Perinatal Diagnostic Center, Inc.

Daryoush Jadali, M.D., F.A.C.O.G.

Patient Demographics

Today's Date: _____

Name_____
First Middle Last

DOB ____/____/____Social Security_____-_____-_____ Driver's License_____

Address_____

City_____ State_____ ZIP_____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____ Pref. Contact Method_____

Employer_____Occupation_____ Marital Status: M S D W

Race/Ethnicity: ◯ White ◯ Black ◯ Hispanic/Latina ◯ Native American ◯ Hawaiian ◯ Chinese ◯ Japanese ◯ Korean ◯ Guamanian ◯ Samoan ◯ Filipino ◯ Vietnamese ◯ Cambodian ◯ Lao ◯ Other Southeast Asian ◯ Middle Eastern ◯ Indian Subcontinent ◯ Other:_____

E-Mail_____@_____

INSURANCE INFORMATION

Primary Insurance_____ ID #_____ Group #_____

Subscriber Name_____Relationship_____ DOB___/____/____SS#_____

Secondary Insurance_____ ID #_____ Group #_____

Subscriber Name_____Relationship_____ DOB___/____/____SS#_____

EMERGENCY CONTACT

Name _____ Phone ( ) _____

Family and Friends Authorization (Persons authorized to receive your medical information.)

Name: _____ Name: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I directly assign all medical benefits to **Daryoush Jadali, MD, F.A.C.O.G. Perinatologist** and understand that I am financially responsible for all charges, whether or not paid by my insurance company. I also understand that I am responsible for any and all collection fees that may be incurred. I authorize **Daryoush Jadali, MD, F.A.C.O.G. Perinatologist** to release all necessary information to secure payment of benefits. I further agree that a copy of this agreement shall be as valid as the original. I also give my permission for **Daryoush Jadali, MD, F.A.C.O.G. Perinatologist** to provide my medical care, or the medical care of my dependent.

Patient/Guardian Signature_____ **Date**_____

New Patient History

Name: _____ DOB: _____

Height_____ Blood Type_____ LMP: _____ Due Date: _____Allergies_____

Current Medications/Vitamins: _____

Who is your OB Doctor and Location? _____

In this pregnancy, do any of the following apply to you?

- ○ Vaginal Bleeding
- ○ Changes in vaginal discharge
- ○ Pelvic pressure/cramping
- ○ Headaches
- ○ Nausea and/or Vomiting
- ○ Weight loss
- ○ Tobacco Use
- ○ Alcohol Use
- ○ Drug Use
- ○ Fever or night sweats
- ○ Rashes
- ○ UTI
- ○ Dizziness
- ○ Swelling
- ○ High Blood Pressure
- ○ Depression
- ○ Psychiatric Condition
- ○ Prior Ultrasound
- ○ Abnormal Ultrasound
- ○ Abnormal blood test
- ○ Amniocentesis
- ○ Heart Palpitations
- ○ CVS (chorionic villus sampling)
- ○ Anxiety
- ○ Domestic Violence

Are you and the father of the baby blood related? Y N
Is this a Surrogate Pregnancy? Y N

Past & Present Pregnancies

Total Pregnancies Including Current: _____ Miscarriage: _____ Abortions/Terminations: _____

Ectopic: _____ Twins/Triplets: _____ Living Children: _____

Date of Delivery	Gestational weeks	Birth Weight	Baby's Sex	Hours of Labor	Delivery Type	Anesthesia Used	Place of Delivery	Comments/ Complications
			M F					
			M F					
			M F					
			M F					
			M F					
			M F					
			M F					

IVF ONLY		
CIRCLE: IVF or IUI pregnancy	**CIRLCE: DONOR or OWN egg**	**CIRCLE: FRESH or FROZEN egg**
Age of Donor:	**Transfer Date:**	

1. Are you less than 19 years old?	**Y**	**N**	19. Did you ever have positive PPD, exposure to tuberculosis or history of BCG vaccine?	**Y**	**N**
2. At time of delivery, will you be 35 or older?	**Y**	**N**	**20.** Do you have history of urinary tract infections?	**Y**	**N**
3. Have you terminated more than 2 pregnancies?	**Y**	**N**	**21.** Have you ever had renal (kidney) disease?	**Y**	**N**
4. Have you had more than 2 miscarriages in a row?	**Y**	**N**	**22.** Have you had or currently have gestational or pre-gestational diabetes? If so, were/are you medicated?	**Y**	**N**
5. Did you have a newborn weighing less than 5lb. 8oz.?	**Y**	**N**	**23.** Do you have a history of hypo- or hyper-thyroids?	**Y**	**N**
6. Did you have a newborn weighing more than 9lb. 8oz.?	**Y**	**N**	**24.** Any history of an autoimmune disease, like Lupus?	**Y**	**N**
7. Have you had a child with a birth defect?	**Y**	**N**	**25.** Do you have a history of hematologic disease, like anemia?	**Y**	**N**
8. Did you have a fetal demise in 2nd or 3rd trimester?	**Y**	**N**	**26.** Any history of deep vein thrombosis or pulmonary embolus?	**Y**	**N**
9. Did you have a baby born before 37 weeks?	**Y**	**N**	**27.** History of neurologic disease? Even Migraines?	**Y**	**N**
10. Have you ever had a cerclage?	**Y**	**N**	**28.** Any history of gastrointestinal disease, like Hepatitis?	**Y**	**N**
11. Have you had a cesarean section?	**Y**	**N**	**29.** Do you have HIV?	**Y**	**N**
12. Did you ever have placenta abruption?	**Y**	**N**	**30.** Have you had an HIV test?	**Y**	**N**
13. Did you ever have placenta previa?	**Y**	**N**	**31.** Do you have or are a carrier of Cystic Fibrosis?	**Y**	**N**
14. Any history of fetal isoimmunization?	**Y**	**N**	**32.** Any history of varicella (chicken pox/shingles)?	**Y**	**N**
15. Do you have history of pregnancy induced hypertension?	**Y**	**N**	**33.** Have you had a rash or any viral illness since your last period?	**Y**	**N**
16. Do you have chronic hypertension or high blood pressure?	**Y**	**N**	**34.** Any history of orthopedic problems?	**Y**	**N**
17. Do you have a heart disease?	**Y**	**N**	**35.** Have you ever had cancer of any kind?	**Y**	**N**
18. Do you have pulmonary disease/ asthma?	**Y**	**N**	**36.** Any significant skin/dermatologic problems?	**Y**	**N**

Gynecological History	**Genetic History**	
○ Infertility	○ Cystic Fibrosis	○ Huntington's Disease
○ Abnormal Pap Smear	○ Thalassemia	○ Mental Retardation
○ Abnormal Uterus	○ History of other Birth defects_____	○ Hemophilia
○ Fibroids/ Myomas	○ Muscular Dystrophy	○ Autism
○ Herpes/STD's	○ Tay-Sachs Disease	○ Sickle cell carrier
○ Hepatitis B or C	○ Jewish decent	○ Heart
○ Ovarian Cyst	○ French Canadian/Cajun decent	○ Down Syndrome
○ Irregular Periods	○ Other genetic or chromosome abnormality _____	

Family's Medical History: (parents, siblings, grandparents, cousins, etc.) Please Check anything that applies.

○ Diabetes	Relationship:_____	○ High Cholesterol	Relationship:_____
○ Hypertension	Relationship:_____	○ Renal Disease	Relationship:_____
○ Cancer	Relationship:_____	○ Psychiatric Disorder	Relationship:_____
○ Twins/Triplets	Relationship:_____		

Perinatal Diagnostic Center, Inc.

Daryoush Jadali, M.D., F.A.C.O.G.

2100 Lynn Rd., Suite 125, Thousand Oaks, Ca 91360 29 N Brent St, Ventura, Ca 93003
23101 Sherman Pl., Suite 304, West Hills, Ca 91307 14901 Rinaldi St, Unit 320, Mission Hills, Ca 91345
Phone: (805) 643-9781 Fax: (805) 494-6825

REQUEST FOR MEDICAL INFORMATION

Perinatal Diagnostic Center, Inc. is currently treating the patient identified below, and we are requesting that medical information for that patient be released to **Perinatal Diagnostic Center, Inc.** and forwarded to us at the above address.

Patient's Full Name: _____

Date of Birth: _____

Patient's Signature: _____ **Date:** _____

Information Requested: Perinatal Screening Results

I hereby authorize release of the above records to **Perinatal Diagnostic Center, Inc.**

OFFICE USE ONLY

Medical Information being requested from:

Facility: California Department of Public Health, Genetic Disease Screening Program

Or

Physician

Name: _____

Address: _____

City: _____ **Zip:** _____

Phone: _____ **Fax:** _____

Please return a copy of this form with the records. Thank you.

Perinatal Diagnostic Center, Inc.

Daryoush Jadali, M.D., F.A.C.O.G.
Phone: (805) 643-9781 Fax: (805) 494-6825

OFFICE POLICY ON PAYMENT OF SERVICES

Dr. Jadali is a Perinataologist specializing in the field of maternal-fetal medicine and the care of high risk pregnancy. Your obstetrics physician has requested a consultation and ultrasound with Dr. Jadali.

Services for a normal pregnancy at your OB physician office include the following: all the services at your OB physician are billed to the insurance as global billing. One fee for 12-13 prenatal visits, 1 ultrasound, non-stress test, delivery and 1-2 postpartum visits, with one co-pay due for global billing.

Services received during your visit with Dr. Jadali are outside of normal pregnancy care. All services: office visits, ultrasounds and amniocentesis services are billed; fee for service to your insurance company.

Co-pay is due at each visit as Dr. Jadali is a specialist.

All services will be billed to your insurance company. Insurance carriers will only pay for services which are a covered benefit of your insurance policy, deemed reasonable and medically necessary.

The patient or insured is responsible for payment if any and all Deductibles, Co-insurance, Co-pays and any other balance not paid to your insurance company.

In the event you're insurance company denies a service for payment; by determining that a particular service is experimental, investigational, not a medical necessity or not a covered benefit of your policy, it is understood that you are responsible for full payment of all such services. A statement will be sent monthly for all patients' responsible balances and is due in full upon receipt.

Genetic counseling is provided by genetic Genetics Center. Genetic counseling and related lab work (Amniocentesis, DNA Analysis, etc.) is a separate charge from the ultrasound services. Genetic Center will be billing your insurance for the counseling visit. You will receive a separate charge and bill from Genetics Center.

PSP Program (California Prenatal Screening Program) will pay for one (1) office consultation and one (1) Ultrasound only. All follow up visits and ultrasounds are billed to your medical insurance.

3-D/4-D Ultrasounds is not a benefit of most insurance company policies and is only covered in the event of a fetal abnormality. The procedure code for the 3D ultrasound is 76376; you may call your insurance to verify if they will cover this type of service.

I acknowledge by requesting a 3D ultrasound for entertainment purposes during the course of my care, I am responsible for full payment of the 3D ultrasound.

I understand that I am responsible for the payment of all services incurred. As a courtesy my insurance will be billed for me. I authorize the insurance benefits to be paid directly to the provider, Perinatal Diagnostic Center, Inc.; Daryoush Jadali, M.D.

Signature: _____ **Date:** _____

Perinatal Diagnostic Center, Inc.

Daryoush Jadali, M.D., F.A.C.O.G.

Payment Policy

Thank you for choosing us as your Perinatologist. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any question you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefit is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and Deductibles. All co-payments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-Covered Services.** Please be aware that some-and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information promptly, you may be responsible for the balance of a claim.
5. **Claim Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you have secondary insurance that is not provided and causes an issue with coordination of benefits that leads to your claim being denied you will be responsible. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.
8. **Missed Appointments.** Our policy is to charge $25.00 for missed appointments not canceled within 24 hrs. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment.

Our practice is committed to providing the best care to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient/Responsible Party Signature **Date**

Perinatal Diagnostic Center, Inc.

Daryoush Jadali, M.D., F.A.C.O.G.

HIPPA Notice of Privacy Practices

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 how we may use and disclose your protected health information (PIH) 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 or 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 bill, to support the operation of the physicians 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, tour protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review qualities, training of medical students, licensing, 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 in 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 your or remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These saturation 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, and organ Donation: Research: Criminal Activity: Military Activity and National Security: workers Compensation: Inmates: Required uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With your Consent, Authorization of Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated on the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. **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 purpose 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 whom 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 a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. **You have the right to request to receive confidential communications 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 receive an accounting of certain disclosures we have made, if any, of your protected health information**. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or 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 privacy contact of your complaint. We will not relate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

Signature_____ **Date:**_____