MARICOPA OBGYN
AOA family of obgyn physicians

Welcome to Maricopa Obstetrics and Gynecology Associates. We are pleased that you have chosen to have your medical care with us. We hope the following information will prepare you for your upcoming visit. Please see attached reminder notice of the date, time and location of the appointment.

Information To Bring to Your Appointment

- Insurance Card (so we may make a copy).
- Driver's License or other picture ID.
- Insurance Referral from primary care physician, if required.
- Required co-pay, deductible or co-insurance. Payments methods accepted are cash, check or credit card.
- Any medical records requested by our staff when you called to make your appointment.
- Updated and signed Patient Information Sheet. Note – it is critical that we have your current contact information so we can communicate clinical results to you, as needed.
- Completed Patient Medical Questionnaire.

Arrival Time

Please arrive 30 minutes before your appointment time to check-in and complete all your paperwork. If you do not arrive in time to complete the check-in process, your appointment will be rescheduled.

Need to Cancel

If you need to cancel your appointment, please contact the office at least 48 hours in advance so another patient may have the appointment time. To cancel or reschedule please call:

E. Camelback Road Office	(602) 241-1671
E. Ray Road Office	(480) 759-9191

Parking

Parking is readily available at both locations in the parking area designated for visitors. Please do not park in any spaces marked reserved for any other practice or business in the building.

MARICOPA OBGYN
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Dear Patient,

We appreciate you trusting us with your healthcare.

Maricopa Ob/Gyn is a group practice comprised of seven physicians, both male and female. Our goal is to provide you with the best care possible when you need it, therefore you may need to be cared for by someone other than your selected physician in both the office and hospital.

We ask that you please take the time to fill out the following forms carefully and correctly. We are transferring all of our medical records to an electronic platform.

Although you may have completed these forms many times in the past, we need to update this information to ensure that we have the most current and complete health history at this time.

Please return them to us within the next five days.

You may return these pages to us in one of the three ways:

Mail: Maricopa OB/GYN
1661 E. Camelback Rd. #160
Phoenix, AZ 85016

Email: mogaforms@aoafamily.com

Fax: 602-230-7982

Thank you for your attention to this matter.

MARICOPA OBGYN
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Confidential Obstetrical History

Name _____ Birth date _____ Age _____ Date _____

Gynecologic Health History

LMP (first day of your last period): _____

___ Definite
___ Unknown date
___ Approximate date

Were your periods regular before pregnancy? No____ Yes____

How often did your cycles occur? _____-(# of days from start of one cycle to start of next cycle)

Were you on Birth Control at time of conception? No___ Yes___
If yes, what type of Birth Control were you using? _____

What age were you when you started your first period? _____

Have you had a positive pregnancy test? No___ Yes___
If yes, when and where was the test done? _____

Was this a planned pregnancy? No ____ Yes ____

Was this pregnancy a result of In vitro fertilization? No____ Yes____

If yes, donor sperm? No ____ Yes ____

If yes, donor egg? No ____ Yes ____

If yes, what was date of conception? _____

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Confidential Obstetrical History

Name _____ Birth date _____ Age_____ Date _____

Total number of pregnancies

Full Term	Premature	Cesarean Section	Vaginal Delivery	Living	Multiple births	Abortion	Miscarriage	Ectopic

Have you had a positive Group B Strep status with any pregnancies? No _____ Yes____ Unsure____

Pregnancy Details

Preg #	Sex	Month/ Year of delivery	Number of weeks	Babies Weight	Hrs of Labor	Delivery Type	OB/Neonatal Problems	Delivery Doctor

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Confidential Obstetrical History

Name _____ Birth date _____ Age_____ Date _____

Current Medications (Prescription, over the counter, herbal)	Prescribing Doctor	Dose	Instructions	Reason Used

Medical History

Have you had or have any of the following conditions:

Disease/Condition	Yes	No	Onset date	Treatment
1. Diabetes				
2. Hypertension				
3. Heart Disease				
4. Autoimmune Disorder				
5. Kidney Disease/UTI				
6. Neurologic/Epilepsy				
7. Psychiatric				
8. Depression/Postpartum Depression				
9. Hepatitis/liver disease				
10. Varicosities/phlebitis/ blood clot				
11. Thyroid Dysfunction				
12. Trauma/Violence				
13. History of blood Transfusions				
14. RH Negative				
15. Pulmonary (TB/Asthma)				
16. Seasonal Allergies				
17. Breast problems				
18. Anesthetic complications				
19. Uterine anomaly/ DES exposure				
20. Infertility				
21. History of abnormal pap smear				
22. Received HPV vaccine				

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Confidential Obstetrical History

Name _____ Birth date _____ Age_____ Date _____

Infection History

	Yes	No	Onset Date	Treatment
1. Exposed to/live with someone with TB				
2. Patient/Partner with History genital Herpes				
3. Rash/viral Illness since Last period				
4. Have you had Chicken pox				
5. Hepatitis B				
6. Hepatitis C				
7. **History of:**				
STD				
Gonorrhea				
Chlamydia				
HPV/Warts				
HIV				
Syphilis				
8. Other				

Medical / Surgical History ***(Include injuries and conditions requiring medications i.e.-high blood pressure, diabetes, seizures, etc)***

Condition/Disease	Date	Treatment

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Confidential Obstetrical History

Name _____ Birth date _____ Age_____ Date _____

Allergies to medications/food/environment	Reaction

Family History

Please complete if any of your close relatives have had any of the following:

Disease	Circle Yes/No	Family Member	Family Members 1st Name	Age of Onset	Age of Death	Cause of Death (Circle)
Cancer of Breast	Yes No					Yes No
Cancer of Ovary	Yes No					Yes No
Cancer of Uterus	Yes No					Yes No
Cancer of Cervix	Yes No					Yes No
Cancer of Colon	Yes No					Yes No
Diabetes	Yes No					Yes No
Tuberculosis (TB)	Yes No					Yes No
Heart Disease	Yes No					Yes No
High Blood Pressure	Yes No					Yes No
Blood clot/PE	Yes No					Yes No
Other:						Yes No
						Yes No
						Yes No
						Yes No

Symptoms since your last period?

_____

_____

What medications have you taken since your last period?

_____

_____

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Confidential Obstetrical History

Name _____ Birth date _____ Age _____ Date_____

Genetic History
(Includes patient, baby's father, or anyone in either family)

	Yes	No	Mother(patient)	Father(baby's)	Other relative and relationship
1. Patient's age 35 or older at delivery					
2. Thalassemia					
3. Neural tube defect					
4. Congenital heart defect					
5. Down syndrome					
6. Tay-sachs					
7. Canavan disease					
8. Familial dysautonomia					
9. Sickle cell disease or trait					
10. Hemophilia or other Blood disorders					
11. Muscular dystrophy					
12. Cystic fibrosis					
13. Huntington's chorea					
14. Mental retardation/ Autism					
15. Other inherited genetic or chromosomal disorder					
16. Metabolic Disorder (e.g. PKU, Type 1 Diabetes)					
17. Patient or baby's father had a child with birth defects not listed above					
18. Recurrent pregnancy loss or stillbirth					
19. Other					

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Confidential Obstetrical History

Name _____ Birth date _____ Age_____ Date_____

Social History

Primary LanguageSpoken_____Race_____

Education_____ Degree Obtained_____

Baby's father _____ Baby's father race _____

Support person for pregnancy _____

Pediatrician _____

Will you be breast feeding? No ____ Yes___
Will you be bottle feeding? No ____ Yes ___
Will you be breast and bottle feeding? No ___ Yes ___

If medically necessary, would you agree to a transfusion? No_____ Yes_____

Do you desire sterilization after pregnancy? No ___ Yes ___

Do you smoke? No_____ Yes_____ If yes, type of tobacco?_____ Pks/day_____ Number of years_____
If yes, amount during pregnancy? _____
Second hand smoke exposure? No _____ Yes _____

Do you drink alcohol? No_____ Yes_____ If yes, type of alcohol _____
How often? _____ Amount _____Last drink_____
If yes, amount during pregnancy? _____

Do you consume caffeine? No_____ Yes_____ If yes, amount daily? _____ Type _____

Do you use recreational drugs? No_____ Yes____ If yes, what type? _____ Amount _____
If yes, amount during pregnancy? _____

(We do recommend that you discontinue use of nicotine, alcohol, caffeine, and recreational drugs)

Do you have a regular exercise program? No_____ Yes_____ Hours/week_____

Are there animals in the home? No_____ Yes_____ If yes, what kind? _____

Is the patient the individual who cleans up after the animals? No_____ Yes_____

Do you have smoke detectors in your home? No____ Yes____

How many sexual partners do you have? None_____ One_____ 2-5_____ 5+_____

Have you been exposed to sexual or physical violence or abuse? No_____ Yes_____
If yes, please explain _____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION – OB RECORDS

I hereby authorize **Arizona OBGYN Affiliates** (Maricopa OB/GYN Division) to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand copies of records received from other health care providers may not be released.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g., insurance company or health care provider; the released information may no longer be protected by Federal and State privacy regulations. I also authorize the release o f records by fax transmission and agree to hold **Arizona OBGYN Affiliates** (Maricopa OB/GYN Associates) harmless for errors in receipt of transmission.

I hereby authorize the release of my prenatal records to Banner Good Samaritan Regional Medical Center.

I understand that I may revoke this authorization at any time by notifying Arizona OBGYN Affiliates in writing. I understand the written revocation must be signed and dated with a date that is later than the date of this authorization.

PRINT PATIENT NAME: _____

DATE OF BIRTH: _____

TELEPHONE NUMBER_____

Signature of Patient or Legal Guardian_____

Date_____

If other than patient, print name here_____

Relationship to Patient_____

Legal Authority (attach supporting documentation)_____

Witness Signature_____

Cord Blood Collection Information Form

It is required by the State of Arizona that you be informed about opportunities to save your baby's cord blood at the time of delivery.

The blood in the baby's cord is a rich source of stem cells. These cells have been used to treat nearly 70 diseases including leukemia, other cancers, blood and immune system disorders and some genetic diseases. Researchers are studying their use for things such as heart disease, juvenile diabetes, brain injury and many more.

You have only one chance to collect and save your baby's genetically unique cord blood. The collection is simple and painless from the cord and placenta after birth and doesn't interfere with baby's care.

Currently there are over twenty family banks which store your baby's blood frozen specifically under your name and charge you for this ($1000 to $2000 and then annually $100 to $150).

There is one public bank which accepts donations (Cryobank International). The blood is stored anonymously and categorized by cell type there. It might not be available specifically for your child in the future.

If the blood is not saved, it is medically disposed of with the placenta. There are occasional problems at the time of collection which result in inadequate samples.

See also the AZ Department of Health Services brochure for further information. There is also available material from the banking companies.

I acknowledge I have been informed about the option of saving my newborn's umbilical cord blood for my family and received the AZDHS information.

Should I wish further information about umbilical cord blood preservation or to enroll with a cord blood bank, I fully understand this responsibility will solely and completely be my own.

_____

Patient Name (print)

_____ _____

Signature Date

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Ultrasounds during Your Pregnancy

When your prenatal care begins, an ultrasound is performed to confirm the health of your pregnancy, the number of babies and your due date. If you are less than 14 weeks pregnant a vaginal ultrasound will help us get the best information. Women greater than 14 weeks will have an ultrasound through the abdomen.

If you choose to obtain the first trimester screening test for Down's syndrome, you will have another ultrasound between 12 and 13 weeks.

At 19 weeks, another ultrasound is done to more thoroughly evaluate your pregnancy. This ultrasound will confirm you due date, locate the placenta, measure the fluid in the uterus and survey the baby. *Most of the time, but not always, the sonographer can determine the sex of the baby at this visit. However, the sex of the baby cannot always be determined accurately due the baby's position during the exam*. In addition, ultrasounds, even though reassuring, cannot find all birth defects in babies.

Additional ultrasounds will be performed in the last 20 weeks in your pregnancy when your doctor deems it medically necessary. For example, women with high blood pressure, diabetes, and twins will have more ultrasounds during their pregnancy.

Please feel free to bring friends and family to your ultrasound. The ultrasound room at Maricopa OB/GYN can comfortably hold at least 5 visitors. If you are obtaining an ultrasound at an alternate facility, please ask in advance how many visitors you may bring. Please have children supervised so that you and your partner may enjoy this peek into the uterus without distraction.

Unfortunately, your ultrasound cannot be filmed or recorded. Photos of your baby are usually available for you to take home.

Ultrasounds for Determination of Baby's Sex

If we are unable to determine your baby's sex at your second trimester ultrasound and you desire this information, please let your provider know and our staff will schedule time for you.

Your health insurance will not cover this service consider since it is for your information only and not medically necessary. There is a $150 charge for this ultrasound. Payment is due on the day of your appointment.

Please remember, the sex of the baby cannot always be determined due to the baby's position during the exam. We cannot guarantee we will be able to determine the baby's sex during the exam or the accuracy.

Patient Signature: _____ Date: _____

FETAL TESTING INFORMATION

Please read this important information carefully.

Birth defects affect 3-4% of all pregnancies. Some, but not all, of the possible birth defects can be discovered by blood tests, ultrasound and genetic testing.

The testing that you decide to perform for your pregnancy is an individual choice based on many factors such as your health, age, previous pregnancy experiences, family's health history and the number of fetuses you carry.

There are two types of testing for your pregnancy: screening/non-invasive and invasive testing.

Screening and Non Invasive Testing

Screening tests have ***no risk*** to the fetus or the mother. Screening tests include blood tests and ultrasound. Screening tests can identify a women who is at higher risk than expected of having a baby with a birth defect, but cannot detect all of these birth defects (such as spinal cord defects or heart problems).

First trimester (11-13 weeks) screening tests includes a **blood test** combined with an **ultrasound.** This testing can detect **up to 85%** of Down's syndrome and **up to 98%** of Trisomy13, Trisomy 18 and Turner's syndrome. This test is performed at another doctor's office.

For women over 35 or with a personal or family history of chromosomal defects a **blood test** is available at 10-18 weeks which identifies more than 99% of fetuses with the four most common genetic defects: Down's, Trisomy 13, 18 and Turner's syndrome.

Second trimester (15-20 weeks) screening blood test called a **MSAFP** is done at 15 weeks in our office. This test predicts fetal risk for spinal cord defects (neural tube defects), Down's syndrome and Trisomy 18.

At 18-20 weeks an **ultrasound** will confirm your baby's growth, your due date and can detect 35% of fetal birth defects, but misses 65% of all birth defects.

Invasive Testing

Invasive tests have a ***very small risk*** to the fetus and an extremely rare risk to the mother. Invasive tests include chorionic villous testing and amniocentesis. Invasive tests can diagnose chromosomal birth defects in the fetus (such as Down's syndrome).

First trimester invasive testing is called a **chorionic villous sampling** (CVS). A small catheter is passed through the cervix under ultrasound guidance to obtain a small sample of the placenta which contains the baby's chromosomes. Results in 7-10 days. Risk of miscarriage is 1 in 200.

Second trimester invasive testing is called an **amniocentesis**. This test is performed by inserting a needle through the mother's abdomen into the uterine cavity to obtain fetal cells.
Results in 7-10 days. Risk of miscarriage is 1 in 250.

We can refer you to a genetic counselor for more information on invasive testing if needed.

All testing is optional and is your personal choice.

FETAL TESTING PLAN

Patient: _____ Date: _____

First trimester blood test for Downs (Done at MOGA office)	10-12 weeks
First trimester screening for Down's (Schedule with specialist)	11-13 weeks
Second trimester blood test for spine and Down's (Done at MOGA office)	15-18 weeks
Chorionic Villous Sampling (Schedule with specialist)	12-13 weeks
Amniocentesis (Schedule with specialist)	15-20 weeks
Second trimester ultrasound	18-20 weeks

Decline	**Accept**	**My choice for testing is:**
_____	_____	1. I decline all testing except ultrasound.
_____	_____	2. Maternal blood test for fetal chromosomes
_____	_____	3. First trimester blood test and ultrasound
_____	_____	4. Second trimester blood test (MSAFP)
_____	_____	5. Second trimester ultrasound
_____	_____	6. Genetic counseling.
_____	_____	7. Chorionic villous sampling
_____	_____	8. Amniocentesis
_____	_____	9. I am undecided today about what testing is right for me.

I understand that **all** testing must be performed during strict time frames and that it is my responsibility to schedule and perform these tests at the correct time. If I miss a test time I understand that the opportunity to test may be lost.

Any test that I have not scheduled and performed, I have declined to perform.

Patient: _____ Date: _____

Reviewed by: _____ Date: _____

CYSTIC FIBROSIS SCREENING

Cystic fibrosis is a chronic, progressive, inherited disease of the body's mucus glands. This disease affects respiratory and digestive systems of the body. Cystic fibrosis patients require a great deal of care and treatment, medicine and physical therapy, yet many patients often die of the disease at a young age.

One out of every 29 Americans of Northern European descent is an unaffected carrier of the CF gene. Carriers are those who do not have any symptoms of the illness, but have the ability to pass that altered gene onto their offspring.

People who should consider testing are:

1. couples where one partner has CF
2. individuals who have a family history of CF
3. non-Jewish Caucasians and their partners
4. descendants of Ashkenazi Jews
5. men with a congenital absence of the vas deferens

Women of other ethnic backgrounds are at risk too:

Hispanics	1 in 46
African	1 in 60
Asian	1 in 90

If two people are carriers for CF, they have a 25% chance of having a baby with the disease.

Screening blood tests are available that may identify as many as 97% of people who are carriers for CF, depending upon their ethnic background.

These screening tests may not be paid for by your insurance company. It is your responsibility to determine if your insurance will cover the test if it is interesting to you and your partner.

I have been given information about cystic fibrosis screening and have had the opportunity to ask questions.

I accept _____ Date _____

I decline _____ Date _____

MARICOPA
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Your Childbirth Experience at Banner Good Samaritan Medical Center

The physicians and staff at Maricopa Obstetrics and Gynecology Associates have given careful thought to our selection of Banner Good Samaritan Medical Center as the exclusive site for delivering our patients' babies. Some of our patients have questions about why we have chosen Banner Good Sam, when other hospitals may be located closer to our practice offices, so we would like to share our insight directly with you.

The Obstetrics Program at Banner Good Samaritan Medical Center
Banner Good Sam is widely acknowledged for its clinical excellence, having been named to *US News & World Report's* list of the best U.S. hospitals for 10 years, including special recognition for the facility's obstetrics and gynecology programs. The hospital also boasts a Magnet designation for nursing excellence, an elite honor given to only 250 hospitals out of 6,000 nationwide.

Banner Good Sam manages one of the nation's foremost medical education programs; the hospital's physicians, nurses and other frontline health care personnel are on the leading edge of today's obstetrical research and advancements as they work to train the doctors of tomorrow. In fact, our own Dr. Michael Urig is chief of the obstetrics and gynecology department at the hospital, and Dr. Laurie Erickson is vice chief. All of our physicians are on faculty at Banner Good Sam, and the majority of our staff completed their residencies there.

Banner Good Sam is also internationally-renowned for its care of high-risk pregnancies. Women from across the nation and around the world who are pregnant with high-order multiples come to Banner Good Sam for their ante-partum and post-partum care, seeking the expertise of leaders in the obstetrics field who practice exclusively at the hospital. Banner Good Sam serves as a statewide referral center for pregnancy complications, so women in other communities throughout Arizona who face challenges during their pregnancies are often sent to Banner Good Sam for specialized care. Pregnant women who suffer other medical conditions, such as cancer or diabetes, are also treated by Banner Good Sam's extensive team of experts, and the hospital houses Banner's new Maternal-Fetal Center which offers highly-specialized ultrasound and intra-uterine fetal surgery and therapy.

Neonatal Intensive Care and Other Services
Perhaps most important to our medical team at Maricopa Obstetrics and Gynecology Associates, Banner Good Sam enjoys a special partnership with Phoenix Children's Hospital, whose Neonatal Intensive Care Unit is located adjacent to Banner Good Sam's Labor and Delivery unit. The NICU is the nation's largest and was completely renovated in summer 2007 to include the latest advancements and innovations for providing state-of-the-art care to the hospital's tiniest patients. While we don't expect significant complications with most labor and delivery processes, the added comfort of having a nationally-acclaimed Level 3 NICU literally down the hallway from Labor and Delivery, along with access to a health care team trained to manage complex obstetrical and neonatal cases, gives our doctors and our expectant patients a tremendous sense of security and confidence.

The hospital also offers a substantial array of classes for you and your partner, including childbirth preparation, breast-feeding, and other topics relevant to expectant mothers and their families. Recently, Banner Good Sam unveiled its Skylight in-room entertainment system, which offers expanded cable options, on-demand movies, Internet access, video games and other activities to enhance your hospital stay. The Labor and Delivery unit also boasts several rooms with private tubs that women can use to make the laboring process more comfortable.

As one of the largest and most comprehensive hospitals in the state, Banner Good Samaritan Medical Center has been providing care to Arizonans for nearly 100 years and is centrally located near downtown Phoenix, with convenient access from the Interstate 10 freeway. From most locations throughout the Valley of the Sun, it is a quick 20 minute drive to the hospital's private Labor and Delivery entrance.

Should you wish to speak directly to one of our patients about her childbirth experience at Banner Good Sam, or talk further with our staff about our relationship with the hospital, please let your physician know and we will be happy to answer your questions.

NOTICE OF ARIZONA OB/GYN AFFILIATES, P.C. PRIVACY PRACTICES
dba: Maricopa OB/GYN

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

Uses and Disclosures

Treatment. Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan or from other sources of coverage such as an automobile insurer. For example, your health plan may request and receive information on dates of service, the services provided, medical condition being treated, and past medical history pertaining to the condition being treated. Your health information will also be used in obtaining benefit information and prior authorization for treatment and requesting and acknowledging referrals.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Maricopa OB/GYN. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Appointment Reminders. Your information will be used by our staff to contact you regarding appointment reminders.

Law Enforcement. Your health information may be disclosed to law enforcement to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights
You have certain rights under the federal privacy standards. These include:

* the right to request restrictions on the use and disclosure of your protected health information
* the right to receive confidential communications concerning your medical condition and treatment
* the right to inspect and copy your protected health information
* the right to amend or submit corrections to your protected health information
* the right to receive an accounting of how and to whom your protected health information has been disclosed
* the right to receive a printed copy of this notice

Maricopa OB/GYN Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of privacy practices.

We also are required to follow the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our check in desk or our privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Arizona OB/GYN Affiliates, P.C.
dba: Maricopa OB/GYN
1661 E. Camelback Rd., Ste. #160
Phoenix, AZ 85016

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

NAME _____ DATE _____

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Demographic Questionnaire

Our office is participating in a national initiative to measure and improve quality of care. We are asking about your race and ethnicity for demographic purposes. However, providing this information is completely voluntary and will not affect your healthcare. Please circle your answer below.

Name: _____

DOB: _____

Please specify your **race**
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander White
Caucasian
Decline to answer

Please specify your **ethnicity**
Hispanic or Latino
Not Hispanic and Not Latino
Declined to answer

Preferred Language_____
Decline to answer

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FINANCIAL POLICY

Welcome to Maricopa OB/GYN. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office policy.

We will bill insurance claims as a courtesy to our patients provided we have your current insurance information and any necessary referrals. Should your insurance require a referral, and we have not received it prior to your appointment, you will be responsible for payment at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service.

Changing or re-coding claims once they have been billed constitutes fraud and we **do not** do this under any circumstances.

This office bills **only** for services performed by our providers. The laboratory company is a separate entity, and will bill you or your insurance company for labs that are performed. If you have any questions regarding your lab bill, please contact that laboratory or your insurance company.

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. We ask that you notify us 48 business hours in advance to cancel and/or reschedule your appointment. Please be aware that failure to do so may result in a missed appointment fee of $25.00. A fee in the range of $50 - $100 will be charged for a missed procedure appointment.

It is your responsibility to notify our office if there is a change of name, insurance coverage, residence, and/or phone number.

I have read the above Financial Policy. I understand and agree to these terms. _____
(Please initial)

Acknowledgement of Notice

I acknowledge receipt of the Notice of Privacy Practices for Maricopa OB/GYN. _____
(Please initial)

Release of Information

I authorize my Personal Health Information to be disclosed as specified below:

Primary number:_____. Acceptable to leave a message on this number: YES NO

Secondary number:_____. Acceptable to leave a message on this number: YES NO

To the following family member(s) or other person(s):

_____/_____/_____
Name **Relationship** **Phone Number**

_____/_____/_____
Name **Relationship** **Phone Number**

_____ ____/____/____
PATIENT NAME (Please Print) **DATE OF BIRTH**

_____ ____/____/____
SIGNATURE OF PATIENT/GUARDIAN **DATE**