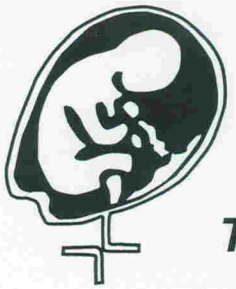

THE PERINATAL CENTER, P.A.

HIGH RISK PREGNANCY
PRENATAL DIAGNOSIS
OB-GYN ULTRASOUND

DATE _____ REFERRING MD? _____ PURPOSE OF VISIT _____
WHO REFERRED YOU TO OUR OFFICE? _____ SEEN BEFORE? _____

I. PATIENT INFORMATION

Name _____ _____
LAST FIRST M.I. PREVIOUS/MAIDEN

Address _____ _____
NUMBER STREET CITY STATE ZIP RENT/OWN

Home Phone _____ Work _____ Cell _____ Marital Status _____

Social Sec. # _____ D.L. # _____ Birthdate _____ Age _____

Employer _____ Occupation _____

Address _____ Phone # _____

SPOUSE INFORMATION

Name _____ _____
LAST FIRST M.I. PREVIOUS/MAIDEN

Address _____

_____ _____
NUMBER STREET CITY STATE ZIP RENT/OWN

Home Phone _____ Work _____ Cell _____ Marital Status _____

Social Sec. # _____ D.L. # _____ Birthdate _____ Age _____

Employer _____ Occupation _____

Address _____ Phone # _____

Name of Emergency Contact (Not living w/you) _____ **Relationship** _____
Address _____ **Phone #** _____

II. PRIMARY INSURANCE COVERAGE

Insurance Carrier _____ Address _____
Phone # _____ Insured's Name _____
Policy/Group # _____ Deductible _____ Met? _____

III. SECONDARY INSURANCE COVERAGE

Insurance Carrier _____ Address _____
Phone # _____ Insured's Name _____
Policy/Group # _____ Deductible _____ Met? _____

POS® Reorder # 1200290

THE PERINATAL CENTER, P.A.

Office Policies and Conditions for Treatment

I greatly appreciate you choosing THE PERINATAL CENTER, P.A. to contribute to your healthcare needs. Please read this letter CAREFULLY. It will help you become familiar with my practice policies. As an obstetrician and gynecologist, I have received specialized training in the care of pregnant and non-pregnant women. In addition, I trained for two additional years in a clinical fellowship in high-risk obstetrics to be able to provide this specialized care. I am board certified in my specialty and the only full private practice maternal fetal specialist in town.

Your first visit to the office involves getting to know each other and establishing lines of communication. An important part of this visit is obtaining a past and present medical history, in addition to performing an initial complete physical examination. This visit requires more time; therefore, it may be more expensive than subsequent visits. I may need to run, and sometimes repeat, some tests and examinations that are necessary to evaluate your condition. On a routine basis, all of my patients are screened for AIDS and other infectious diseases. Detecting the presence of the AIDS virus could carry negative complication to you, your pregnancy, and your family. By having this test performed, I can assist you regarding measures of prevention, exposure, and AIDS transmission and, if necessary, I may refer you to a specialist who handles infectious disease.

OFFICE HOURS: Monday through Friday, 9:00 a.m. to 5:00 p.m.

APPOINTMENT HOURS: Office visits are by appointment only Monday, Wednesday, & Thursday 8:30 a.m. to 3:30 p.m. to allow patients to be seen in a timely manner. Your appointment time is yours and I reserve the time for you alone. If you must cancel an appointment for any reason, we require at least a 48-hour notice. You may be charged for appointments canceled without notice. We understand that there are times when a notice is not possible and these situations will be handled on a case-by-case basis. Prescription refills calls will be taken Monday through Friday, 8:30 a.m. to 4:30 p.m. After office hours phone calls will be billed to you and not to your insurance at the discretion of the nurse and/or physician. (Fees vary from $15 to $75.)

EMERGENCIES: If you feel you have a medical emergency, contact your regular obstetrician or gynecologist. If I am your regular physician, call my office immediately and I will respond. If you feel that your emergency cannot wait, please call 911 or go to your hospital emergency room.

PAYMENT POLICY: It is the policy of my office to request payment of professional services when rendered. All office visit copays or payments are due at the time of your visit, unless special arrangements have been made in advance with the business office. For your convenience, VISA, MASTERCARD, Check, Cash, or Money Order are accepted. Our office will file your insurance as a courtesy, but the bill is your responsibility. In the event that collection of your account becomes necessary, you will be responsible for interest, attorney fees, and all other costs of collection efforts.

Circle one: VISA # / MASTERCARD # / DISCOVER # _____ Expiration Date: _____

SELF-PAY PATIENTS: This category includes those patients with no insurance and those patients who have an indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the service is rendered. My office accepts Visa, Mastercard, Discover, Checks, Cash, and Money Orders. If you will not be able to pay the amount due at time of service, you must contact my office to make a payment agreement with the business office before coming to see me. If you have no agreement with my office, payment in full will be expected. For your convenience, you may fill out the credit card information attached to this policy. My office does not accept Medicaid as payment. If for any reason you apply for this coverage with or without our knowledge, your bill becomes due immediately. With prior arrangements, we will assist you in collecting from these agencies. Nevertheless, the charges are your responsibility. Any balance over 30 days will accrue interest at a rate of 1.5% per month.

PHYSICIANS COVERING IN MY ABSENCE: There will be times when I may be out of town for medical seminars or personal leave. During this time there will be another physician covering my patients. Neither I, nor THE PERINATAL CENTER, P.A. will be held responsible or liable for any charges or incidents occurring during this time. You, the patient, must assume all responsibilities and liabilities during your contact with the covering physician while I am absent. Again, thank your for choosing THE PERINATAL CENTER, P.A. I look forward to taking care of your healthcare needs.

I have read and understand the above letter and I agree with the policies outlined. I hereby authorize THE PERINATAL CENTER, P.A. to furnish information to insurance carriers concerning my illness and treatments. For services rendered to my dependents and/or me, I assign all payments to The Perinatal Center, P.A. I understand that I am responsible for any amount not covered by insurance. I hereby authorize THE PERINATAL CENTER, P.A. to roll over the balance of my account to my credit card if it is more than 60 days overdue:

Date: _____ Signature for file: _____ (over please)

CONDITIONS FOR TREATMENT

1. **Medical and surgical consent for treatment:** I, the patient and/or the parent or legal guardian, hereby give consent to and authorize *The Perinatal Center, P.A. (hereafter referred to as T.P.C., PA)* to furnish me with all treatments, prescriptions, surgical procedures, anesthesia, X-ray examinations or treatments, laboratory procedures, drugs and supplies deemed necessary by the physician(s), nurses, or any employee of *T.P.C., PA*. I acknowledge that no guarantee or assurance has been made as to the results of treatment, surgery, pregnancy, infant or fetal outcomes, or examinations at *T.P.C., PA*. I hereby release *T.P.C., PA* from any and all liability arising from the fact I may have services provided by a nurse, physician's assistant, technician, or other M.D. who may be covering for *T.P.C., PA*'s physician(s), or any other physicians who may be asked to consult in my medical care.

2. **Release from liability for valuables:** I release *T.P.C., PA* from any liability due to loss or damage to any valuables. *T.P.C., PA* shall not in any event be responsible for any loss or damage to any personal property. I understand that personal valuable items should be left at home.

3. **Patient/Guarantor Agreement:**
   A. I agree, whether I sign as agent or patient, that in consideration of the services to be rendered, I hereby individually obligate myself to pay and unconditionally guarantee payment of my account(s) at *T.P.C., PA* in accordance with the regular rates and terms of *T.P.C., PA*'s policy. Payment in full is required on a timely basis regardless of whether any third party payment is pending. Should the account(s) be referred to a collection agency or an attorney for collection, I agree to pay all expenses of collection including reasonable attorney fees or collection agency fees, whether or not suit is filed.

   B. I agree to pay *T.P.C., PA* at the TIME OF DISCHARGE from the hospital or office visit the difference between what insurance is expected to pay and the estimated charges, less any deposit already paid. I agree that if *T.P.C., PA* has been unable to verify insurance coverage, I shall pay the entire estimated charges at the time of discharge or at end of my office visit or services rendered including laboratory and supplies.

   C. I hereby waive any exemptions from garnishment, attachment, or legal process in favor of *T.P.C., PA* to the extent permitted by federal or state law, as amended.

   D. I hereby WAIVE MY RIGHT TO A JURY TRIAL and agree that jurisdiction and venue shall lie solely in the State and Federal courts in and for Orange County, Florida. This waiver is for any and all actions arising out of treatment or lack thereof.

   E. I agree to hold *T.P.C., PA* harmless from all liability of any nature arising as a result of services rendered by *T.P.C., PA* physician(s), nurses, and its employees. I further agree to limit T.P.C., PA's liability as a result of services rendered to actual pecuniary loss not to exceed out of pocket expenses due to *T.P.C., PA* by the patient. I waive all claims to other damages, including damages for pain and suffering.

   F. I agree to permit *T.P.C., PA* to obtain a copy of my credit report from any credit reporting agency.

4. **Assignment of insurance benefits:**
   A. In the event I am entitled to benefits or other recovery of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient (including but not limited to private and group health and hospitalization benefits and automobile liability, personal injury protection, medical payments, and uninsured or underinsured motor vehicle benefits) such benefits or recovery are hereby assigned directly to *T.P.C., PA* for application to my bill, and I authorize direct payment to *T.P.C., PA* of such benefits of recovery. It is agreed that *T.P.C., PA* may receipt for any such payment. I am responsible for charges not covered by this assignment.

   B. I hereby assign the insurance benefits otherwise payable to me (or to the undersigned) to any involved physician(s) and I authorize direct payment to said physicians of such benefits. I am responsible for charges not covered by this assignment.

   C. Section 817.234, Florida Statutes, stipulates that "any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony in the third degree."

5. **Third Party Reviewers:** I understand and acknowledge that the insurance carrier or managed care provider, if any, responsible for payment of any services, lab tests or supplies, may request copies of my medical record, or send agents or representatives to review my medical record, the plan of treatment, and the follow-up plan, which this review may include interviewing me and may result in recommendations concerning the plan of treatment and discharge planning, and payment on claims. I hereby authorize *T.P.C., PA* to disclose my record to such third party reviewers and/or insurance companies. I acknowledge that these third party reviewers are not employees, agents, or representatives of *T.P.C., PA*, that their recommendations are not the recommendations of *T.P.C., PA*, and that they cannot make any representations, agreements or recommendations on behalf of *T.P.C., PA*.

6. **Financial information requirements:** I acknowledge that during the course of any services provided, I may be asked to provide financial information for the purposes of instituting payment arrangements, or for other business-related purposes. I hereby assure that any such information provided by me will be provided in good faith and will be accurate to the best of my knowledge.

7. **Severability:** I understand that if for any reason any part of this contract becomes null and void or is declared unenforceable by any court, that portion of the contract shall be severed and the remainder of the contract shall remain in full force and effect.

8. **Accucam photographs:** I give permission to *T.P.C., PA* to take pictures with the Accucam equipment during examination for purposes of medical documentation or for my personal education regarding my medical problem. I hereby release *T.P.C., PA* physician(s), nurses or other representatives from any responsibility or liability stemming from such pictures.

9. **Release of information:** I hereby authorize *T.P.C., PA* to disclose and release all or any part of my patient record to any person or corporation which is or may be liable under a contract to the *T.P.C., PA*, to me, or to a family member or employer, for all or part of *T.P.C., PA*'s charges, (including but not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or my employer).

10. **I AM AWARE THAT I AM RELEASING CERTAIN LEGAL RIGHTS AND HAVE CAREFULLY READ THIS DOCUMENT BEFORE SIGNING IT.**

Signed: _____ _____

Patient Date Witness Date

_____ _____

Parent or Guardian Date Witness Date

(Over Please)

THE PERINATAL CENTER, P.A.

OB/GYN • High Risk Pregnancies

Practice Financial Policy

The Perinatal Center, P.A. is here to provide you with exceptional care and personalized attention and to ensure that you have accurate information regarding our services in a caring, positive and clear manner.

The last few years have been busy regarding healthcare reform. The Insurance companies have initiated new changes that will affect the way we handle your account. There are some billing guidelines and "hints" that allow us to survive healthcare reform. Please thoroughly read and sign this sheet on the back.

1. We will collect your deductible, co-pay, uncovered services, or percent responsibility at the time of your visit. Please be prepared to pay before or after you are seen by the doctor depending on how busy the reception area is at the time of your visit.

2. Please be thorough with your insurance information if you expect us to file for you. Bring your insurance card with you and any authorization information you may have. You will be responsible for any unpaid balances due to lack of information.

3. It is at our discretion that we will charge your account with a fee to rebill if we must refile balances over 45 days old. This fee will be payable by you.

4. As a courtesy, we will file your insurance. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should, for this will decrease your balance due to us. We allow 2 months for your insurance company to pay on filed claims. After that, if no payment has been received, then it becomes your responsibility to begin payment on the balance.

5. Your insurance company will send you an explanation of benefits that explains what they have paid to our office. This is a record that you must keep on file. If you do not agree with their payment, please contact the insurance company. In many instances they will not cover what you would expect and will state that charges are beyond the agreed and customary fees. We at the Perinatal Center P.A. consider ourselves to be on top of the best HealthCare that can be provided as well as providing State of the Art Technology. We are by no means usual and/or customary in any way. We will not allow any insurance carrier to decrease their reimbursement for our services solely for their financial benefit.

6. If your insurance denies payment on your account, you will be asked to pay by check, cash, Mastercard, Visa or Discover. If you do not pay in a timely fashion, your account may be subject to a monthly finance charge consistent with the maximum amount allowed by law. In many circumstances, credit cards have lesser interest rates than our rate, therefore it is to your advantage to use your credit card. Please understand, we are not a financial institution, our business is that of offering the best health care that we can give you.

7. Cancellations: You must give us 48 hours or more notice that you are cancelling your appointment or a $50.00 charge will be added to your account. It is impossible for us to fill an empty time slot for appointments unless we have that much time.

8. HMO or PPO PATIENTS REQUIRING A REFERRAL: You are responsible for making sure all your visits to our office are authorized by your Primary Care Physician (PCP). If you do not see the doctor for six or more months, you must contact your PCP and be referred to our office again. This is NOT our policy, but the policy of the insurance companies you are contracted with. Ultimately, it is the patient's responsibility to make sure we have received authorization. If authorization is not received, the office visits will be billed to the patient.

9. SELF PAY PATIENTS: This category includes those patients with no insurance and those patients who have an indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the service is rendered. We accept Visa, Mastercard, Discover, Checks, Cash and Money Orders. If you will not be able to pay for services in full, you must contact our office to make a payment agreement before coming to see the doctor. If you have no agreement with our office, payment in full will be expected. For your convenience you may fill out the credit card information at the bottom of this policy.

10. If your insurance is out of state (except PPO insurance) you must pay for your visit at the time of service. 95% of out of state insurance companies pay the patient and will not pay us directly (even if they tell you that they will). We will not bill GHI Insurance or Blue Cross Blue Shield under any circumstances. These insurance companies pay the patient directly. Payment will be collected in full and we will provide you with all appropriate information to file with them yourself.

As a final note;

* We apologize for the inconvenience that these necessary guidelines might cause you. Please understand that you made a personal economic decision when you chose your medical insurance and this decision will also reflect your responsibility to keep up with all information regarding your insurance and your account.

* Our practice is not the cause of insurance delays and denials. We file to insurance companies expeditiously on a daily basis.

* Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you, not us. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims. By law, they must supply you with this information.

* In the event that collection of your account becomes necessary, you will be responsible for interest, attorney fees, and all other costs of collections efforts.

* If you have questions regarding this financial policy, please call BEFORE you are seen by the doctor.

_____ _____

Patient or Guardian Signature Date

IMPORTANT:

Credit Card Information:

Mastercard ☐
Visa ☐
Discover ☐

Name as it appears on card:

_____

Expiration Date: _____ Card # _____

Signature: _____

94 West Underwood Street • Orlando, Florida 32806 • Telephone (407) 425-4422 • Fax (407) 425-4294

Date:_____

I, _____ **, understand that:**

1. It is **my responsibility** to call and schedule any and all tests, consults, or procedures ordered by my physician for as long as I am his patient and in some instances for life. I also understand that it is **my responsibility** to schedule any follow up appointments to the above test or procedure when indicated. I also understand that these tests should be done as soon as possible in order to assure proper medical care. It is also **my responsibility** to choose the hospital or consultants that are contracted with my insurance company. **Failure to comply** with the above could result in inadequate or insufficient medical care and/or additional charges that will not be covered by my insurance.

2. It is **my responsibility** to make sure that Dr. Bayouth receives the results of the test(s).

3. I **will hold harmless** Dr. Bayouth and/or any other employee of The Perinatal Center, P.A. from any liability for condition(s) that might develop resulting from **my non-compliance or failure** to act immediately or on a long term basis upon this order for tests, including but not limited to, future test, follow up appointment, or consults.

4. I understand that I am relinquishing some of my rights by not complying with the above instructions. Nevertheless, I understand the above is for the best of my care and benefit.

Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Patient Name: _____

Insurance Company: _____

My insurance company requires my laboratory services to be sent to:

Please check one:

Quest _____

LabCorp _____

LabOne _____

Other (please specify) _____

It is extremely important that your lab work is sent to the correct lab for insurance purposes. The Perinatal Center, P.A. staff will not be held liable for any labs sent to the wrong location. You will be held responsible for any lab costs incurred.

Signature: _____ Date: _____

CONSENT TO TRANSFUSION OF BLOOD OR BLOOD PRODUCTS DURING SURGERY AND RHOGAM

1. I understand that the transfusion of blood or blood components may be a necessary part of my surgical procedure.

2. It has been explained to me that this procedure involves blood or a blood product being introduced into one of my veins. Depending on my physician's assessment of my needs, the transfusion(s) may be of whole blood, plasma, or some other blood product. The amount of blood or blood product transfused is a judgment my physician will make based on my particular needs. The blood or blood product to be transfused will be carefully screened to assure that it is compatible with my blood.

3. I understand that there are some risks involved in this procedure that may include but are not limited to a transfusion reaction which may cause chills, fever, headache, jaundice or allergic reaction producing itching, rash, hives, and bronchospasm (wheezing and shortness of breath). **Despite extensive testing, I understand that the risks of Hepatitis, HIV, the virus that causes Acquired Immune Deficiency Syndrome (AIDS), Cytomegalovirus (CMV) and other infectious diseases cannot be completely eliminated.** I further understand that everything possible will be done to prevent these complications but there can be no guarantee that they will not occur. I also understand that risks of the transfusion, in most cases, are less than the benefits obtained from the transfusion.

4. I understand and acknowledge that it has been fully explained to me that alternatives to this procedure include:
   A. Autologous donations (self donated blood, drawn and stored for future use) may not always be available or adequate for transfusion needs and still carries risk of adverse physiological reaction and bacterial contamination.
   B. Directed donations (donations from family or friends provided for my use) are not always available or adequate for transfusion needs and have not been demonstrated to be safer than volunteer donations.
   C. Not transfusing blood or blood products when excessive blood loss occurs may result in a drop in blood pressure thay may progress to shock, coma, kidney failure or I may suffer harm or death.

5. I certify that I understand the contents of this consent and have no questions which have not been answered to my full satisfaction.

6. I, the undersigned patient, or patient's legal representative, consent and authorize Dr. _____, and whomever he/she may designate as his/her assistants, including The Perinatal Center, P.A., its employees and its agents, to administer or transfuse blood, plasma, blood products, or blood derivatives to _____ (state name of patient or myself) deemed necessary or advisable by physician(s) attending my care during this surgical procedure.

7. If I change my mind to the above, it is my responsibility to notify The Perinatal Center, P.A. in writing of such change.

_____ _____

Patient/Legal Representative's Signature Date Witness Date

_____

Husband/Significant Other Date

Translator/Interpreter (Print Name, Address, and Phone Number)

_____

_____

THE PERINATAL CENTER, P.A.

OLIVER K. BAYOUTH, M.D.
Diplomate, American Board of
Obstetrics and Gynecology

PRENATAL DIAGNOSIS SCREENING QUESTIONNAIRE

NAME: _____ DATE: _____

1. Age at time of delivery? _____

2. Have you, the baby's father, or anyone in either family ever had a baby with:

		YES	NO
a)	Down Syndrome (mongolism)	____	____
b)	Spina Bifida or any other neural tube defect	____	____
c)	Blood or bleeding disorders	____	____
d)	Muscular Dystrophy or any other muscle or nerve disorder	____	____
e)	Cystic Fibrosis	____	____

If you answered "yes" to any of the above questions, please indicate their relationship to you _____

3. Have you or the baby's father had a child born dead or alive with any birth defects not listed in Question # 2? ____ ____

If "yes", please describe _____
_____

4. Do you or the baby's father have any close relatives with mental retardation? ____ ____

If "yes", list cause if known _____

5. Do you, the baby's father, or any close relatives in either family have any inherited genetic or chromosomal disease, disorder, or birth defect not listed in previous questions? ____ ____

   If "yes", describe _____
   _____

6. Have you had difficulty in conceiving or maintaining a pregnancy? ____ ____

7. Have you or any previous wives of the baby's father (if applicable) had 2 or more spontaneous pregnancy losses (miscarriages) or any stillborn children? ____ ____

8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? ____ ____

   If "yes", indicate who and the test results
   _____

9. If you or the baby's father are Afro-American, have either of you been screened for Sickle cell trait? ____ ____

   If "yes", indicate who and the test results
   _____

10. Excluding iron and vitamins, have you taken any medication or recreational drugs since becoming pregnant (including non-prescription drugs)? *These answers will be kept confidential.* ____ ____

    If "yes", please list _____

11. Have you been exposed to any infectious diseases that you are aware of since becoming pregnant? ____ ____

    If "yes", please indicate _____

12. Have you had any X-rays (unshielded) or accidental radiation exposure since becoming pregnant? ____ ____

13. What is the Maternal Serum Screening Test?

Maternal serum screening is a blood test available to all pregnant women. It is best to have it done between 15-18 weeks of pregnancy (counting from the first day of the last menstrual period). The purpose of the test is to identify pregnant women who may be at increased risk for having a baby with certain birth defects, such as an open neural tube defect, Down syndrome, or trisomy 18. Babies with these disorders are usually born into families in which no one else has had the same disorder.

A screening test DOES NOT provide a diagnosis; rather, it predicts the likelihood of a problem to occur. For example, cholesterol screening determines a person's risk for heart disease based on the amount of cholesterol in the blood, but it does not necessarily mean the person has heart disease. Maternal serum screening determines if a woman is at a higher or lower risk of carrying a baby with an open neural tube defect, Down syndrome, or trisomy 18.

If you do wish to be tested, please check here [ ] _____ _____
Signature *Date*

14. What is Cystic Fibrosis?

Cystic Fibrosis (CF) is one of the most common inherited diseases, affecting about 1 in 3300 people in the United States. It is most common in Caucasians, but can occur in other ethnic backgrounds.

CF causes many parts of the body to produce thick mucus leading to pneumonia, diarrhea, poor growth and infertility. Intelligence is normal. Severely affected individuals die in childhood, but some people are only mildly affected. The average lifespan is around thirty years; this may improve as scientists search for better treatments.

If someone in your family has CF, then no matter what your ethnic background, your chance of being a carrier is increased. The chance is greater if the person with CF is a close relative. Your specific risk can be determined from your family history by a doctor or by a genetic counselor.

CF carrier testing requires a small sample of blood or a cheekbrush sample obtained by rubbing a small brush inside the mouth. The results are usually ready in 10-14 days.

If you do wish to be tested for Cystic Fibrosis, please check here [ ]

_____ _____
Signature *Date*

If there is anything on this questionnaire you wish to discuss with Dr. Bayouth in greater detail, please notify the nurse or receptionist upon returning this form.

Thank you
The Perinatal Center, P.A.

I have read and understand this prenatal diagnosis and screening questionnaire.

_____
Signature

_____
Date

DRUG SCREEN AUTHORIZATION AND CONSENT

I hereby authorize and give my full consent to allow The Perinatal Center, P.A. and/or their medical company physician to collect and send a specimen of my urine and/or blood to a laboratory for a screening test following standards to test for the presence of illegal drugs, alcohol, prescription medication taken without a prescription, and a prescription or over the counter drugs which may impair my ability to safely and efficiently perform the functions of any position to which I am assigned. I also authorize and consent to the release of test results to appropriate insurance and medical professionals that might take care of me or my future infant or infants.

The Perinatal Center, P.A.'s drug and alcohol testing policy and this authorization and consent form have been explained to me in a language I understand. I have been given the opportunity to ask any and all questions I may have regarding this authorization. I understand this is a legal and binding document. I also understand that The Perinatal Center, P.A. is not responsible for payment or for any future or present deleterious effects these results may cause to me or any family member. I also understand that it is my responsibility to pay for this test if my insurance company does not pay for it.

Refusal to sign this consent form and submit to drug testing, or my refusal to sign any additional consent forms related to drug and alcohol testing as they may be requested by The Perinatal Center, P.A. results in no longer being a patient of this practice.

I also understand that I am free to revoke their authorization and consent and that, if and when I do so, I will be considered as having voluntarily resigned my patient status in The Perinatal Center, P.A. and all of my debt becomes due immediately, at the discretion of treating Physicians.

Patient Name: _____

Patient / Guardian Signature: X _____

Witness: _____

Date: _____

THE PERINATAL CENTER, P.A.
OLIVER K. BAYOUTH, M.D.
LILLIAN REGUERO, M.D., F.A.A.P.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient: _____

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other (Please provide specific details.)

_____
_____
_____

_____ _____
Employee Signature *Date*

POS® Reorder # 1200302