

Prenatal Diagnosis Screening Questionnaire

Patient:

Last Name: _____ First Name: _____ DOB: _____

Father of Baby:

Last Name: _____ First Name: _____ DOB: _____

Father's Occupation: _____ and Education: _____

1. How old will you be when the baby is due? _____
2. Have you been diagnosed with phenylketonuria? ___ Yes ___ No
3. Have you, the baby's father, or anyone in either family ever had the following?
 - a. Down's Syndrome ___ Yes ___ No
 - b. Spina Bifida or Open Spine Defect ___ Yes ___ No
 - c. Hemophilia ___ Yes ___ No
 - d. Muscular Dystrophy ___ Yes ___ No
4. Do you or the baby's father have any close relatives who have mental disabilities? ___ Yes ___ No
If YES, describe: _____
5. Have you or the baby's father had a child born dead or alive with a birth defect not listed in question #3. ___ Yes ___ No
If YES, describe: _____
6. Do you, the baby's father, or a close relative in either of your families have any inherited genetic or chromosomal diseases or disorders not listed above? ___ Yes ___ No
If YES, describe: _____
7. Have you or a previous partner of this baby's father had 3 or more spontaneous pregnancy losses? ___ Yes ___ No
If YES, describe: _____
8. What race do you consider yourself? _____
9. Are either you or the baby's father of Ashkenazi or Jewish heritage? ___ Yes ___ No
If YES, have either of you been screened as carriers of Tay - Sachs disease? ___ Yes ___ No
10. If you or the baby's father is African- American, have you been tested as a carrier for sickle cell trait? ___ Yes ___ No
If YES, describe: _____
11. If you or the baby's father is of Italian, Greek, or other Mediterranean heritage, have you been screened for anemia (Thalassemia)? ___ Yes ___ No
If YES, describe: _____
12. If you or the baby's father are Caucasian or Ashkenazi Jewish, have you been screened as cystic fibrosis carriers? ___ Yes ___ No
If YES, describe: _____

Fee Schedule for Obstetrical Patients

Full Routine Obstetric Care, Vaginal Delivery CPT Code = 59400
Full Routine Obstetric Care, Cesarean Delivery CPT Code = 59510
Antepartum Care Only >7 visits CPT Code= 59426
Vaginal Delivery Only CPT Code= 50409
VBAC Only (Vaginal birth after previous cesarean) CPT Code= 59612
Cesarean Section Only CPT Code= 59514
Post-Partum Care Only CPT Code=59430

Most insurance plans pay for routine pregnancy visits, delivery, and delivery follow-up (post-partum) care with a single payment, known as a “global OB package fee.” What they consider as routine or normal, however, can vary from plan to plan.

Antepartum care is 13 visits. This includes the initial and routine subsequent history and physical exams, Patient’s weight, blood pressure, fetal heart tones, and routine urinalysis. Beginning with visit 14, evaluation and management codes will be billed, and **there may be a copayment** depending on your insurance coverage.

Please Note:

- Medical management of problems that are not related to pregnancy such as bladder, vaginal or lung infections, allergies, rashes, etc.- are billed separately as an office visit from the global OB package, the same way it would be if you had gone to an urgent care center or to your Primary Care Physician. Insurance covers them, but separately, and **there may be a copayment**, depending on your insurance plan.
- High-risk conditions in pregnancy that require greater evaluation and treatment than covered by your insurance plan may also need to be billed separately from a global fee. Examples of these could be diabetes or high blood pressure.
- Any special testing or medications received during the course of your pregnancy care is an additional charge. These charges are billed to your insurance carrier at the time of testing. They may include: Amniocentesis, non-stress testing, ultrasound, and genetics testing.
- We perform a 20-week ultrasound to verify your due date, screen for fetal anatomy, and location of the placenta. We feel this is an important test and recommend that you have this done. However, if there is no medical indication for this, it will be billed as a routine screening. Some insurance companies may or may not pay for this. Please check with your insurance company, if there is a medical indication we will use that diagnosis. The cost for the ultrasound is approximately \$ 765.

1651 W. Lake Lansing Road T 517.253.3910
Suite 300 F 517.253.3911
East Lansing, MI 48823
901 S. Oakland Suite 102 T 989.227.3435
St. Johns, MI 48879 F 989.227.3436

SMG OB/GYN
Lake Lansing & St. Johns

Please notify us at once of any changes in your insurance carrier, coverage, or policy numbers. Please check with your insurance regarding any prior authorization requirements for your hospital stay. Failure to do so could adversely affect your insurance benefits for both Physician and hospital charges.

Prior authorization requirements are the responsibility of the Patient for all insurance carries.

We DO NOT accept responsibility for this, regardless of what your insurance company may state.

_____	_____
Patient name (Please Print)	DOB
_____	_____
Patient's Signature	Date

Sometimes an insurance plan requires additional documentation to approve payment for something done that is beyond the global OB package fee. Occasionally, they may initially refuse payment for these charges, and pass them on to you. If you have any questions or problems with your bill, or wonder what you might be responsible for in the future, please talk with our billing specialist, at 517.364.7999 or 855.221.0336. She also has voice mail for your convenience. We want to give you not only the best medical care we can during your pregnancy, but also the best experience.

Sincerely,

The providers and staff of
SMG OB/GYN Lake Lansing
SMG OB/GYN St. Johns

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Lake Lansing & St. Johns

Sparrow Hospital Obstetrics and Maternity Care Services Agreement for Hospital Care

At Sparrow Hospital's Labor and Delivery Unit, we will do everything possible to give you the best care in your upcoming delivery. We provide:

- Obstetric care 24 hours a day, 365 days a year
- Experienced professionals that deliver thousands of babies every year
- A supportive environment during labor, birth, and after delivery

The doctors that **may** take care of you include: your personal Physician, other hospital Physicians, Resident Physicians, Nurses, Anesthesia Staff, and Pediatricians.

When you first come to the hospital, you will be seen by the Resident Physician who will evaluate you and call your personal physician group. If you are to be admitted to the hospital, a member of your personal physician group will be in charge of your care and present for your delivery. There will be times, though rare, when a member of your personal physician group may not be available for your delivery. If a member of your physician group is not available, Sparrow Hospital will provide another qualified obstetric physician to care for you.

The doctors that will provide your care may be male. There is no guarantee that a female Physician will deliver your child.

Your pregnancy and the birth of your baby will be one of the most exciting and emotional experiences of your lifetime. At Sparrow Hospital, we are honored to have the opportunity to share this wonderful event with you and your family. We are looking forward to meeting and caring for you!

I understand that the care provided to me by the staff of Sparrow Hospital Obstetrics and Maternity Care Services:

- May not always be the Physician that provided my prenatal care
- May include male Physicians

Patient name (Please Print)

DOB

Patient Signature

Date

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1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

**Communication with
Family & Friends Involved in My Care
or Payment of My Care**

Patient's Name: _____

Birth date: _____

Patients may allow family and friends, such as spouse, parent(s), significant others, guardians or others, to call and discuss medical information, request prescriptions, obtain vaccine information, request test results, pick-up completed forms (i.e., FMLA, sport physicals), and have messages left on answering machines or voicemail. They may also designate an individual to accompany them to medical appointments.

Completion of this form authorizes the release of the information identified above, to the individuals indicated below.

1. Name: _____ Phone #: _____ Relationship: _____

I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

(Please check all that apply)

- Receive information regarding appointments, including dates & times, and to pick up completed forms
- Discuss medical care or concerns including test results, prescriptions, and vaccines
- Accompany patient to appointments (Parent/guardian must still provide consent to treat.)
- Other (describe) _____

2. Name: _____ Phone #: _____ Relationship: _____

I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

(Please check all that apply)

- Receive information regarding appointments, including dates & times, and to pick up completed forms
- Discuss medical care or concerns including test results, prescriptions, and vaccines
- Accompany patient to appointments (Parent/guardian must still provide consent to treat.)
- Other (describe) _____

3. Name: _____ Phone #: _____ Relationship: _____

I authorize representatives of Sparrow Health System to allow the person listed above to do the following:

(Please check all that apply)

- Receive information regarding appointments, including dates & times, and to pick up completed forms
- Discuss medical care or concerns including test results, prescriptions, and vaccines
- Accompany patient to appointments (Parent/guardian must still provide consent to treat.)
- Other (describe) _____

I understand that the individual receiving my information is not a health care provider or health plan covered by state or federal privacy laws and regulations and that the information described above may no longer be protected by those laws and regulations.

I understand that I may revoke or change this authorization by sending notification to the Sparrow Health Information Management at the address above or by communicating with my Sparrow Medical Group office.

Signature of patient/parent/guardian

Date & Time