# High Risk Pregnancy Center of Kansas City

Last Name: _____ First Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Provider: _____Date of Birth: _____ Marital Status: _____

Social Security Number: _____ Employer: _____

**Emergency Contact:**
Name: _____ Relationship: _____Number: _____

**Primary Insurance Company:** _____
Policy's Holder's Information:

Name: _____ DOB: _____ Relationship: _____

Social Security #: _____ Address: _____

Member ID: _____Group Number: _____

**Secondary Insurance Company:** _____
Policy Holder's Information:

Name: _____ DOB: _____ Relationship: _____

Social Security #: _____ Address: _____

Member ID: _____Group Number: _____

**Patient's Email:** _____ Leave Message ☐ Home ☐ Cell

**Race:** ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White

☐ Black or African American ☐ Hispanic ☐ Another Race **Primary Language:** _____

**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/not Latino

*****__In addition to myself__, I authorize High Risk Pregnancy Center to speak with or leave messages with

_____regarding my care or billing. *****

Name: _____ Date: _____

**Current Pregnancy**

Date of Last Menstrual Period: _____Due Date: _____

Use of Fertility Treatment: ☐ Yes ☐ No (If No then skip to Pregnancy History, If Yes then select all that apply)

Medication_____

☐ IVF (In-Vitro Fertilization) ☐ IUI (Intrauterine Insemination) ☐ ICSI (Intracytoplasmic Sperm Injection)

☐ Other: _____

| Date of Birth | Weeks at Delivery | Vaginal/C-Section | Sex | Gestational Complications | Birth Complications |
|---|---|---|---|---|---|
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**Pregnancy History**

| Date | Weeks Pregnant | Miscarriage | Elective Abortion | Ectopic Pregnancy | With D & C |
|---|---|---|---|---|---|
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**Miscarriages & Abortions**

| Name | Dosage | Frequency |
|---|---|---|
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| | | |
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**Current Medications**

**Height: _____**

Name: _____ Date: _____

| Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |

**Allergies**

| | | | |
|---|---|---|---|
| Cardiovascular | ☐ Arrhythmia<br>☐ Coronary Artery Disease<br>☐ Hypertension<br>☐ Stroke<br>☐ Blood Clots | Gastrointestinal | ☐ Acid Reflux<br>☐ Gallbladder Disease<br>☐ Peptic Ulcer Disease<br>☐ Inflammatory Bowel Disease<br>☐ Hepatitis |
| Respiratory | ☐ Asthma<br>☐ Cystic Fibrosis<br>☐ Pulmonary Embolism<br>☐ Sleep Apnea | Neurological | ☐ Headaches/Migraines<br>☐ Seizures<br>☐ Multiple Sclerosis |
| Oncology | ☐ Leukemia/Lymphoma<br>☐ Breast Cancer<br>☐ Cervical Cancer | Endocrine | ☐ Diabetes<br>☐ Thyroid Disorder<br>☐ PCOS |
| Psychiatric | ☐ Depression<br>☐ Schizophrenia<br>☐ Bipolar Disorder<br>☐ Anxiety | Immunologic | ☐ Raynaud's<br>☐ Lupus<br>☐ Rheumatoid Arthritis<br>☐ Other Connective Tissue Disease<br>☐ HIV/AIDS |
| Renal | ☐ Renal Disease<br>☐ Kidney Infection | Other Medical History:<br>1.)<br>2.)<br>Past Surgical History with Dates:<br>1.)<br>2.)<br>3.)<br>4.) | |
| Hematologic | ☐ Anemia<br>☐ Sickle Cell<br>☐ Thrombophilia<br>☐ Hemophilia<br>☐ Thrombocytopenia<br>☐ Blood Transfusions | | |

**Past Medical History**

**Social History**

Tobacco: Never

Name: _____ Date: _____

Former: How long since you last smoked? _____ Amt. per day? _____
Current: Amt. per day? _____ how long have you smoked? _____

Substance Use: Never Former Current What Type? _____ Amount _____

Alcohol Use: Never Former Current Since Last Menstrual Period? Yes No How many? _____

**Family Medical History (**Please check all the disorders that apply & who's affected.)

| Family Member | Circle one | Cleft Lip/Palate | Heart Defect | Spinal Bifida | Blood Disorder | Down Syndrome or Chromosomal Problems | Tay Sach's/Canavan Dz. | Cystic Fibrosis | Mental Retardation/ Developmental Delay | Other Birth Defects/ Genetic Disorders |
|---|---|---|---|---|---|---|---|---|---|---|
| Children (Alive) | | | | | | | | | | |
| Children (Deceased) | | | | | | | | | | |
| Father of Baby | Alive or Deceased | | | | | | | | | |
| Sister | Alive or Deceased | | | | | | | | | |
| Brother | Alive or Deceased | | | | | | | | | |
| Mother | Alive or Deceased | | | | | | | | | |
| Maternal Grandmother | Alive or Deceased | | | | | | | | | |
| Maternal Grandfather | Alive or Deceased | | | | | | | | | |
| Father | Alive or Deceased | | | | | | | | | |
| Paternal Grandmother | Alive or Deceased | | | | | | | | | |
| Paternal Grandfather | Alive or Deceased | | | | | | | | | |

# High Risk Pregnancy Center of Kansas City, P.A.

Thank you for choosing **High Risk Pregnancy Center of Kansas City, P.A.** We strive to provide the very best care and in order to do so we would like to take this opportunity to acquaint you with our office policies. Please take a few moments to read over the following information. In addition, we suggest you review your health insurance policy and familiarize yourself with the coverage it provides.

**Insurance and Driver's License due at time of service**

I understand that in order for High Risk Pregnancy Center of Kansas City to file insurance claims on my behalf, I must present proper proof of insurance at the time of my appointment. High Risk Pregnancy Center of Kansas City, P.A. accepts several insurance plans and every plan is different. It is up to the insured to know the exact requirements of their own insurance plan. **INSURANCE WILL NOT BE FILED WITHOUT A COPY OF THE INSURANCE CARD.**

**Assignment of Insurance Benefits**

I hereby authorize and assign, my insurance carrier(s), to make payment directly to High Risk Pregnancy Center of Kansas City, P.A. of insurance benefits for services herein specified and otherwise payable to the insured. High Risk Pregnancy Center of Kansas City, P.A. files both primary and secondary insurance as a courtesy to patients. I understand and agree that I am financially responsible to High Risk Pregnancy Center of Kansas City, P.A. for all charges incurred regardless of potential insurance benefits. I understand High Risk Pregnancy Center of Kansas City, P.A. will not become involved in disputes between the patient and the insurance company. I understand it is my responsibility to verify with my insurance company the physician(s) treating me are covered under my insurance and to get referrals and/or authorization for services.

**Costs**

I understand that I am financially responsible for all charges arising for treatment of my dependents or myself by High Risk Pregnancy Center of Kansas City, P.A. Not all services are a covered benefit in all contracts. I understand that if I am delinquent and default on the terms of this agreement then my account will be turned to a collection agency.

**Referral Forms**

I understand that if I have an HMO or PPO insurance requiring a referral, a completed referral form, or referral number from my primary care physician (PCP); then it must be provided at the time of my appointment. I understand that failure to provide referral information at the time of my visit will necessitate either rescheduling my appointment, or payment in full at the time of the service.

**Payments**

I understand that all copays must be paid the day of my appointment. I understand that self- pay and non-covered benefit fees are payable at the time of my appointment.

**Appointments**

I understand that a $50.00 service charge may be incurred for failure to notify the office at least 24 hours in advance of a cancellation. I understand this charge is not covered by my insurance policy. I understand that if I arrive late for an appointment I may be asked to reschedule my appointment.

High Risk Pregnancy Center of Kansas City

George Lu M.D.

1201 NW Briarcliff Parkway Ste 310
Kansas City, MO 64116
816-541-2700

**Reinstatement**

I understand that if I am turned to a collection agency by High Risk Pregnancy Center of Kansas City, P.A. it will be at management's discretion to accept me back into the practice. If accepted back I know I am responsible to have that balance paid in full before having any future treatments with High Risk Pregnancy Center of Kansas City, P.A. I also understand that there will be a minimum of a $25 charge for reinstatement fee applied to my account. The reinstatement fee and the full amount of the visit is due at the time of service as a guarantee of payment. We will submit your claim to your insurance company and you will be reimbursed once your claim is processed.

**Noncompliance**

I understand that High Risk Pregnancy Center of Kansas City, P.A. reserves the right to discharge any patient from this practice at any time for failure to comply with treatment recommendations or office policy responsibilities. High Risk Pregnancy Center of Kansas City, P.A. will suggest referral options in this event.

**Prescriptions**

I understand that prescription refills need to go through the pharmacy. Please allow 24 hours for any prescription refill, Monday – Thursday. Any prescriptions received on Fridays will not be filled until the following Monday. I understand that most prescriptions will be sent electronically to the pharmacy that I have requested.

Can High Risk Pregnancy Center of Kansas City, P.A. have your permission to view your prescription history from external sources? Yes ☐ No ☐

Please provide your pharmacy information:

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone Number _____

Pharmacy Fax Number _____

**Signature:_____Date:_____**

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# High Risk Pregnancy Center of Kansas City, P.A.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ❑ The patient refused to sign.
- ❑ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ❑ We weren't able to communicate with the patient.
- ❑ Other *(Please provide specific details)*

_____

_____

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_____ _____

Employee Signature Date