New Jersey Perinatal Associates, LLC
Phone: 973-322-5287
Fax: 973-322-2309

NJPA
New Jersey Perinatal Associates
Compassionate Care. Clinical Excellence.

Tania L. Kasdaglis, MD
Sean M. Keeler, MD
Richard C. Miller, MD
Jonathan E. O'Brien, MD
Linda M. Peláez, MD
Leon G. Smith, Jr., MD
Dom A. Terrone, MD
Wendy B. Warren, MD
Edward J. Wolf, MD

Welcome to New Jersey Perinatal Associates. You have been scheduled for an appointment in our offices.

The doctors in our practice are Board Certified in Obstetrics and Gynecology with specialty training in Maternal –Fetal Medicine (high-risk pregnancies). Your doctors have requested that we provide consultative services during your pregnancy. Please read through the enclosed information in order to facilitate your visit with us.

Medical History
We would like to know about your medical history. Please fill out the following Health Information Form for that purpose.

Genetic and Family History
As part of our routine evaluation, we will ask you about your family and the father of the baby's family. If there is someone in the family with birth defects, intellectual disability or a significant genetic disease or if your ethnic backgrounds indicate that you are at risk for genetic disease in your child, it may be beneficial for you to have a thorough consultation.

Ultrasound Examination
If you are pregnant, we may be performing an ultrasound examination of your pregnancy at the time of your visit.

A full bladder **is necessary** for first trimester screening (11 weeks – 14 weeks), chorionic villi sampling (CVS), amniocentesis, targeted anatomic survey (i.e., Level II ultrasound). We would recommend **two** 8 oz glasses of non-carbonated fluid, finished about one hour prior to the ultrasound. Do not urinate. Fasting is not required.

A full bladder is generally **not** required for a transvaginal ultrasound prior to 11 weeks of pregnancy, an ultrasound after 28 weeks of pregnancy, a non-stress test (NST), or a biophysical profile (BPP).

Insurance Coverage
Please completely fill out the enclosed patient information form to assist us in processing your insurance claims. As always, you need to inquire with your insurance company before your visit to verify that the specialty services we provide are covered under your policy. In many cases, preauthorization from your primary obstetrician is needed before your appointment. If co-pay is required for specialist visits, payment will be expected at the time of your visit.

If you have any questions, please do not hesitate to call our office prior to your appointment.

Sincerely,
New Jersey Perinatal Associates, LLC

****PLEASE COMPLETE ALL FORMS AND BRING TO YOUR APPOINTMENT****
Revised 9/5/14

New Jersey Perinatal Associates, LLC
Health Information Form

Name_____ DOB____/____/____ Today's date ___/___/___

Partner's Name_____ Referred by _____

Reason for consultation today: _____

MEDICATION ALLERGIES (list drug and reaction) _____

First day of last menstrual period ____/____/____ Estimated due date ____/____/____

How did you conceive this pregnancy? [ ] Natural [ ] IVF [ ] IUI

If you had IVF or IUI, please answer the following:

[ ] Sperm donor [ ] Egg donor, age _____ Fresh or Frozen cycle? _____

Retrieval date ____/____/____ Transfer date ____/____/____ # days embryo transferred _____

PREGNANCY HISTORY (please list ALL pregnancies including miscarriages, stillbirths, ectopic, and terminations)

Year	Weeks pregnant	Miscarriage or abortion?	Birth weight	Sex	Vaginal or Cesarean	Pregnancy complications (diabetes, preeclampsia, etc.)

FAMILY & GENETIC HISTORY:

Your ethnic background: _____

The baby's father's ethnic background: _____

PLEASE CHECK YES OR NO:

	Yes	No		Yes	No
You will be 35 or older when baby is born			X-ray exposure during the pregnancy		
Father of baby 50 or older when the baby is born			Rash or fever during the pregnancy		
Medication exposure					

Name: _____ Date ____/____/____

WERE YOU, THE BABY'S FATHER, OR ANY FAMILY MEMBERS BORN WITH ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
Mental retardation or Autism			Mediterranean anemia			Neural tube defect/Spina bifida		
Down Syndrome			Sickle cell disease			Heart defect		
Fragile X			Cystic fibrosis			Birth defect		
Tay Sachs			Muscular dystrophy			Other genetic disease (which?)		

Doctor's Notes: _____

_____

YOUR GYNECOLOGIC HISTORY – HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
LEEP or Cone biopsy			Abnormal PAP smear		
Uterine abnormality (septum, bicornuate, etc.)			Sexually transmitted disease (which?)		
Uterine fibroids			Myomectomy		

Doctor's Notes: _____

_____

YOUR MEDICAL HISTORY – HAVE <u>YOU</u> HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
High blood pressure			Seizures			Anemia/Blood transfusions		
Diabetes			Hepatitis			Kidney problems		
Asthma			Thyroid disease			Lupus or other autoimmune disease		
Heart problems			Cancer			HIV		
PCOS			Bariatric surgery			Psychiatric treatment		
Other? (please describe)								

Doctor's Notes: _____

_____

CURRENT MEDICATIONS OR VITAMINS: _____

LIST ANY PRIOR SURGERIES: _____

Name: _____ Date ____/____/____

DO YOU CURRENTLY DO ANY OF THE FOLLOWING?

	Yes	No	If yes, what and how much?
Drink alcohol			
Smoking			
Drug use			

REVIEW OF SYSTEMS – DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

	Yes	No	Notes		Yes	No	Notes
1. Constitutional				7. Skin/Breast			
Fever				Masses			
Severe fatigue				Rash			
Weight loss				Pruritus			
2. Eyes				8. Gastrointestinal			
Double vision				Diarrhea			
Spots before eyes				Constipation			
Vision changes				Nausea/vomiting			
3. Ears, Nose, Throat				Bloody stool			
Ear ache				9. Neurological			
Ringing in ears				Dizziness			
Sinus problems				Seizures			
Sore throat				Numbness			
Mouth sores				10. Psychiatric			
4. Cardiovascular				Depression			
Chest pain				Anxiety			
Palpitations				11. Hematologic			
Swelling of legs				Frequent bruising			
5. Respiratory				Bleeding does not stop			
Shortness of breath				Enlarged lymph nodes			
Wheezing				12. Genitourinary			
Coughing				Blood in urine			
6. Endocrine				Painful urination			
Abnormal thirst							
Dry skin							

Competed by: [ ] Patient [ ] Nurse [ ] Physician

Signature of patient: _____

Date reviewed by physician: _____

Physician signature: _____

Follow up reviews:

Physician signature: _____ Date: _____

Physician signature: _____ Date: _____

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Instructions before your visit

Amniocentesis: 2 (8 ounce) glasses of fluid (non-carbonated). Finish drinking one hour prior to ultrasound. Do not urinate (full bladder required). Light Breakfast recommended.

CVS: 2 (8 ounce) glasses of fluid (non-carbonated). Finish drinking one hour prior to ultrasound. Do not urinate (full bladder required). Light Breakfast recommended.

First Trimester Screening: 2 (8 ounce) glasses of fluid (non-carbonated). Finish drinking one hour prior to ultrasound. Do not urinate (full bladder required). Light Breakfast recommended.

First Trimester Transvaginal Ultrasound: (up to 12 weeks pregnant): No prep required.

Ultrasound: (Second trimester targeted ultrasound): 2 (8 ounce) glasses of fluid (non-carbonated). Finish drinking one hour prior to ultrasound. Do not urinate (full bladder required). No prep required after 28 weeks of pregnancy.

Non-stress test or Biophysical profile: No prep required.

PATIENT INFORMATION **Marital Status: M S W D**

Name:_____Maiden Name: _____
Address: _____
City: _____State:_____Zip: _____
Home Phone:_____Work:_____Cell :_____
Date of Birth:_____Age:_____SS# _____
Ethnicity: _____
Partner's Name:_____Partner's DOB :_____
Emergency Contact Person:_____Relationship :_____
Phone Number_____
Pharmacy Name/Address: _____
Pharmacy Phone Number: _____
EMPLOYER:
Patient's Employer:_____Occupation:_____
Employer's Address:_____ Phone:_____
Partner's Employer:_____Occupation:_____
Employer's Address:_____ Phone:_____
REFERRING PHYSICIAN:
Doctor's Full Name:_____Phone:_____
Address:_____
Reason for today's visit:_____
First Day of Last Menstrual Period:_____Estimated Due Date:_____
Did another patient refer you to us? ☐ Yes ☐ No If Yes, who?_____
PRIMARY INSURANCE COMPANY:
Insurance Co. Name:_____Address:_____
City:_____State:_____Zip:_____
Insured's Name:_____Date of Birth:_____
Relationship to Insured:_____SS#_____
I.D.#_____Group Number:_____

The information I have provided is true and accurate to the best of my knowledge. I understand that if my insurance information changes, it is my responsibility to notify New Jersey Perinatal Associates, LLC (NJPA, LLC) prior to my next visit.
I authorize benefits due for services rendered to be paid directly to NJPA, LLC. I understand that the insurance payments may not meet the customary and reasonable fees of NJPA, LLC and that I will be responsible for any balance after insurance payments. I also understand that any late fees or insufficient fund charges will be my responsibility.
I further understand that if NJPA, LLC does not participate with my insurance company, payment for all services is expected at the time of my visit. My payments to NJPA, LLC may represent a discounted rate for the services rendered. If my insurance company reimburses NJPA, LLC for the services rendered, NJPA, LLC is responsible to refund to me only the amount that I have paid NJPA, LLC out of pocket.
Note: Laboratory fees for analyzing of amniotic fluid, chorionic villi, blood, etc. will be billed to your insurance company by the performing laboratory. NJPA, LLC has no authority over the billing policies of these laboratories.

Patient Signature:_____Date_____

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Dear Patient:

Please be advised that it is your responsibility to inform the office of any change in your insurance, home address or phone numbers.

It is important that we know what laboratory and/or radiology center your insurance will allow you to participate with. Failure to provide this information may result in fees being billed to you.

Patient
Signature_____Date_____

New Jersey Perinatal Associates, LLC

Patient name: _____DOB:_____

Acknowledgement of receipt of Notice of Privacy Practices:

1. I acknowledge receipt of the notice of privacy practices for New Jersey Perinatal Associates, LLC.
2. I understand that highly sensitive protected health information will be sent by facsimile to my primary doctor and other consulting doctors including results of genetic testing, HIV or sexually transmitted disease testing or information from federally funded drug or alcohol treatment programs.

_____ _____

Signature of Patient Date

Consent for disclosure of genetic testing to partner or designee:

1. If you authorize this office to speak to anyone other than yourself regarding your highly sensitive protected health information including results of genetic testing, amniocentesis or chorionic villus sampling, please supply name and relationship below:
2. I understand that this consent for disclosure of health information will be terminated automatically in one year unless otherwise specified by me.

_____

Authorized name and relationship (please print)

_____ _____

Signature of Patient Date

Office Staff Only:

I have given the above named patient a copy of Notice of Privacy Practices for New Jersey Perinatal Associates, LLC. I have made a good faith effort to have the above named patient sign this acknowledgement of receipt of the Notice. However, the above named patient refused to sign this acknowledgement.

_____ _____

Signature of Staff Date

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HIPAA Notice of Privacy Practices

Effective Date: October 1, 2003
Our Privacy Officer is Jennifer Josephs

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.
If you have any questions about this notice, please contact Jennifer Josephs.

I. OUR OBLIGATIONS:

We are required by law to:
· Maintain the privacy of protected health information
· Give you this notice of our legal duties and privacy practices regarding health information about you
· Follow the terms of our notice that is currently in effect

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Highly Sensitive Protected Health Information: For the purposes of your treatment we may send by facsimile highly sensitive information including results of genetic testing, HIV or sexually transmitted disease testing or information from federally funded Drug or Alcohol Treatment Program to your primary physicians and other consultants.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fund Raising Activities. We may contact you as part of our fund raising activities, as permitted by law.

III. SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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 Health 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 are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information 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 Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency 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 Health 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if 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) the safety and security of the correctional institution.

IV. YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our Privacy Officer

Right to Amend. If you feel that Health Information we have 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 our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. 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 by mail or at work. To request confidential communication, you must make your request, in writing, to our Privacy Officer Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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. You may obtain a copy of this notice at our web site, www.njperinatal.com when available. To obtain a paper copy of this notice, please ask at our reception desk

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer All complaints must be made in writing. You will not be penalized for filing a complaint.