The Midwives & Associates, Inc.

NAME_____
Last First MI

DATE OF BIRTH_____MARITAL STATUS_____

ADDRESS_____
Street City State Zip Code

HOME #_____WORK#_____CELL#_____

SOCIAL SECURITY#_____FAMILY DOCTOR_____

YOUR EMPLOYER_____LOCATION_____

___SPOUSE ___SIGNIFICANT OTHER: NAME _____
(please check one)

DATE OF BIRTH_____ SOCIAL SECURITY#:_____

EMERGENCY CONTACT#_____INSURANCE_____

SUBSCRIBER_____SUBSCRIBER'S EMPLOYER_____

RELATIONSHIP_____SECONDARY INS:_____
(Ex: husband/ parent)

HOW DID YOU HEAR ABOUT US?_____

New regulations are now in effect as to how we handle your protected health information. This is known as HIPAA (Health Insurance Portability & Accountability Act of 1996). We will provide a copy of our "Notice of Privacy Practices" to you. We request your signature to verify that you have received this information. In the questions below, we are giving you the opportunity to specify how we may communicate with you and you may designate others to also be given your health information.

Release of Information

It is the policy of The Midwives & Associates, Inc. and staff to not release protected health information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we will not leave health information if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

over…

I authorize The Midwives & Assoc. Inc. and staff to communicate health information pertaining to my care by the following methods and will assume responsibility to notify them when this information changes:

Home Telephone	____Yes ____No	Answering Machine	____Yes ____No
Work Telephone	____Yes ____No	Voice Mail	____Yes ____No
Cell phone/or voice mail	____Yes ____No	Pager	____Yes ____No

Any special requests in contacting you or confirming appointments? _____

_____

Please list names of authorized people with whom we may discuss your care:

Spouse_____ _____Yes _____No

Parent_____ _____Yes _____No

Others: Name _____Relationship _____

Name _____Relationship _____

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Client/GuardianSignature_____Date_____

Print Name _____ Relationship if not self_____

Assignment of Benefits

I hereby authorize The Midwives & Associates, Inc. to release to my insurance carriers or its intermediaries, any information needed for processing my claims, including the medical record. I request payment of medical benefits to The Midwives & Associates, Inc. I understand that any service not covered by my insurance company is my responsibility to pay.

Client/Guardian Signature_____Date_____

Print Name_____ Relationship if not self_____

Responsible party: Please complete ONLY if you are a minor:

Mother's Name:_____SS#:_____DOB:_____

Father's Name:_____SS#:_____DOB:_____

Other Responsible party:_____SS#:_____DOB:_____

Address:_____Phone#:_____

The Midwives & Associates, Inc

Health History Summary

Date:

Name _____

Age ____ Date of birth _____ Race or ethnicity _____ Religion _____ Marital status _____ Years married _____ Education _____

Social Security Number _____ Occupation _____ Work Tel. no. _____ Home Tel. no. _____

Alternate contact _____ Relation to patient _____ Work Tel. no. _____ Home Tel. no. _____

Referring physician _____ Attending physician _____

Medical History

Check and detail positive findings including date and place of treatment. Precede findings by reference number.

	Self	Family
1. Congenital anomalies	☐	☐
2. Genetic diseases	☐	☐
3. Multiple births	☐	☐
4. Diabetic mellitus	☐	☐
5. Malignancies	☐	☐
6. Hypertension	☐	☐
7. Heart disease	☐	☐
8. Rheumatic fever	☐	☐
9. Pulmonary disease	☐	☐
10. GI problems	☐	☐
11. Renal Disease	☐	☐
12. Genitourinary tract problems	☐	☐
13. Abnormal uterine bleeding	☐	☐
14. Infertility	☐	☐
15. Venereal disease	☐	☐
16. Phlebitis, varicosities	☐	☐
17. Neurologic disorders	☐	☐
18. Metabolic./endocrine disorders	☐	☐
19. Anemia/hemoglobinopathy	☐	☐
20. Blood disorders	☐	☐
21. Drug abuse	☐	☐
22. Smoking/Alcohol use	☐	☐
23. Infectious diseases	☐	☐
24. Operations/accidents	☐	☐
25. Allergies/meds sensitivity	☐	☐
26. Blood transfusions	☐	☐
27. Other hospitalizations	☐	☐
28. _____	☐	☐
29. _____	☐	☐
30. No known disease/problems		

Menstrual History	Onset (age)	Cycle (q. / days)	Length (days)	Amount	LMP

Pregnancy History	Grav	Term	Pret	Abort	Live	EDC

#	Month/ year	Sex	Weight at birth	Wks. gest.	Hrs. in labor	Type of delivery	Details of delivery: Include anesthesia and maternal or newborn complications. Use Risk Guide numbers where applicable.
1							
2							
3							
4							
5							
6							
7							
8							

Preexisting Risk Guide

Indicates pregnancy/outcome at risk

31. ☐ Age <15 or > 35
32. ☐ < 8th grade education
33. ☐ Cardiac disease (class I or II)
34. ☐ Tuberculosis, active
35. ☐ Chronic pulmonary disease
36. ☐ Thrombophlebitis
37. ☐ Endocrinopathy
38. ☐ Epilepsy (on medication)
39. ☐ Infertility (treated)
40. ☐ 2 abortions (spontaneous/induced)
41. ☐ ≥ 7 deliveries
42. ☐ Previous preterm or SGA infants
43. ☐ Infants ≥ 4,000 gms
44. ☐ Isoimmunization (ABO, etc.)
45. ☐ Hemorrhage during previous preg.
46. ☐ Previous preeclampsia
47. ☐ Surgically scarred uterus
48. ☐ Preg. without familial support
49. ☐ Second pregnancy in 12 months
50. ☐ Smoking (≥ 1 pack per day)
51. ☐ _____
52. ☐ _____
53. ☐ _____

Indicates pregnancy/outcome at high risk

54. ☐ Age ≥ 40
55. ☐ Diabetes mellitus
56. ☐ Hypertension
57. ☐ Cardiac disease (class III or IV)
58. ☐ Chronic Renal disease
59. ☐ Congenital/chromosomal anomalies
60. ☐ Hemoglobinopathies
61. ☐ Isoimmunization (Rh)
62. ☐ Alcohol or drug abuse
63. ☐ Habitual abortions
64. ☐ Incompetent cervix
65. ☐ Prior fetal or neonatal death
66. ☐ Prior neurologically damaged infant
67. ☐ Significant social problems
68. ☐ _____
69. ☐ _____
70. ☐ _____

Historical Risk Status

71. ☐ No risk factors noted
72. ☐ At risk
73. ☐ At high risk

_____
Signature

HEALTH HISTORY SUMMARY

OBSTETRICAL CLIENT MEDICAL HISTORY

Yes	No	Do you:	Comments:
( )	( )	1. Have Diabetes?	_____
( )	( )	2. Have seizures or epilepsy?	_____
( )	( )	3. Have kidney disease?	_____
( )	( )	4. Does your husband/boyfriend have a history of treatment for cancer?	_____
( )	( )	5. Have any dermatological disorders including skin moles, acne, light or dark patches of skin?	_____
( )	( )	6. Have rheumatoid arthritis or systemic lupus crythematosis (SLE)?	_____
( )	( )	7. Have a history of being on a special diet as a baby or small child due to PKU or another condition?	_____
( )	( )	8. Have any other medical condition not mentioned?	_____
( )	( )	9. Know the results of your routine prenatal blood test for rubella (german measles)? ( ) immune ( ) susceptible (non immune)	_____
		FAMILY HISTORY	
( )	( )	10. Are you 35 years old or older?	_____
( )	( )	11. Is your husband/boyfriend 55 years old or older?	_____
( )	( )	12. Are you and your husband/boyfriend blood relatives? (e.g. cousins)?	_____
( )	( )	13. Are you or your husband/boyfriend of : ( ) Jewish ( ) Black ( ) Mediterranean descent?	_____
( )	( )	14. Have you had a stillbirth or more than one miscarriage?	_____
( )	( )	15. Have any birth defects, handicapping condition or disorder that might be hereditary?	_____
( )	( )	16. Have any previous children with birth defects, handicaps, or genetic disease?	_____
( )	( )	17. Have any children who died (other than in accidents)?	_____
( )	( )	18. Have a brother, sister, or parent with a handicap, birth defect or genetic disorder?	_____
( )	( )	19. Have uncles, cousins, nieces, nephews, grand-parents with birth defects or genetic disorders?	_____
( )	( )	20. Know of any family member with mental retardation (even mild) or learning disabilities?	_____

Have you or anyone in your family experienced any of the following? Check which apply.

( ) Anencephaly (open skull)
( ) Malformation or birth defects
( ) Cerebral Palsy
( ) Neurofibromatosis
( ) Deafness
( ) Sickle cell anemia
( ) Heart defect
( ) Hemophilia (bleeding tendency)
( ) Hydrocephalus (water on brain)
( ) Kidney disease
( ) Limb defects
( ) Bone disorders
( ) Muscular Dystrophy
( ) Cystic fibrosis
( ) Short stature (under 5 ft)
( ) Epilepsy or seizures
( ) Skin disease (including dark or light patches)
( ) Urinary tract abnormality
( ) Other
( ) Blindness or eye problems
( ) Mental illness
( ) Cleft lip/palate
( ) Neurologic or degenerative disorder
( ) Downs syndrome
( ) Skeletal problems (easily broken bones or curvature of the spine)
( ) Spina bifida (open spine)
( ) Infertility

ENVIRIONMENTAL EXPOSURES HISTORY

Yes	No	Have you…
( )	( )	21. Taken ay prescription drugs or over the counter medications since becoming pregnant or since your last period? _____
( )	( )	22. Taken any of the following since becoming pregnant or since your last period? Check any that apply

( ) Accutane or other dermatologic or acne medications
( ) Antibiotics such as Tetracycline or Streptomycin
( ) Anticoagulants (blood thinners)
( ) Anti-thyroid drugs
( ) Birth control pills
( ) Chemotheraputic drugs (anti-cancer)
( ) Diet pills
( ) Female hormones
( ) Male hormones
( ) Medications for epilepsy
( ) Multi-vitamins
( ) Steroids
( ) Tranquilizers
( ) Vitamin A supplements
( ) Other high dose vitamins
( ) Herbal supplements

( )	( )	23. Have any illness or infection during pregnancy?
( )	( )	24. Had fever over 101 or taken saunas or hot whirlpool baths during pregnancy?
( )	( )	25. Had x-rays or surgery since becoming pregnant?
( )	( )	26. Been exposed to anesthetic gases, lead , other heavy metals or radiation in your occupation?
( )	( )	27. Been exposed to pesticides or potentially toxic chemicals at home or elsewhere?
( )	( )	28. ( ) Drink well water ( ) or city water ( ) or bottled water?
( )	( )	29. Drink more that one glass of alcohol per week (including beer)?
( )	( )	30. Have a household cat?
( )	( )	31. Clean a cat litter box?
( )	( )	32. Eat raw or very raw meat?
( )	( )	33. Smoke more than ½ pack of cigarettes per day?
( )	( )	34. Use any other drugs or medications not previously listed?
( )	( )	35. Has rape, incest, domestic violence or other violence been a part of your life?

Our Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Our Pledge Regarding Your Health Information

The Privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements. We may not use or disclose any more of your health information than is necessary. Below we have described the ways we may use and share your health information about you. We also describe your rights and certain duties we have regarding the use and disclosure of your health information.

Our Legal Duty .

The Law Requires Us To:

1. Keep your health information private
2. Give you this policy describing our legal duties, privacy practices and your rights regarding your health information.
3. Follow the terms of the notice that is now in effect.

We Have the Right To:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and make the new terms effective of our notice effective for all health information that we keep, including information previously created or received before the change.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Health Information .

Under the law, we may use and disclose health information for many different reasons. We will not use or disclose your health information for any purpose not listed below, without your specific written authorization. If you give us an authorization, you may revoke it in writing at any time.

For Treatment:
We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, midwifery students or other people who are taking care of you.
Example: * Our backup physician requires details of your health information in order to advise the midwife in your care.
*The perinatologist or other specialist we have referred you to for testing and consult requires information on your prenatal lab results.
*The pharmacist needs information about other medications you are taking.

We may share medical information with your other health care providers to assist them in treating you.

For Payment:
We may use and disclose your health information for payment purposes.
Example: *We may need to give your health insurance plan information about care you received at our organization so that your health plan will pay us or repay you for any care that you paid for.
*We may need to give your health information to your insurance company in order to get approval or to determine if your plan will pay for services.

For Health Operations:
We may use and disclose your health information to support our business activities. Examples of this would include internal quality assurance or employee evaluation, employee training, and getting necessary credentialing and certificates.

Family and Others Involved in Your Health Care:
We may share health information to the extent necessary to obtain help from a family member or other person you indicate is involved in your care. This may include information to your employer for disability or leave of absences. In the event emergency treatment is needed, we will use our professional judgement to act in your best interest in sharing information with family or your representative. This may include such things as picking up filled prescriptions, x-rays, or other protected health information.

Disaster Relief:
Health information may be shared with a public or private organization authorized by law, for the purpose of providing disaster relief.

Our Notice of Privacy Practices

Research, Funeral Directors, Coroner, Organ Donation:
We may use or disclose your health information for research purposes in limited circumstances. We may disclose health information to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Public Health Activities:
We may disclose your health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your health information to a government agency authorized to oversee the health care system or government programs or its contractors and to public heath authorities for public health purposes.

Victims of Abuse, Neglect, or Domestic Violence:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes.

Required by Law:
We may disclose your health information when we are required to do so by law. For example, we must disclose health information to the U.S. Department of Health and Human Services upon request to determine whether we are in compliance with federal privacy laws. We may disclose your health information when authorized by worker' compensation or similar laws.

Process and Proceedings:
We may disclose your health information to an authorized agency providing health oversight activities such as audits. We may disclose information in response to a court or administrative order, subpoena, or other lawful process. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your health information to law enforcement officials or federal officials for lawful intelligence and other national security activities.

Your Individual Rights

You have the following rights with respect to your protected health information.

The Right to Request Access to Your Health Information. In most cases you have to right to look at or obtain a copy of your health information. This request must be made in writing on a form available from our staff. There will be a charge for copies made and postage.

The Right to Request an Amendment to Your Health Information. If you believe that the health information we have about you is incorrect or incomplete, you have the right to request that we correct or update this information. We may deny the request if we received the information from another source. If we deny your request for an amendment, you may respond with a statement, which will be attached to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to inform others that need to know about the change to your information.

The Right to Receive an Accounting of Certain Disclosures of Your Health Information.
You have the right to receive a list of certain instances in which we have disclosed your health information to our associates since April 14, 2003. This list will not include any disclosures that we make for the purposes of treatment, payment, and health care operations and other specified exceptions. This list will not include yourself, your family or others involved in your care.

The Right to Request Confidential Communication.
You have the right to request that we send your health information to you by alternative means or to an alternative location if this is required to avoid harm to you. Requests are made in writing to the practice Privacy Officer.

The Right to Request a Restriction on Uses and Disclosures of Your Health Information.
You have the right to ask that we place additional limits on how we use and disclose your health information. However we are not required to agree to such requests.

The Right to Receive a Written Copy of our Notice of Privacy Practices. You have the right to receive a paper copy of this Notice of Privacy Practices at any by requesting from our Privacy Officer.

Privacy Questions and Complaints

If you are concerned that we may have violated your privacy rights, please ask to speak to our Privacy Officer or request the form needed to issue a complaint. You may also submit a complaint with the U.S. Department of Health and Human Services. That address will be provided upon request.

Contact our office to reach the privacy officer.