PATIENT INFORMATION

COTTONWOOD

(PLEASE PRINT)

NAME_____ EMAIL ADDRESS _____

DOB____/____/_____ MARITAL STATUS_____ AGE_____ SOCIAL SECURITY # _____/_____/_____

ADDRESS _____ APT# _____
STREET CITY STATE ZIP

HOME PHONE_____ CELL PHONE_____ BUSINESS PHONE _____

EMPLOYER_____ OCCUPATION_____ REMINDER CALL PREFERENCE
TEXT___ VOICE MESSAGE___

SPOUSE/GUARDIAN_____ DOB____/____/_____ SOCIAL SECURITY # _____/____/_____

EMPLOYER_____ OCCUPATION_____ CELL PHONE _____

YOU ARE HERE TO SEE: _____ DR. BARTON _____ DR. CRACROFT _____ DR. FROERER _____ DR. GIBSON
_____ DR. GILBERT _____ DR. KAELBERER _____ DR. PIERSON _____ DR. THACKERAY

REFERRED TO OUR OFFICE BY: _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU_____ PHONE _____

ADDRESS _____

PRIMARY INSURANCE:_____ ADDRESS _____

GROUP #_____ POLICY #_____

POLICY HOLDER: ____SELF ____SPOUSE ____FATHER ____MOTHER ____STEPFATHER ____STEPMOTHER

*IF POLICY HOLDER IS OTHER THAN SELF OR SPOUSE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

POLICY HOLDER'S NAME_____ INSURED'S DOB____/____/_____

INSURED'S SOCIAL SECURITY # _____/_____/_____ ADDRESS_____

SECONDARY INSURANCE:_____ ADDRESS _____

GROUP #_____ POLICY #_____

POLICY HOLDER: ____SELF ____SPOUSE ____FATHER ____MOTHER ____STEPFATHER ____STEPMOTHER

*IF POLICY HOLDER IS OTHER THAN SELF OR SPOUSE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

POLICY HOLDER'S NAME_____ INSURED'S DOB____/____/_____

INSURED'S SOCIAL SECURITY # _____/_____/_____ ADDRESS_____

DR. BARTON, DR. CRACROFT, DR. FROERER, DR. GIBSON, DR. GILBERT, DR. KAELBERER, DR. PIERSON, & DR. THACKERAY are specialists in Obstetrics and Gynecology. **Each patient, not the insurance company, is responsible for payment of all charges at the time services are rendered. This includes copays, deductibles and percentages not covered by insurance.** We cannot bill the insurance company for maternity benefits until after delivery for those who are covered by insurance. If you are not covered 100% by your insurance company, we require that the portions that are not covered be paid prior to delivery. **We will help with all pre-authorizations,** however, it is the patient's responsibility to inform us of their correct insurance and to make sure any hospital stay or extension of stay has been pre-authorized. Any financial arrangements other than those stated above will need prior approval from our business office. The patient is responsible for payment of charges within 30 days following services. If this account is sent to collections, I agree that in addition to any amount owing, I will be responsible for interest at the rate of 18% annually on any past due balance calculated from the date of service, plus court costs and reasonable attorney's fees with or without suit, incurred in collecting any past due balance and a collection fee.

I HEREBY AUTHORIZE COTTONWOOD OB/GYN TO FURNISH MY DESIGNATED INSURANCE CARRIER ALL INFORMATION CONCERNING MY PRESENT ILLNESS OR INJURY. I ALSO AUTHORIZE BENEFITS UNDER THIS CLAIM TO BE MADE DIRECTLY TO COTTONWOOD OB/GYN.

SIGNATURE _____ DATE _____

Prenatal Record

COTTONWOOD OB GYN

Jeffrey H. Barton, M.D. ☐
Mallorie J. Cracroft, M.D. ☐
Christian D. Froerer, M.D. ☐
Daniel F. Kaelberer, M.D. ☐
Spencer E. Pierson, M.D. ☐
Steven M. Thackeray, M.D. ☐

PATIENT NAME LAST, FIRST MI

ALLERGIES

PATIENT ADDRESS _____ CITY _____ STATE/ZIP _____ TODAY'S DATE _____

PATIENT PHONE: HOME _____ WORK _____ BABY'S FATHER _____ LAST _____ FIRST _____ HOSPITAL FOR DELIVERY _____

INSURANCE _____ POLICY HOLDER _____ GROUP# _____ POLICY# _____

MOTHER OF BABY					
FATHER OF BABY					

GRAVIDA _____ TERM _____ PREMATURE _____ MISCARRIAGES/ ABORTIONS _____ LIVING _____ MULTIPLE BIRTHS _____

1										
2										
3										
4										
5										
6										
7										

GENETIC RISK FACTORS

☐ 1 - Drug, medication or radiation exposure in 1st trimester
☐ 2 - Family Hx of birth defects
☐ 3 - Previous fetus / infant with a birth defect
☐ 4 - Age > 35 at time of delivery

Personal or family history of:

☐ 5 - Tay sachs
☐ 6 - Sickle cell trait / disease
☐ 7 - Thalassemia

Personal or family history of: (continued)

☐ 8 - Huntington chorea
☐ 9 - Cystic Fibrosis
☐ 10 - Muscular Dystrophy
☐ 11 - Hemophilia
☐ 12 - Spina Bifida / Anencephaly
☐ 13 - Down Syndrome
☐ 14 - Hydroencephaly
☐ 15 - Other

MEDICAL RISK FACTORS

☐ 30 - Seizure disorder
☐ 31 - Stroke
☐ 32 - Thyroid disease
☐ 33 - Diabetes mellitus
☐ 34 - Cardiac disease
☐ 35 - Hypertension
☐ 36 - Lung disease
☐ 37 - Gastrointestinal disease
☐ 28 - Surgeries
☐ 29 - Drug allergy
☐ 40 - Liver disease
☐ 41 - Renal disease
☐ 42 - Venous thrombosis / Pulmonary embolism
☐ 43 - Blood disease / transfusion
☐ 44 - Cancer
☐ 45 - Organ Transplant
☐ 46 - Psychiatric disease
☐ 47 - HIV
☐ 48 - Other

OBSTETRICAL RISK FACTORS

☐ 16 - Previous stillbirth/neonatal death
☐ 17 - Previous infant admitted to NICU
☐ 18 - Previous infant with IUGR
☐ 19 - Abruption in prior pregnancy
☐ 20 - Placenta previa in prior pregnancy
☐ 21 - Previous cesarean section
Scar type
☐ 22 - Previous infant > 9 pounds
☐ 23 - History of fetal distress in labor
☐ 24 - History of preeclampsia
☐ 25 - History of poly/oligohydramnios
☐ 26 - History of recurrent UTI
☐ 27 - Antibody sensitization
☐ 28 - Multiple gestation
☐ 29 - History of Gestational Diabetes
☐ 30 - History of Group B Strep
☐ 31 - History of Chicken Pox

OTHER FACTORS OF INTEREST TO CONSIDER

☐ 49 - Age < 18 or > 35
☐ 50 - Black race
☐ 51 - Weight < 55 kg
☐ 52 - History of STDs
☐ 53 - Previous uterine surgery
☐ 54 - Known uterine malformation
☐ 55 - Prior preterm birth (37 weeks)
☐ 58 - Incompetent cervix
☐ 57 - DES exposure
☐ 58 - 2 or more abortions requiring D&C
☐ 59 - Drug abuse (including alcohol)
☐ 60 - Smoking
☐ 61 - Psychosocial / physical abuse
☐ 62 - Other

Interviewer's Signature _____ Date faxed to Health Plans _____

PHYSICAL EXAMINATION

	1 - SKIN		9 - EXTREMITIES
	2 - HEENT		10 - PELVIS (NL + ADEQ)
	3 - NECK		11 - VAGINA
	4 - BREASTS		12 - CERVIX
	5 - LUNGS		13 - UTERUS
	6 - HEART		14 - ADNEXA
	7 - ABDOMEN		15 - RECTUM
	8 - MUSCULOSKELETAL		16 - OTHER

NOTES

EXAMINER'S SIGNATURE _____

PLANS / EDUCATION / COUNSELED

☐ PTL / Labor Signs
☐ Lifestyle, Tobacco, Alcohol
☐ Nutrition Counseling
☐ Travel
☐ Physical / Sexual Activity
☐ Childbirth Classes
☐ Anesthesia
☐ L & D Preferences
☐ VBAC Counseling
☐ Breast or Bottle Feeding
☐ HIV Counseling
☐ Environmental / Work Haz.
☐ PP Birth Control
☐ Genetic Counseling
☐ Circumcision
☐ Baby's Dr.
☐ Tubal Sterilization Informed Consent Signed ____/____/____ Approval#
Other

NAME ____________ PARA ____________ LMP ____________ EDC ____________

LABORATORY EXAMINATION

Blood Group	Hep B	Pap Smear	Menses ☐Reg ☐Irreg	U/S
RH Type	Rubella	Date:	Interval:	
Antibody	Serology / RPR	Integ. Screen	Gluc. Screen	U/S
Father's BT	HIV	Quad	3° GTT ___/___/___/___	
RhoGAM	GC / Chlam	CF DNA	GBS:	Urine Cx:
Hct. Δ / Δ			Prenatal Sent: (1)	(2)

PERINATAL CARE

POSTPARTUM EXAM

Childbirth Prep	
Vaccines: Tdap: Flu:	
Anesthesia	
P.P. Contraception ☐Desires BTL	
Feeding ☐Breast ☐Bottle	
Baby's Doctor	

PROBLEMS/RISK FACTORS & PLANS

Ht Pre-Pregnancy Wt.

PRENATAL EXAMINATIONS

DATE	WEEKS	WEIGHT	BP Systolic / Diastolic	URINE Protein / Sugar	FUNDUS CM	FHR	STA	POS	CERVIX Eff. / Dil	COMMENTS: Include all medications, treatments, illnesses, diarrhea, flu, colds, virus infections, fever, etc.

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Cottonwood OB/GYN
5063 S. Cottonwood St. Suite 400
Murray, Utah 84107
801-507-1950

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Cindi Townsend	801-507-1950	N/A
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

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Cindi Townsend	801-507-1950	N/A
HIPAA COMPLIANCE OFFICER	Phone	email

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

Cottonwood OB/GYN

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Persons Authorized to Use or Disclose the Above Information:

Cottonwood OB GYN Physician and Staff

Persons to Whom Information May Be Disclosed: _____

_____

_____

(Name of person or organization)

Expiration Date of Authorization
This authorization is effective through (check one) ☐ _____/_____ OR ☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

_____

Name of patient (Please/Print) Date of Birth

_____

Signature of Patient Date

_____

Signature of Patient Representative (if applicable)

_____

Relationship of Patient Representative to Patient (if applicable)

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Cottonwood OB-GYN Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) ***Date***

_____

Signature