, for example, disclosures to your spouse.

  We are not required to agree to your request except in limited circumstances where you have paid for medical services out-of-pocket in full and have requested that we not disclose your medical information to a health plan. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Notice of Breach**. You have the right to receive written notification of a breach if your unsecured medical information has been accessed, used, acquired or disclosed to an unauthorized person as a result of such breach, and if the breach compromises the security or privacy of your medical information. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first-class mail or, if necessary, by such other substituted forms of communication allowable under the law.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise the above rights, please contact the following individual to obtain a copy of the relevant form you will need to complete to make your request: Mr. Ron Russell, Privacy Officer, Maternal Fetal Medicine of Arizona LLC, 4852 E Baseline Rd Ste 104, Mesa AZ 85206, Phone (480) 467-3545.

Section F: Changes To This Notice.

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have as well as any information we receive in the future. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up. The footnote of our Notice will contain the Notice's effective date.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with Maternal Fetal Medicine of Arizona LLC, write to: Mr. Ron Russell, Privacy Officer, Maternal Fetal Medicine of Arizona LLC, 4852 E Baseline Rd Ste 104, Mesa AZ 85206, Phone (480) 467-3545. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Section H: Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Maternal Fetal Medicine of Arizona

Written Acknowledgement of Receipt of our Notice of Privacy Practices

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of a copy of the Maternal Fetal Medicine of Arizona, PLLC Notice of Privacy Practices.

_____

(Signature of Patient or Legal Representative)

_____

(Print Name of Patient or Legal Representative)

_____

(Relationship of Legal Representative to Patient)

_____

(Date)

Maternal Fetal Medicine
Of Arizona

Communication Use and Disclosure Authorization Form

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

1. You may email and/or leave the following messages on answering machines:

    - information regarding my appointments
    - prescription information
    - test results
    - patient statements
    - payment reminders
    - other

2. You may discuss information regarding my treatment and care with the following family members and/or friends:

    _____
    _____
    _____
    _____
    _____

3. You may contact me regarding my treatment and care at the following numbers:

    _____
    _____
    _____
    _____
    _____

_____

Signature of Patient or Legal Representative

_____

Print Name of Patient or Legal Representative

_____

Relationship of Legal Representative to Patient

_____

Date

Maternal-Fetal Medicine of Arizona

CONSENT FOR OBSTETRIC ULTRASOUND EXAMINATION

Prenatal ultrasound is a powerful method of evaluating the unborn fetus. The ultrasound begins by placing gel over your abdomen to help the technician get a picture of the baby. Then a transducer (or scanning device) is moved lightly over your abdomen making sound waves that pass through the abdomen and uterus. These sound waves bounce off of the developing baby and are sent back to the transducer. The information that comes back to the transducer is used to generate pictures of the baby, the uterus and other nearby structures. These pictures can then be seen on a monitor. Available data show that diagnostic obstetric ultrasound is **not** associated with adverse maternal, fetal or neonatal outcome.

An obstetrical ultrasound is not a treatment for any condition but is performed solely for diagnostic purposes. Information obtained can be used to evaluate the baby's growth, confirm the presence of a heart beat or detect certain birth defects. By undergoing this ultrasound, I understand that it is likely to be reassuring and confirm normal development of my baby, but I also understand that birth defects may occasionally remain undetected. Specifically, I understand that the ultrasound accuracy in detecting birth defects depends on the fetal gestational age, fetal position, maternal body habitus and that there are also certain birth defects that are not detectable at all by prenatal ultrasound.

Certain "marker" ultrasound findings may also be seen in the minority of normal fetuses. While some of these findings may slightly increase the risk of Down syndrome or other birth defects, they are usually not important in which case they may cause unnecessary anxiety.

Maternal Fetal Medicine of Arizona uses state of the art technology and clinical expertise to promote knowledge in the field of prenatal diagnosis. I therefore acknowledge my willingness to participate in clinical research as long as all patient information is anonymous (my name will not be given to others). For quality control and ongoing clinical research, I agree that I or my physician's office can be contacted at a later date to determine the outcome of this pregnancy.

- *I acknowledge that I understand the ultrasound procedure, its purpose and its limitations.*
- *I have read the above information and I consent to an obstetric ultrasound examination.*

Patient signature _____ Date _____