FAR HILLS
ob/gyn

JOHN M. SHIE, M.D. CAROLINE H. KENNEBECK, M.D. KELLY L. McCLUSKEY, M.D.
SHANNON N. McAFEE, D.O. JENNIFER A . MITTLESTEAD, M.D. SAMANTHA E. HOUSER, D.O.

OBSTETRICAL CARE FINANCIAL CONTRACT

This following document disclosed the details that you are agreeing to as an obstetrical patient of Far Hills Ob/Gyn Inc.

- The fee for routine prenatal visits with a Vaginal Delivery: **$2900.00 [includes postpartum care]**
- The fee for routine prenatal visits with a Cesarean Section: **$3000.00 [includes postpartum care]**
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Laboratory testing is billed separate by the lab, which at this time we use Compunet Lab.

Additional charges that incur will be charged as services are rendered, example:

- **Ultrasounds * fetal non stress test * hospital visits * infant circumcisions**
- **Visits that are not routine due to complications or illnesses**
- **If you are High Risk twins, hypertension, toxemia, diabetes, etc. fees will be increased accordingly to service rendered.**

TERMS OF PAYMENT DUE:

- **Your benefits will be verified by your insurance company Depending on your deductibles, co-insurance, and out of pocket expenses**
- **A monthly payment plan will be established**
- **Payment is due 6 weeks prior to your estimated due date.**
- **At any time during your pregnancy should your insurance policy change, it is your obligation to notify our office immediately so we can do a new insurance verification.**
- **This could result in a change with your payment plan.**
- **If you have any questions regarding your insurance or payments please feel free to contact our billing department [937] 435-6222.**
- **Should you have no insurance coverage for your pregnancy then a monthly payment plan will be established on the above fees and additional services will need to be paid as services are rendered.**
- **If these payments are not paid or you feel you are unable to make these payment arrangements then you will be referred to another facility such as Miami Valley Women's Center or Southview Women's Center or a physician that you choose for your pregnancy.**
- **If you are in the process of getting insurance you will need to pay for services rendered until insurance is presented to our office and verified.**
- ***All insurance verifications are not a guarantee of payment and are an estimated quote given by your insurance.*** **Any remaining balances not covered by your pre-payment will be due and payable in full within 90 days of your claim being processed.**

I understand and agree to all terms of this contract as described.

Patient:_____ **Date:** _____

Responsible Party:_____ **Date:** _____

(over)

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NEW OB HISTORY QUESTIONNAIRE

PREGNANCY HISTORY

Delivery Date	Weeks	Length Of Labor	Sex	Delivery Type	Anesthes. Type	Location	Complication

GYNECOLOGY HISTORY

Age at first period _____ Last period date _____ Regular periods? Yes No

Date of [+] Pregnancy Test _____

History of Abnormal Pap Smear _____

MEDICAL HISTORY - Please circle any conditions for which you have been diagnosed

Diabetes
High Blood Pressure
Heart Problems
Kidney Problems
Seizures/epilepsy
Mental Health/psychiatric problem
Depression
Liver Disease
Thyroid Problems
Domestic Violence
History of Blood Transfusion
Smoking
Asthma or lung problems
Seasonal Allergies
Breast problems

Operations or Hospitalizations: _____

_____

_____

INFECTION HISTORY

Do you live with someone with tuberculosis or exposed to tuberculosis?	NO YES
Do you or your partner have a history of Herpes?	NO YES
Have you had a rash or viral illness since your last period?	NO YES
Do you have a history of Gonorrhea, Chlamydia, HPV, Syphilis or Trichomonas?	NO YES
Have you ever had Chicken Pox?	NO YES

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PRENATAL DIAGNOSIS SCREENING QUESTIONS

1. Will you be age 35 or older when the baby is due? ❑ Yes ❑ No
   Your age when you are due? _____
2. Have you or the baby's father or anyone in either of your families ever had:
   a. Down Syndrome or mongolism? ❑ Yes ❑ No
   b. Spina Bifida or meningomyelocele (open spine)? ❑ Yes ❑ No
   c. Hemophilia? ❑ Yes ❑ No
   d. Muscular dystrophy? ❑ Yes ❑ No
3. Have you or the baby's father had a child born dead or alive with a birth defect not listed in question 2 above? ❑ Yes ❑ No
4. Do you or the baby's father have any close relatives who are mentally retarded?
   If yes, list cause if known: _____ ❑ Yes ❑ No
5. Do you or the baby's father or close relative in either of your families have any inherited genetic or chromosomal disease or disorder not listed? ❑ Yes ❑ No
   If yes, describe: _____
6. Have you, or the spouse of this baby's father in a previous marriage, had three or more spontaneous pregnancy losses? ❑ Yes ❑ No
7. Do you or the baby's father have any close relatives descended from Jewish people who live in Eastern Europe (Ashkenazic Jew)? ❑ Yes ❑ No
   If yes, have either you or baby's father been screened for Tay-Sachs disease? ❑ Yes ❑ No
   If yes, please indicate results and who screened: _____
   _____
8. Have you been exposed to any infectious diseases (such as measles) during pregnancy? ❑ Yes ❑ No
9. Have you taken any drugs other than iron or Vitamins during this pregnancy? ❑ Yes ❑ No
10. If patient or her spouse are Black/African American have you or the baby's father or any close relative been screened for sickle cell trait and was found to be positive? ❑ Yes ❑ No

I have discussed with my doctor the above questions which are answered "Yes" and understand that I am at Increased risk for _____ and that is usually possible to diagnose an affected fetus amniotic fluid at about 16 weeks of pregnancy. **I DO NOT** want the test _____.

_____ _____
PATIENT SIGNATURE **DATE**

Patient wants amniocentesis and fetal diagnosis for: _____

Patient referral for further testing or counseling concerning: _____

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PATIENT:_____ **DOB:**_____ **DATE:**_____

PRETERM DELIVERY RISK ASSESSMENT

1.	Have you experienced a preterm delivery (before 37 weeks)?	❑ Yes ❑ No
2.	Have you experienced a preterm delivery without feeling contractions?	❑ Yes ❑ No
3.	Have you had any bleeding during this pregnancy?	❑ Yes ❑ No
4.	Do you have twins or triplets?	❑ Yes ❑ No
5.	Have you ever had a LEEP procedure of conization of your cervix?	❑ Yes ❑ No
6.	Have you had more than 2 pregnancy terminations?	❑ Yes ❑ No
7.	Have you had more than 2 D&C procedures, pregnancy related or not?	❑ Yes ❑ No
8.	Do you have uterine anomaly?	❑ Yes ❑ No
9.	Was your mother treated with DES while she was pregnant with you?	❑ Yes ❑ No

FOR TECHNICIAN ONLY

Does patient have polyhydramnios?	❑ Yes ❑ No
Is patient at high risk? (any yes answers)	❑ Yes ❑ No
Is gestational age between 14-24 weeks?	❑ Yes ❑ No

If yes then proceed with cervical length measurement

1. Over 25mm	Routine follow-up no special treatment.
2. 21-25mm	Reduced physical activity. Repeat measurement in 2 weeks.
3. 16-20mm	Bed rest, repeat in 1 week, notify physician.
4. <15mm	Notify physician for cerclage placement.

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CYSTIC FIBROSIS CONSENT TEST

You should be certain that you understand the six items listed below. If you are not certain about any of them, please ask your healthcare provider to explain them further before signing this form accepting or declining Cystic Fibrosis (CF) carrier testing.

1. I understand that the decision to be tested for CF carrier status is completely mine.
2. I understand that the test does not detect all CF carriers.
3. I understand that if I am a carrier, testing the baby's father will help me learn more about the chance that my baby could have CF.
4. I understand that if one parent is a carrier and the other is not, it is still possible that the baby will have CF, but that the chance of this is very small.
5. I understand that if both parents are carriers, additional testing can be done in order to know whether or not the baby will have CF.
6. I understand that if the baby had inherited a changed CR gene from each parent, the only way to avoid the birth of a baby with CF is by terminating the pregnancy.

I have read and understand the information in this form and:

_____ I do not want Cystic Fibrosis Carrier Testing.

_____ I want Cystic Fibrosis Testing.

PATIENT SIGNATURE _____ **DATE** _____

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ALPHA-FETOPROTEIN TEST (AFP)

The Alpha-fetoprotein test (AFP) is a blood test given to women in their second trimester of pregnancy, usually between weeks 15 and 20. When a woman is pregnant, alpha-fetoprotein is produced by the fetus and mixes with the mother's blood. Alpha-fetoprotein can be detected in a blood sample taken from the arm. A high level of AFP can be an indication of a neural tube defect (problem with the baby's brain or spinal cord) such as spina bifida.

CONSENT

After reviewing the above and discussing with the physician I have consented to the following tests/procedures understanding that Far Hills OB/GYN is not responsible for the cost of these procedures.

Accept	Decline	Test Name
		Cell-Free DNA
		Nuchal Translucency with Biochemistry
		Maternal Serum Alpha-Fetoprotein

NAME (PRINT): _____

SIGNATURE: _____ **DATE** _____

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IMPORTANT INFORMATION

This packet contains important information regarding your pregnancy

* **Billing Information**
* **Contacting the Office or Doctor**
* **FMLA/Disability Forms**
* **Read Prenatal Booklet - Your Guide to Pregnancy**

*****please note there is a $20 charge for each FMLA/Disability Form completed. Please turn in and pay for these forms at the front desk.**

Thank you

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TO OUR OBSTETRICAL PATIENTS

During your pregnancy you should be assured that you have a physician on call twenty-four hours a day. Our call coverage is set for our patients to be covered by Dr. John Shie, or Dr. Caroline Kennebeck, or Dr. Kelly McCluskey, or Dr. Shannon McAfee, or Dr. Jennifer Mittlestead, or Dr. Samantha Houser, or Dr. Lisa Egbert, or Dr. Helen Mirau. Dr. Lisa Egbert and Dr. Helen Mirau mostly share weekends and Holiday coverage with us. They are very respected and capable physicians that we have worked with for many years and feel that they provide excellent care. Please feel free to ask who is on call as we try to have 2 months scheduled in advance. Also please know that there are times that the call may be changed at a last minute notice due to unforeseen circumstances. Holiday coverage is such as New Year's Eve, New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving Day and the Friday and Weekend for this holiday, Christmas Eve, and Christmas Day.

As always, you need to only call our office number, 937-435-6222, twenty-four hours a day to get in touch with us. Our office staff or answering service will make sure to get in touch with the physician on call immediately, as your care is of utmost importance. We feel very comfortable and confident in our working relationship with Dr. Lisa Egbert and Dr. Helen Mirau. We know that all of us desire and deliver the medical care that our patients expect and deserve.

If you do have a medical emergency please call 911 so they may get you to the nearest emergency room. Kettering Medical Center is our primary hospital for deliveries and care, unless arrangements have been made with your physician to have care at another hospital.

Sincerely,

John M. Shie, M.D.

Caroline H. Kennebeck, M.D.

Kelly L. McCluskey, M.D.

Shannon N. McAfee, D.O.

Jennifer A. Mittlestead, M.D.

Samantha E. Houser, D.O.

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SCHEDULE OF DISABILITY TIME

MATERNITY LEAVE: Leave begins at the time of delivery unless indicated otherwise due to complications.

Six weeks are allowed from the date of delivery for a vaginal delivery. We will complete Family Leave Act Forms if you choose to extend your time off and your employer allows such.

Eight weeks are allowed for a Cesarean Section, however not all disability companies will pay for the extra two weeks. Check with your disability company to obtain their policies.

SURGERIES: When looking at time off, the day of the procedure is included in the day count.

Disability Forms: There is a $20.00 charge (payable at the time you provide the form) for each disability form to be completed. Disability forms are not completed until the surgery has been performed and forms for deliveries are completed when patient is started on disability or after delivery. We require three days from the date that we receive your form for us to have it fully completed.

Family Leaves Forms Or Any Other Required Forms: There is a $20.00 Charge (payable at the time you provide the form) for each family leave form or other required forms to be completed for you or a family member. For pregnancy, these forms can be completed as soon as your point of disability becomes known. For surgery, these forms are completed after surgery is performed. If you required a letter giving the date of surgery and estimated time off, we can provide this beforehand at no charge. We do require three days from the time we receive your form for completion.

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At your first appointment you can expect the following Labs to be done:

- Antibody Screen
- Blood Type
- CBC –Complete Blood Count
- Hepatitis B and C
- Syphilis Screen [RPR]
- Rubella Titer
- Urine Culture and Urinalysis
- Urine Drug Screen
- Cultures – Gonorrhea / Chlamydia / Trichomonas
- HIV
- A Pap Smear may be done if you are due for screening

This is informing you what tests we will be performing and are the Standard of Care recommended by ACOG [American College of Ob/Gyn], as well as required testing by Kettering Hospitals. This office follows these guidelines. Your signature is acknowledgement that your physician will be performing the above tests.

Patient Name Date of Birth date

5701 FAR HILLS AVENUE · DAYTON, OH 45429
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