Obstetrics and Gynecology Associates of Central Florida
REGISTRATION SLIP

NAME _____ **DATE** _____
(last) (first) (middle)

ADDRESS _____ Apt#: _____ **MARITAL STATUS** _____

_____ **RACE** _____
(city) (state) (zip code) **ETHNICITY** _____

HOME # _____ **EMAIL** _____

CELL PHONE # _____

AGE _____ **DATE OF BIRTH** _____ **SOCIAL SECURITY #** _____

SPOUSE'S NAME _____ SS# _____

D.O.B. _____ SPOUSE PHONE# _____

PARENT'S NAME IF MINOR _____

PATIENT'S OCCUPATION _____

EMPLOYED BY _____
(name) (telephone) (ext.)

PHARMACY NAME: _____ PHARMACY PHONE #: _____

PHARMACY ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

PRIMARY PHYSICIANS ADDRESS: _____

MEDICAL INSURANCE

PRIMARY: Name of Insurance _____ Insured's Name _____

SECONDARY: Name of Insurance _____ Insured's Name _____

RELATIVE NOT LIVING IN YOUR HOME WHOM WE MAY CONTACT IN CASE OF EMERGENCY

NAME _____ PHONE # _____

ORDERED TEST:

___ (Int.) I understand that my provider at Obstetrics and Gynecology Associates of Central Florida, LLC may order additional services (Example: Blood Work, Ultrasound, mammogram, etc) and it is my full responsibility to check with my insurance regarding coverage prior to having test performed. Obstetrics and Gynecology Associates of Central Florida, LLC is not responsible for any non-covered services.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

___ (Int.) I authorize treatment of the person named above and agree to pay all fees charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless prior arrangements have been made in writing prior to billing date.

It is agreed that payments will not be delayed or withheld because of any insuance coverage or pendency of claims thereof, and proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for collection.

ASSIGNMENT OF BENEFITS:

___ (Int.) I hereby authorize Obstetrics and Gynecology Associates of Central Florida, LLC, to release to my insurance company or it representative any information including the diagnosis and the records of any treatment or examination rendered to me during one (1) year from date signed of such surgical or medical care. I also aurthorize and request my insurance company to pay directly to the above named Doctors the amount due me in my claim for basic medical, major medical and/or surgical treatment or services, by reason of such treatment or services rendered to:

___ (Int.) I agree that Obstetrics and Gynecology Associates of Central Florida LLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____
(Please print name) (Signature)

Obstetrics & Gynecology Associates of Central Florida, LLC

Date:

HPV Testing

At Obstetrics and Gynecology Associates of Central Florida, LLC we pride ourselves on offering our patients the most advanced preventative care available. We now offer our patients the only FDA-approved high risk HPV test. This test is a highly sensitive viral test used in conjunction with a pap test for cervical cancer screening in woman. Persistent infection with high-risk human papillomavirus (HPV) is the primary cause of cervical cancer. Our providers, based on clinical judgment, will provide the HPV testing to patients. If you have any questions please speak with your provider.

Patient Signature

Date

Obstetrics & Gynecology Associates of Central Florida, LLC

Date:

I, _____, give permission for the person(s) listed below, to accompany me in the exam room, to pick up **ANY** medical records on my behalf, and to speak with any employee over the telephone, **with the full knowledge that any and all past and present medical history may be divulged**. This *consent for permission is active for 1 (one) year. Any changes to this consent should be submitted in writing.*

_____ - Accept (If you checked Accept, please fill in names below)
_____ - Decline

_____	_____
First Name, Last Name	Relationship
_____	_____
First Name, Last Name	Relationship
_____	_____
First Name, Last Name	Relationship
_____	_____
Patient Signature	Date

Consent to Call

When sending artificial, prerecorded, or automated calls and text messages, receipt of prior written and/or oral consent is required by our practice. By signing below you are consenting Obstetrics and Gynecology Associates of Central Florida, LLC to send artificial, prerecorded, or automated calls/text messages to you the patient.

_____ _____

Patient's Signature Date

If you wish not to receive artificial, prerecorded, or automated calls/text messages, please sign below declining Obstetrics and Gynecology Associates of Central Florida, LLC to send.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Date

Obstetrics & Gynecology Associates of Central Florida, LLC

Date:

Medical Malpractice Insurance

Under Florida Law, physician are generally required to carry medical malpractice insurance or otherwise demonstate financial responsibility to cover potential claims for medical malpractice.

OUR PHYSICIANS HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida Law and subject to certain conditions. Florida Law imposes penalties against non insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

FLORIDA STATUTE 458.320 (5)(G)(1)

I, _____, have received and read the above statements.

Signature:_____
Date of Birth:_____

Date:

Obstetrics & Gynecology Associates of Central Florida, LLC
2400 North Orange Blossom Trail, Suite 300
Kissimmee, FL 34744
407-846-7200
Fax: 407-846-3989

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated: _____

Patient or Patient's Representative Signature: _____

Print Patient's Name: _____

If signed by Representative, state name of Representative: _____

Relationship to Patient: _____

Today's Date: _____

Do you have any problems you would like to discuss with your health care provider today?

_____

Have you been diagnosed with any of the following conditions? Please CIRCLE all that apply.

Cancer
Breast cancer or BRCA testing
Ovarian cancer
Uterine (endometrial) cancer
Colon cancer
Skin cancer
Cervical Cancer
Other cancer: _____

Cardiac – Heart
Irregular Heartbeat
Heart Disease
High blood pressure
High cholesterol
Other: _____

Dermatology – Skin
Acne
Eczema or Psoriasis
Other: _____

Ear Nose or Throat – ENT
Hearing loss
Other:_____

Endocrinology
Diabetes
Gestational Diabetes (during pregnancy)
Nipple Discharge
Bone Loss (Osteoporosis)
Thyroid Problems
Other: _____

Eyes
Cataracts
Glaucoma
Loss of sight (Macular Degeneration)

Infectious Disease
Chicken Pox or Shingles
HIV
MRSA
Rheumatic Fever
Tuberculosis (TB)
Unusual Childhood Disease
Other: _____

Neurology – Nerve Problems
Headaches or Migraines
Memory Loss or Dementia
Neuropathy or Nerve Pain
Seizures or Epilepsy
Stroke
Other: _____

Orthopedic
Chronic Back Pain
Degenerative Joint Disease
Fractures or Broken Bones
Other: _____

Psychiatric
Attention Deficit Disorder (ADD)
Anxiety Disorder
Bipolar Disease
Depression
Eating Disorder
Premenstrual Syndrome (PMS) or PMDD
Other: _____

Pulmonary
Asthma
COPD or Emphysema
Seasonal Allergies
Sleep Apnea
Other: _____

Gastrointestinal (GI)

Colon polyps
Crohn's or Ulcerative Colitis
Gallbladder Disease
Hemorrhoids
Irritable Bowel Syndrome (IBS)
Liver Disease or Hepatitis
Stomach Ulcers – Reflux (GERD)
Other: _____

Hematology – Blood Disorders

Anemia – Low Blood Count
Bleeding Disorder
Blood Clotting Disorder
Blood Transfusion
Deep Vein Thrombosis (DVT) or Pulmonary Embolism
Other: _____

Rheumatology

Arthritis (Osteo or Rhematoid)
Autoimmune Disorder or Lupus
Fibromyalgia or Chronic Pain
Restless Leg Syndrome
Other: _____

Urology

Frequent Urinary Tract Infections
Bladder Infections
Blood in the Urine (Hematuria)
Interstitial Cystitis
Kidney Disease
Kidney Stones
Urinary Incontinence or Uncontrollable Loss of Urine
Other: _____

List any and all surgery you have had and the approximate dates of the surgery.

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

List all Allergies to Medication:

_____
_____
_____

Are you Allergic to Latex: **YES OR NO**

List all medications you take **(Including over the counter medicines and vitamins).**

_____ _____
_____ _____
_____ _____

1 Last menstrual period? _____
2 Age of first menstrual period? _____
3 What age did you become sexually active? _____
4 Last Pap Smear? _____
5 Total number of lifetime partners? **Less than 5** **More than 5**
6 History of abnormal Pap Smear? **YES OR NO**
7 Are you sexually active currently? **YES OR NO**

8 Have you ever been diagnosed with a Sexually Transmitted Disease? **YES OR NO**

9 Are you trying to become pregnant? **YES OR NO**

10 Are you in a relationship? **YES OR NO**

11 What is your form of birth control?

NONE - CONDOMS - BIRTH CONTROL PILLS - IUD - HYSTERECTOMY - OTHER

12 List the number of previous pregnancy:

____ ***Living Children*** ____ ***Miscarriage*** ____ ***Abortion***

Does anyone in your close family have the following conditions?

		Relative: (Please specify Maternal or Paternal)
1.	Heart Disease or Stroke: **Yes or No**	
2.	High Blood Pressure: **Yes or No**	
3.	Diabetes: **Yes or No**	
4.	*Cancer*: **Yes or No**	
5.	Breast Cancer: **Yes or No**	
6.	Uterine Cancer: **Yes or No**	
7.	Ovarian Cancer: **Yes or No**	
8.	Colon Cancer: **Yes or No**	
9.	Other Serious Illness: **Yes or No**	
10.	Blood Clotting Disorders **Yes or No**	

P Smoke cigarettes? **YES OR NO**

Packs per day? _____ **Years?** _____

2 Drink Alcohol? **YES OR NO**

Drinks per day? _____ **Per Week?** _____

3 Street Drug Use? **YES OR NO**

4 Caffeinated beverages? **YES OR NO**

5 Do you exercise regularly? **YES OR NO**

6 Seat Belt Use? **YES OR NO**

7 Do you work outside of the home? **YES OR NO**

8 What is your highest level of education? _____

9 What type of work do you do? _____

10 What is your religious affiliation? _____

11 *Is a blood transfusion acceptable to you in an emergency situation?* **YES OR NO**

12 History of Domestic Violence? **YES OR NO**

13 Marital Status? **Single Married Divorced Widowed Partner**

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date

Obstetrics and Gynecology Associates of Central Florida, LLC
Obstetrical History Form:

Date:_____

Who have you chosen as your Pediatrician? _____
What is your racial origin? ☐Caucasian ☐African American ☐Hispanic ☐Asian Other_____

How many pregnancies have you had? _____
How many babies did you carry full term? _____
How many premature deliveries have you had? _____
How many abortions have you had? _____
How many miscarriages have you had? _____ How many weeks at the time? _____
How many ectopic pregnancies have you had? _____
How many multiple births have you had? _____
How many living children do you have? _____
When was your last menstrual period? _____ (State Unsure if not known)
Were you on any type of birth control when you became pregnant? ☐ Yes ☐ No
At what age did you begin your menstrual cycle? _____
Are your periods regular (once a month)? ☐ Yes ☐ No
How long do your periods last? _____ When was your last pap/location? _____
Have you taken a pregnancy test? ☐ Yes ☐ No When was your first positive test? _____

List below information from your last pregnancies:

	1st	2nd	3rd	4th	5th	6th
Date month/year of Delivery?						
How many weeks at the time of delivery?						
How many hours were you in labor?						
Baby's birth weight?						
Male/Female?						
Type of Delivery? (Vaginal or Cesarean)						
What anesthesia (if any) was used?						
Name of Delivering hospital?						
Did you deliver premature? If yes, did you take progesterone injections?						

List any complication you may have had with any of the above pregnancies/deliveries:

☐ Gestational Diabetes
☐ Preeclampsia
☐ Other _____
☐ Post Partum Hypertension
☐ Take baby aspirin, Lovenox, Heparin during pregnancy.

Past/Current Medial History:

Do you have a history of any of the following? If yes, please give date you were first diagnosed and list any treatment or medication you may be taking:

	Yes:	No:	If Yes, Explain:
1. Diabetes	☐	☐	
2. Hypertension	☐	☐	
3. Heart disease:	☐	☐	
4. Autoimmune disorders:	☐	☐	
5. Kidney disease/Urinary tract infections:	☐	☐	
6. Neurologic/Epilepsy:	☐	☐	
7. Psychiatric/Depression:	☐	☐	
8. Hepatitis/Liver disease:	☐	☐	
9. Varicosities/Phlebitis:	☐	☐	
10. Thyroid dysfunction:	☐	☐	
11. Trauma /Domestic violence:	☐	☐	
12. History of blood transfusion:	☐	☐	
13. Tobacco usage:	☐	☐	
14. Alcohol:	☐	☐	
15. Street drugs:	☐	☐	
16. Pulmonary (asthma/tuberculosis):	☐	☐	
17. Allergies (Drugs/Latex):	☐	☐	
18. Breast disease/cancer:	☐	☐	
19. Gynecologic surgery:	☐	☐	
20. Operations/Hospitalizations:	☐	☐	
21. Anesthesia complications:	☐	☐	
22. History of abnormal pap:	☐	☐	
23. Uterine anomaly/D.E.S.:	☐	☐	
24. Infertility:	☐	☐	
25. Cancer of breast, ovary, or uterus.	☐	☐	
26. Stroke	☐	☐	
27. Twins	☐	☐	
28. GI disorders	☐	☐	
29. Other:			

List below any symptoms you may have experienced since your last menstrual period (Example: nausea, headache, fever):

Please indicate below if you or your family (Patient, baby's father, or anyone in either family) has a history of any of the following: If yes, describe in the comments area below:

Yes	No	
☐	☐	Your age will be over 35 years when you deliver this baby?
☐	☐	Thalassemia Trait (Italian, Greek, Mediterranean, or Asian background) MCV-DO
☐	☐	Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly)
☐	☐	Congenital Heart Disease
☐	☐	Down Syndrome
☐	☐	Tay-Sachs (ED, Jewish, Cajun, French Canadian)
☐	☐	Sickle Cell Disease (African)
☐	☐	Hemophilia
☐	☐	Muscular Dystrophy
☐	☐	Cystic Fibrosis
☐	☐	Huntington Chorea

☐ ☐ Mental Retardation
☐ ☐ Other inherited genetic or chromosomal disorder
☐ ☐ Maternal metabolic disorder (PKU, Insulin dependent diabetes)
☐ ☐ Patient or baby's father had a child with a birth defect.
☐ ☐ Recurrent pregnancy loss or stillborn.
☐ ☐ Medication/alcohol/street drugs since last menstrual period.
☐ ☐ Autism

Comments:_____

_____

Yes	No	
☐	☐	Do you have or have you been treated for Hepatitis A,B, or C?
☐	☐	Do you live with someone with TB (tuberculosis)?
☐	☐	Have you ever been exposed to TB?
☐	☐	Have you or your partner ever had Genital Herpes?
☐	☐	Have you had a rash or viral illness since your last menstrual period?
☐	☐	Have you ever had an STD (sexually transmitted disease)?
☐	☐	Have you ever had the Chicken Pox?
☐	☐	Do you have cats?

Comments: _____

_____

Pre-Pregnancy weight? _____ Height?_____

Current Medication_____

Circle one:

Yes No Are you allergic to any medication?
Yes No Are you against receiving blood transfusions?
Yes No Have you felt the baby move? **If yes, When was the first time?** _____
Yes No Have you had an ultrasound? **If yes, When:**_____ **Where:**_____
Yes No Have you been treated by any other physician for this pregnancy or seen at the Emergency room? If yes, When and Where? _____

Patient Acknowledgement:

Obstetrics and Gynecology Associates of Central Florida, LLC are entering into a physician/patient relationship with you. We are reviewing your medical history and assessing our ability to care for you during your pregnancy. We are also agreeing to accept your insurance for the duration of this pregnancy. Therefore, if your situation should change, medically or financially, we may need to re-evaluate our relationship with you and it is possible that you may be discharged out of our care, if your new situation warrants a change.

Complications of pregnancy can require advanced treatment. There are physicians in our community, maternal fetal medicine specialists, who specialize in complicated, high risk pregnancy. If your pregnancy requires this type of treatment, we may refer/transfer you to a maternal fetal medicine specialist for consultation or, if necessary, for the duration of your pregnancy.

Our contractual relationship with many insurance companies limit the number of patients we may treat at any one time. For instance, we are limited in the number of patients we can care for with some insurance. If you change to one of these companies mid-pregnancy, we may need to discharge you from the practice.

Please sign below to indicate that you completed the above information to the best of your knowledge and have read and understand the patient acknowledgement.

_____ _____

Patient Signature **Date**

Obstetrics and Gynecology Associates
Of Central Florida, LLC

Date: _____

This informed consent document discusses the risk and benefits of the different ways to deliver a baby, including vaginal delivery, vacuum delivery, forceps delivery and cesarean delivery. While most deliveries are joyous events, unfortunately certain high risk conditions, or just the process of having a baby, may lead to unforeseen complications. We believe that pregnant women and their families should be aware of the different routes of delivery, so that they may make an informed decision regarding their pregnancy. As always, please ask any questions you may have. Please do not sign this form until you have read it and understand its contents.

Vaginal Delivery

I understand that vaginal delivery may have unpredictable and unforeseen complications. Some of the possible complications of vaginal delivery include (not limited to):

Shoulder dystocia (after the delivery of the baby's head the shoulders of the baby are trapped in the vagina). This is an unforeseen and unpredictable event. It is an emergency that can lead to partial or total brain or physical damage to the baby. This includes but is not limited to damage to the nerves that control the arms and hands, the spinal cord, and the baby's neck, scalp, and collar bones.

Abruption placenta (separation of the placenta from the inside wall of the uterus), this can lead to severe blood loss, coagulation disorders, maternal death, and lack of oxygen to the baby which can lead to fetal death or permanent brain damage. Often this can lead to vaginal bleeding, but not always.

Uterine atony (the uterus will not contract properly after delivery or after cesarean section). This could lead to profuse bleeding with the need for a blood transfusion, emergency hysterectomy and prolonged recovery in the hospital or intensive care unit.

Postpartum bleeding due to retained placental tissue. Despite careful technique, a small piece of placenta may remain stuck to the inside wall of the uterus after delivery. This could lead to uterine bleeding requiring uterine curettage. This procedure may not stop the bleeding for a variety of reasons (placenta accreta, uterine atony, etc.) requiring hysterectomy (remove the uterus). One of the possible consequences of such a curettage is the development of intrauterine adhesions with the possibility of future infertility.

Nerve injuries due to position, compression or effort during the delivery process. These injuries may make it difficult to walk, and may require consultation with a neurologist (nerve specialist) and may lead to long term use of crutches, walkers, or other assisting devices.

Although controversial, there is some evidence that urinary incontinence and pelvic prolapse, where the muscles surrounding the vagina weaken, are more common after a vaginal delivery than cesarean delivery. However, just being pregnant regardless of the type, may lead to an increased risk of urinary incontinence. During vaginal delivery, the baby may create a tear between the vagina and anus, an area called the perineum. This tear may occur spontaneously, or via an episiotomy. Tears and episiotomies might have consequences including, but not limited to, scar tissue formation, painful sexual intercourse, infection, the perforation of a fistula (a hole between the vagina and rectum, where gas or feces escapes into the vagina uncontrollably, bleeding and even fecal incontinence).

Vacuum and Forceps Deliveries

A vacuum extractor is a plastic cup your doctor applies to the top of the baby's head to help deliver the baby vaginally. Forceps are metal instruments that your physician places a long side the baby's head to help guide the baby through the vagina. There are many reasons why a vacuum or forceps delivery may be warranted. Your physician will discuss these with you at the time of the delivery. However, on occasion the baby's heart rate will drop dangerously at the time of the delivery, or there will be profuse bleeding. Both of these are emergencies. Some patients wish for their doctors to deliver the baby vaginally if at all possible. Due to the need to deliver the baby as fast as possible, it may be necessary to use a vacuum extractor or forceps. Some patients prefer this over a cesarean delivery, whereas other patients do not want their physician to use vacuum or forceps, and prefer a cesarean delivery.

It is always preferable to discuss these issues with your doctor prior to the time of an emergency, because it can be hard to concentrate when you are bleeding or your baby's heart rate is abnormal. We encourage you to ask any questions you may have. Vacuum and forceps each have possible risks and benefits. Vacuum devices have a higher chance of bleeding of the baby's scalp or brain and the development of jaundice. Forceps have a higher chance of damage to the mother's vagina and anus with the potential for fecal incontinence or formation of a fistula. Both have a higher chance of shoulder dystocia than spontaneous vaginal delivery and cesarean.

The risk of bleeding into the baby's brain, although uncommon, is somewhat higher for vacuum deliveries than forceps deliveries. It is least common for planned cesarean deliveries, slightly more common for spontaneous vaginal deliveries, and most common for forceps and vacuum deliveries.

Cesarean Delivery

Cesarean deliveries, sometimes called "cesarean sections," involve making an incision into the lower abdomen and delivering the baby by abdominal surgery. As described above, there are several risks versus benefits one should consider when comparing cesarean delivery to vaginal delivery. Although controversial, cesarean delivery likely decreases the risk to the baby of shoulder dystocia and injury to the baby during delivery. Cesarean deliveries may also decrease the risk of developing urinary and rectal incontinence. However, cesarean deliveries may lead to more babies needing respiration care after delivery due to amniotic fluid within the lungs.

Cesarean delivery is a major surgical procedure, which, along with all surgical procedures, has certain risk and benefits. These include but are not limited to infection, profuse bleeding (which may require blood transfusion and removal of the uterus, called a hysterectomy), blood clots (in the legs, pelvis area, abdomen, and lungs), pneumonia, damage to internal organs, (like the bladder, intestines, female organs, or muscles and nerves), and the potential for the incision to open up after the procedure. All of these may require a longer time in the hospital or intensive care unit, or the need for the further surgery or procedures. Unfortunately, undergoing a cesarean delivery may lead to scar tissue within the abdomen or uterus, making it harder to get pregnant in the future. Also, such scar tissue may lead to abdominal pain and painful intercourse. The need for blood transfusion or blood product may increase the risk of acquiring AIDS, hepatitis and other transmissible diseases. In addition, having a first cesarean delivery increases the risk of later suffering a uterine rupture during vaginal delivery which may lead to future cesarean deliveries.

_____ _____

Patient Signature Date

Obstetrical Information Consent:

Date:_____

1. I, the patient understand that Obstetrics and Gynecology Associates have many providers. Dr. Winger, Dr. Reinoso and Dr. Starr are the three providers who deliver babies in the practice. One of these providers will be on call on the day that I go into labor and any of them may deliver my baby. I agree to allow these providers to share in my care during my pregnancy.

   _____ Initial

2. There is a charge to complete all disability and FMLA forms. The charge is $15.00 per form. It will be necessary to pay the fee prior to forms being released to you. Please allow 5-7 business days for completion of forms.

   _____Initial

3. Obstetrics and Gynecology Associates provide obstetrical delivery services at Florida Hospital Celebration. We do not regularly staff any other Osceola/Orange County hospital for obstetrical care. A patient who requires emergency room care should proceed to Florida Hospital Celebration if she desires our physicians to care for her. Patients who visit any other hospital will be treated by staff physicians at the hospital and our physicians will NOT likely be notified that the patient is in the emergency room. Our physicians prefer to be involved in every part of your medical care. They encourage you to visit Florida Hospital Celebration for any medical need you may have during your pregnancy.

   _____Initial

4. Due to Hospital guidelines, all scheduled deliveries, whether by induction or by cesarean section, will be allowed only after the patient has reached a gestational age of 39 weeks or greater. We will not be allowed to schedule your delivery prior to 39 weeks unless medically necessary. But, if you go into labor on your own, this restriction does not apply.

   _____Initial

I have read the above information and understand the guidelines of the practice.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Obstetrics & Gynecology Associates of Central Florida, LLC

Date:

CONSENT TO TESTING

Cystic Fibrosis

I, the patient, acknowledge that the physicians at Obstetrics and Gynecology Associates of Central Florida have offered the carrier screening for CF. I understand that the purpose of this test is to determine if I am a carrier of Cystic Fibrosis.

____ I **DO** wish to have the CF Screening performed.
____ I **DO NOT** wish to have the CF Screening performed.

HIV:

I, the patient, have been counseled about the benefits of HIV testing & have been offered the test. I have been counseled about the treatment available to reduce the transmission of HIV from HIV infected women to their babies. With that knowledge, I hereby decline HIV testing.

____ I **DECLINE** HIV testing.

NT Screening/Sequential Screening:

I, the patient, acknowledge that the physicians at Obstetrics and Gynecology Associates of Central Florida, LLC have offered me the Nuchal Translucency Screening, also known as the NT. The purpose of this test is to screen for birth defects of my unborn child. These birth defects include Down Syndrome, Trisomy 13, Trisomy 18 and other chromosomal abnormalities. I am aware that this screening is not 100% accurate & further testing might be offered if my test comes back with an "increase risk" results. The screening consists of blood work & an ultrasound. The 2nd part of this test known as Sequential Screening is drawn between 15 & 22 weeks gestation & tests for Open Neural Tube Defects. This test may NOT be covered benefit by my insurance. I, the patient take full responsibility of all fees pertaining to this screening if my insurance does not cover it.

____ I **DO** wish to have the NT/Sequential Screening performed.
____ I **DO NOT** wish to have the NT/Sequential Screening performed.

Quad:

I, the patient, acknowledge that the physicians at Obstetrics and Gynecology Associates of Central Florida, LLC have offered the Quad Screen. I understand that the purpose of this test is to screen for birth defects of my unborn child. These birth defects include Down Syndrome, Trisomy 18 and Neural Tube Defects.

____ I Do wish to have the Quad Screening performed.
____ I DO NOT wish to have the Quad Screening performed.

All of my questions about the above offered testing have been answered.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Obstetrics & Gynecology Associates of Central Florida, LLC

Date:

Counseling Appt. Scheduled on: _____

CARRIER TESTING FOR GENETIC BIRTH DEFECTS

Our goal as a practice is to make sure your have the healthiest baby possible. About 1 out of 100 babies are born with an inherited genetic birth defect and the vast majority of these babies are born without any previous family history of that disease. The Counsyl Test screens the PARENTS for being carriers of genetic diseases. Most carriers of the disease have no symptoms and are not affected. However, if you and your partner are carriers for the same mutation, your child is at a significantly higher risk of being affected with that disease. Knowing some of these diseases ahead of time could help improve the outcome of your baby with treatment. These are some of the diseases we are looking for:

Fragile X- Causes some forms of autism
MCAD- A treatable condition that causes brain damage
PKU- A treatable condition that causes brain damage
Cystic Fibrosis- Causes lifetime breathing problems
Spinal Muscular Atrophy- Leading genetic cause of death for children under the age of two
Sickle Cell/Beta Thalassemia- Blood disease
Tay-Sachs disease- Causes neurological and mental problems
Bloom Syndrome- Causes physical abnormalities
Familial Dysautonomia- Causes Neurological problems
Gaucher Syndrome-Causes physical abnormalities
Mucolipidosis- Causes nerve disease
Canavan disease- leads to severe mental disability
Niemann Pick Disease- Causes mental disabilities
Fanconi Anemia- Causes clotting disorders and Cancer

How will my insurance pay for this?
Your Counsyl test will be billed to your insurance, and your out-of-pocket costs will never exceed **$99 (if any),** you may likely owe nothing at all. If you receive an EOB (Explanation of Benefits) from your insurance, please do not pay, as an adjustment will be made to your bill. If you have Medicaid or no insurance you would pay only $349.

I/we have been offered genetic testing by OB/Gyn Associates and its benefits. By signing below, I:

___ Request to have the Counsyl Testing done

___ Do not want the Counsyl testing done

Patient Signature: _____ Date: _____

Patient name:_____DOB:_____