Coast OB/GYN
DR. HIND AL-AZAWI

Hind Al-Azawi,MD
Email: patientcare@coastobgyn.com

Phone: 949-520-7078
Fax: 949-209-4177

366 San Miguel Dr. #209, Newport Beach, CA 92660

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PATIENT INFORMATION FORM

This information is confidential. We appreciate your cooperation in filling out this form as completely as possible.

Please Print Clearly _____.

Your Full Name: _____ Date: _____

Birthdate: _____ Age: _____

Home Address: _____

Phone; Home: _____ Mobile: _____

Work: _____ E-Mail: _____

Married: _____ Single: _____ Widowed: _____ Divorced: _____ Separated: _____

Social Security Number: _____ Drivers License Number: _____

Who referred you to us?: _____

Your Employer: _____ Occupation: _____

Race / Ethnicity: _____ Language: _____

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Spouse/Insured's Information:

Name: _____ Relationship: _____

Home address: _____

Birthdate: _____ Age: _____

Social Security Number: _____ Occupation: _____

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Person to contact in case of emergency: _____ Phone: _____

Relationship to the patient: _____

I/We hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Coast OBGYN. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges to services rendered for me whether or not paid by said insurance or in the event I am not eligible for insurance. I hereby authorize and assign to release all information necessary to secure payment.

Signature _____ Date:_____

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PATIENT HISTORY

Patients Name:_____ Date of Birth: _____ Age:_____

PREGNANCY HISTORY: PAST PREGNANCIES (LAST 6)

# of Pregnancies: _____	# of Premature Births: _____	# of Miscarriages: _____	# of Induced Abortions _____	# of Living Children: _____

# of Term Births	Born Month/Year	Baby's Sex F/M	Weight At Birth	Weeks Pregnant Term-40wks	Hours In Labor	Type of Delivery	Type of Anesthesia	Complications? yes/no
1	/		lbs. oz.					
2	/		lbs. oz.					
3	/		lbs. oz.					
4	/		lbs. oz.					
5	/		lbs. oz.					

MENSTRUAL HISTORY

First Day of Last Menstrual Period ____/____/____
- Menarche (Age at 1st Period):_____
- Interval (# of days between periods):_____
- Length of Period:_____

Abnormalities: (check all that apply)
_____ Excessive Bleeding ____ None
_____ Discharge
_____ Pain

HOSPITALIZATIONS (list all hospitalizations and or Surgeries)

Month / Year Illness or Operation

_____/_____ _____
_____/_____ _____
_____/_____ _____

MEDICAL HISTORY (check all that apply)
Have you or any member of your family had:

	Yes / No		Yes / No
- High Cholesterol	Y / N	- Blood Transfusion	Y / N
- Heart Disease	Y / N	- Allergies	Y / N
- Rheumatic Fever	Y / N	- Breast Problems	Y / N
- High Blood Pressure	Y / N	- Cancer	Y / N
- Asthma	Y / N	- Infertility	Y / N
- Tuberculosis	Y / N	- Female or Sexual Problems	Y / N
- Diabetes	Y / N	- Chlamydia	Y / N
- Thyroid Problems	Y / N	- Gonorrhea	Y / N
- Liver Disease	Y / N	- Herpes	Y / N
- Stomach, Bowel or Gallbladder Problems	Y / N	- Syphilis	Y / N
		- Birth Defects or Inherited Diseases	Y / N
- Kidney or Bladder Disorder	Y / N	- Sexual Abuse or Domestic Violence	Y / N
- AIDS (HIV)	Y / N	- Other Medical Problems:	Y / N
- Hepatitis (type_____)	Y / N	_____	
- Anemia or Blood Disorder	Y / N	- No Known Medical Problems	Y / N

Comments:_____
_____

GENETIC SCREENING (Includes Patient, Baby's Father or anyone in either family with):

	Yes / No		Yes / No
- Patients age is greater than 35 at time of delivery	Y / N	- Huntington's Disease	Y / N
		- Mental Retardation / Autism	Y / N
- Thalassemia (Italian,Greek, Mediterranean, or Asian background	Y / N	- Other Inherited Genetic or Chromosomal Disorder:_____	Y / N
- Neural Tube Defects (Meningomyelocele, Spina Bifida or Anencephaly).	Y / N	- Maternal Metabolic Disorder (Eg, Type 1 Diabetes, PKU)	Y / N
		- Patient or Baby's Father had a child with Birth defects not listed above_____	Y / N
- Congenital Heart Defect	Y / N		
- Down Syndrome		_____	
- Tay-Sachs (Eg,Jewish,Cajun,French Canadian)	Y / N	- Recurrent Pregnancy Loss, or a Stillbirth	Y / N
		- Medications (including supplements, Vitamins, Herbs or OTC drugs, Illicit/ Recreational drugs, Alcohol since the Last Menstrual Period._____	Y / N
- Canavan Disease	Y / N		
- Sickle Cell Disease or Trait (African)	Y / N		
- Hemophilia or other Blood Disorders	Y / N		
- Muscular Dystrophy	Y / N	_____	
- Cystic Fibrosis	Y / N	_____	

INFECTION HISTORY

	Yes / No		Yes / No
- Live with someone with TB or Exposed to TB	Y / N	- Rash or Viral Illness since last period	Y / N
- Patient or Partner has history of Genital Herpes	Y / N	- History of Sid, Gonorrhea, Chlamydia HPV or Syphilis.	Y / N

SUBSTANCE USE

- Alcohol	- Tobacco	- Caffeine	- Street Drugs
Type:_____	Type:_____	Type:_____	Type:_____
Amt/Day:_____	Amt/Day:_____	Amt/Day:_____	Amt/Day:_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Coast OBGYN may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Coast OBGYN's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Coast OBGYN reserves the right to revise it's Notice of Privacy at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Office of Coast OBGYN at 366 San Miguel Dr. #209, Newport Beach, CA 92660.

With my consent, Coast OBGYN may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Coast OBGYN may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Coast OBGYN's use and disclosure of my PHI to carry out TPO

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Coast OBGYN may decline to provide treatment to me.

_____
Print Patient's Name

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Office Staff Signature Date

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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Coast OBGYN to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Coast OBGYN to use or disclose to any laboratory, hospital, or other physicians or insurance company, the following individually identifiable health information (such as date(s) od service, level of detail to be released, origin of information, etc.): as it relates to my care at Coast OBGYN.

This authorization will expire on:_____.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization inwriting except to the extent that Coast OBGYN has acted in reliance upon this authorization. My written revocation must be submitted to the Coast OBGYN Privacy officer at 366 San Miguel Dr. #209, Newport Beach, CA 92660.

_____
Patient's Print Name

_____ _____
Patient's Signature Date

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FINANCIAL POLICY

Thank you for choosing Coast OBGYN We are committed to the success of your treatment. We hope you understand the payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctor.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any copay amount due at the time of services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are **NOT contracted** with or **DO NOT have insurance** will be required to pay as a “Out of Pocket Patient” for the initial consultation in full. For any follow up visits, patients will need to pay accordingly. There may be 30% or more down payment prior to any surgery needed.

For prescriptions, if you are in need of a refill, please have your pharmacy fax a request to **949-520-7078** (Please allow 48 to 72 hrs.) No pain medication will be given to post operative patients after 90 days of surgery. Our physician **DOES NOT** prescribe pain medications to chronic pain patients. Patients with chronic pain syndrome are referred to pain management specialists for long term management.

FEES AND PAYMENTS

Physicians share the concern of their patient regarding the increasing cost of medical care. Our fees are within the customary range for this area and reflect the high level of care you will receive. We have standardized charges for various procedures, but these can vary depending on unforeseen circumstances that might arise. If you have any questions about fees, we encourage you to discuss them with our business office. The fees for obstetrical care include all routine obstetrical care from your first visit through your prenatal care, your delivery and your post partum visit six weeks following delivery. If a cesarean birth is necessary there will be additional charges.

ALL MEDICAL BILLS ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED FOR CASH PATIENTS

We accept payments by cash, personal checks, Mastercard and Visa. This will help control the expensive process of billing and collections. If your medical services are greater than anticipated, we will be happy to arrange a payment plan with you. If you are having financial difficulty, please contact our business office.

INSURANCE

Please remember that your insurance coverage is a contract between you and your insurance carrier. Please contact your insurance company to verify that your doctor is a provider with your insurance. If you wish to file an insurance claim, we will furnish you with an itemized statement of your services and diagnosis, if one is established, and you can forward this statement on to your insurance company. Payment for services rendered is expected at the time of each

visit, regardless of your insurance coverage. In some cases, your insurance company will only cover a portion of our fees. Since our relationship is with you and not your insurance company, our bill is your responsibility. We would appreciate it if you would give it a prompt attention. We will be glad to help you if you have a problem with your claim.

PPO INSURANCE

If you are a member of a Preferred Provider Organization (PPO) and our office has signed a contract to provide services for your PPO, we will handle all the billing of your insurance. You MUST provide us with a copy of your insurance card at the time of service. You are REQUIRED to pay any co-payments at this time. If you require lab work it will be sent to an outside lab. Certain PPO's have contracts with specific labs. You will be given a referral slip and you may go to that lab for your test. If you do not ask for a referral, we will Send your specimen to our usual lab and we WILL NOT be responsible for any outside lab fees that you may be charged. We realize this can be confusing and we will work with you in any way we can to maximize your insurance benefits.

HMO INSURANCE

If you are a member of a Health Maintenance Organization (HMO) and our physicians have signed a contract to provide services for your HMO, we will handle all the billing of your insurance services. Our doctors, in this practice, cannot be listed as your primary care physicians. They are SPECIALISTS. You are required to pay any co-payments at the time of service. Please be aware that due to specific policies in HMO contracts, ALL LABS AND ULTRASOUNDS MUST be done outside our offices to be covered.

Coast OBGYN has financial interests in certain facilities/companies she operates with. These include but are not limited to: Prime Surgical Centers and Memorial Care Surgical Center at Orange Coast.

Three will be a fee of $100 for any surgery cancellation. These fees will offset the surgical preparations which are separate from the surgical facilities.

If you are insured with a plan, which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your copay amount at time of each visit.

There is a fee of $25.00 or more for all disability, FMLA and any other forms/paperwork that you need to have filled out by the physicians. We may ask that you make an appointment to complete these forms.

There is a fee for any reports or medical records requested by attorneys, insurance companies, disability companies, etc… This charge will be determined by the information requested.

Our accepted methods of payments are VISA and MasterCard, cash and checks. There will be a $45 fee for any bounced checks, thereafter, patients are required to pay with 'cash'. If requested a short payment schedule may be arranged for those patients who have special financial conditions.

It is the patients responsibility to verify their benefits for their particular plan and to make sure all proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating the doctors outside of the designated network or if the proper authorizations have not been obtained.

Again, thank you for trusting us with your gynecological and obstetrical care. If you have any questions regarding financial responsible or payment options, please contact our office.

_____ _____

Signature Date

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DISABILITY FORM POLICY

We require a one-time fee of $25.00 for all disability forms.

I have read the disability form policy and i understand that there is a fee for all disability forms.

_____ _____

Name Date Of Birth

_____ _____

Signature Date

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CANCELATION POLICY

We require a 24 hour cancellation notice for all appointments. There will be a $50 dollar charge for missed appointments unless you have notified the office in advance.

I have read the cancellation policy and I understand that there will be a charge for all missed appointments.

_____ _____

Name Date of Birth

_____ _____

Signature Date

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GENETIC CARRIER SCREENING

What is Genetic Carrier Screening?

Carrier Screening, as prescribed by your healthcare provider, is a way to identify whether you are a "Carrier" of various genetic disorders. Typically carriers are healthy individuals; but when two parents are carriers of the same genetic disorder they can have a child affected with the disorder. Knowing if you and your partner are carriers can help define your risk of having a child with that disorder.

What are the advantages of Genetic Carrier Screening?

- For patients who are not carriers, expanded carrier screening provides reassurance that their child will be at a significantly reduced risk of developing any of the included genetic disorders.
- In most cases, if both parents are found to be carriers for the same disorder, there is a significantly increased chance of having an affected child, and this knowledge can help guide future decisions.
- For couples who are found to be at increased risk for an affected pregnancy:
  - Your healthcare provider can help you understand the medical options available if you are planning on having a family.
  - If you are pregnant, you can pursue testing to determine if the pregnancy is affected, as well as work with your physician to learn about how to best care for treatable diseases.

Some of the conditions you may be screened for include:

Cystic Fibrosis (CF)	CF affects many different organs in the body, including the lungs, pancreas, and liver, lining them with an abnormally thick, sticky mucus. CF may cause chronic breathing problems and lung infections and CF patients have a lower life expectancy.
Spinal Muscular Atrophy (SMA)	SMA causes certain nerves in the brain and spinal cord to die, impairing the person's ability to move.
Fragile X Syndrome	Fragile X syndrome causes serious intellectual impairment and behavioral problems and is the most common form of inherited intellectual disability.

PLEASE MAKE A SELECTION AND SIGN BELOW:

____ I have received information from my healthcare provider regarding genetic carrier screening and Hereby ACCEPT this screening.

____ I have received information from my healthcare provider regarding genetic carrier screening and hereby DECLINE to undergo this screening, despite being advised of the benefits of this option.

Patient name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____

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HIV TESTING CONSENT

We recommend that all of our pregnant patients have AIDS testing

H.I.V. (Human Immunodeficiency Virus) is the cause of A.I.D.S. The blood test checks for this virus.
If you are at high risk for A.I.D.S. The test should be repeated at the end of pregnancy. The Following factors would place you at higher risk:

- Intravenous drug use by you or any other sexual partner (current or past).
- If you have had multiple sex partners.
- If any of your sexual partners (current or past) have had multiple sexual partners.
- Prior blood product transfusion by you or any sexual partner (curent or past).

If you think you are at higher risk for A.I.D.S. Please inform your physician. If you have any Questions, please ask us.

YES, I wish to undergo A.I.D.S. testing

_____ _____
Signature Date

NO, I refuse to undergo A.I.D.S. I understand H.I.V. infection is a possible risk for me, my baby, and my sexual partners, but i do not want to be tested.

_____ _____

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IMAGING AND LAB PROCEDURES

Please be aware that imaging, including mammograms and lab procedures recommended by your doctor, may not be covered by your insurance.

It is important for you to contact your insurance to ask if these services are covered under your policy. Covered benefits may be subject to deductible, co-insurance and copays.

These procedures are coded according to your health needs, These codes may be routine screening or specific diagnostic codes.

Codes cannot be changed, once the orders have been written and the procedure is done.

Print Name: _____ Date: _____

Signature: _____ Date: _____

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Dear Patient,

Every patient I have the opportunity to care for is entitled to and will receive the best care that we can provide. Taking into account medical seminars, meetings and periodic vacations, it is humanly impossible for any physician to be available 24 hours a day, 365 days a year. I will do my best to be there for your delivery, but may not be available when you deliver. This does not mean that you will not receive the medical attention that you require.

When I am not available, another equally qualified doctor will provide medical care for you. These arrangements help assure us that you will be cared for by a physician who is Able to function at peak efficiency. The on-call physician will provide care for labor and Delivery, gynecological problems and emergency room visits.

In case of emergency, please call my office phone number and the exchange will put you In contact with the on-call physician. If you are having an emergency, and your callus not Returned immediately, proceed directly to the hospital or call 911. In case of non-emergency Calls, the on-call physician will call you back as soon as possible.

When calling the physician for a problem, please have your pharmacy's phone number Ready in case a medication needs to be prescribed.

If you have any questions, please do not hesitate to ask at the time of your visit.

Sincerely,

_____

Hind Al-Azawi, MD

I ACKNOWLEDGE RECEIPT OF THIS LETTER.

PATIENT SIGNATURE_____ DATE:_____

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CORD BLOOD RELEASE FORM

Dear Patient,

Did you know what Umbilical Cord Blood Stem Cells can be used to treat nearly 80 diseases, including several forms of cancers and blood related diseases, immunity and metabolic disorders and disease, such as leukemia and lymphomas?

Future applications such as regenerative medicine are also in an emerging area of medicine that will help treat many diseases that have previously been through to be untreatable. Currently, there Are over 3,000 clinical trials worldwide that involve researching the application of stem cells to treat Injuries and disease, and that number will continue to grow.

As of February 2007, California state law requires care providers to inform expecting parents of their Options regarding preserving umbilical cord stem cells.

The options for umbilical cord blood stem cells include the following:

- Discarding the stem cells as medical waste
- Donating the stem cells to a public bank for public use or for research
- Preserving the stem cells with a family cord blood bank for exclusive use for your child or immediate family

I acknowledge that i have been informed about the options concerning my newborn's umbilical cord blood.

Should i wish to obtain additional information about umbilical cord blood stem cell preservation, I fully understand that this responsibility will be solely and completely my own.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date