Janet E. Davis, M.D., P.C.

Maternal Fetal Medicine

Today's Date:	Referral Source:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	□ Mr. □ Miss □ Mrs. □ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? □ Yes □ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:

Street address:	Social Security #: - -	(Home/Cell) Phone # ( ) -

P.O. Box/Apt#:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone #: ( ) -

Employer Address:

Emergency Contact Name:	Phone #:	Relationship to Patient:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	(Home/Cell) Phone #: ( ) -

Is this person a patient here? □ Yes □ No

Occupation:	Employer:	Employer address:	Employer Phone #: ( ) -

Is this patient covered by insurance? □ Yes □ No

Please indicate primary insurance:

Subscriber's Name:	Subscriber's SSN: - -	Birth Date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other:

Name of secondary insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other:

SPOUSE INFORMATION

Name:	SSN: - -	(Home/Cell) Phone #:	Employer Phone #:
Employer:	DOB: / /	( ) -	( ) -

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Janet E. Davis, M.D., P.C. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

1348 Walton Way • Suite 4300 • Augusta, GA 30901
706.722.4300 • www.janetdavismd.com • 706.722.7337 (f)

Janet E. Davis, M.D., P.C.
Maternal Fetal Medicine

PATIENT CONSENT

I hereby authorize and consent to examinations, treatments, release of medical information to my insurance company/companies, claim representative(s), adjuster(s), and other physicians by Janet D. Larson, MD, PC. I hereby assign all payments for medical services rendered to Janet D. Larson, MD, PC. I understand that all co-payments are due at the time of my appointment as in agreement with my insurance coverage. I also understand that I am personally responsible for paying the remaining balance for medical services after third party payer coverage benefits are applied. If I should be determined ineligible by any third party payer (including Medicaid); I am responsible to pay for all services rendered.

My signature verifies that I have read and understood this consent.

Printed Name: _____

Signature: _____

Guarantor's Name (if different from above): _____

Policy Holder's Name (if different from above): _____

Date: _____

Witness: _____

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Travel History Questionnaire

1. In the past 30 days, has the patient traveled outside of the United States?

   Circle One: Yes No

   Comment:

2. Has the patient been to Guinea, Liberia, Nigeria, Senegal, Sierre Leone, or Democratic Republic of Congo?

   Circle One: Yes No

   Comment:

3. Has the patient been near persons or remains of persons with Ebola in the past 30 days?

   Circle One: Yes No

   Comment:

_____ _____

Signature Date

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JANET E. DAVIS, M.D., P.C.
NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE APRIL 1, 2009
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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services.

We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as any employees, staff, and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The demographic information you provide to us will be entered into our patient management system, which is shared over a hospital-wide network. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information including: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Ave., Washington, DC 20201. To file a complaint with the practice, address to the Privacy Officer, Janet E. Davis MD, PC, 1348 Walton Way, Suite 4300, Augusta, GA 30901. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer at (706) 722-4300.

Signature: _____ Date: _____

Janet E. Davis, M.D., P.C.
Maternal Fetal Medicine

WAIVER OF LIABILITY FOR LABS

Date: _____/_____/_____

Please circle where you would like for us to send our lab work; preferably the lab that your insurance will pay for should be your choice if you do not want to be charged 'out of pocket' costs:

University Hospital Labcorp Quest Mullins

This office will make every attempt to submit your lab work to the in-network lab covered by your insurance. However, if an out-of-network lab must be used for any reason, please understand that you will be fully responsible for any incurred charges not covered by your insurance.

_____
Print Patient's Name

_____
Patient's Signature

_____
Witness (Office Staff Only)

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Janet D. Larson, M.D., P.C.
Maternal Fetal Medicine

Date: _____

Patient Name: _____

I understand that my insurance may not cover the lab charges for the tests that my doctor has ordered on the above date.

I understand that I will be responsible for any charges not covered by my insurance.

_____ _____

Patient Signature Date

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Janet E. Davis, M.D., P.C.
Maternal Fetal Medicine

MATERNAL-FETAL MEDICINE CONSULTATION

Referring Physician:_____**Date:**_____

Patient Name:_____**DOB:**_____

SS#_____

Address:_____

Contact #1:_____**Contact #2:**_____

Primary Insurance:_____**ID#:**_____

Subscriber: YES NO: Name:_____

Secondary Insurance:_____**ID#:**_____

Seen Before: Yes/Year_____ **NO**

EDD/ Weeks gestation:_____

Referring Diagnosis:

- **Abnormal Screening for:**_____
- **Abnormal Ultrasound:**_____
- **AMA**
- **Anatomy Scan**
- **Diabetes: Pre-Gestational or Gestational**
- **Epilepsy**
- **Fibroids**
- **History of previous pregnancy:**_____
- **Hypertension: Chronic or Pregnancy Induced**
- **IVF Pregnancy**
- **MTHFR/Thrombophilia/Anti-Phospholipid syndrome**
- **Multiple gestation**_____
- **Previous Preterm Delivery**
- **Threatened Preterm Labor**
- **Shortened Cervix/Cervical Insufficiency**
- **Vaginal Bleeding**
- **Other:**_____

Please include Prenatal Record, All labs and Ultrasound

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Dear Doctor:

My goal is to partner with your office to provide the best in high risk obstetric care!

My office is open Mondays through Thursdays, from 8:00 AM through 5:00 PM, and half days on Fridays, 8:00 AM until 12 noon.

We have same-day urgent availability, and can usually see non-urgent referrals within 2 to 3 days.

Thank you for trusting us with your high risk pregnancies!

You can call or text me at any time on my cell phone, 706-513-3032.

For you convenience, I am enclosing referral forms.
Please fill out the referral form and fax to: 706-722-7337, or e-mail to

jdavis@janetdavismd.com

Thank you for your referrals!

Thanks again,

Janet E. Davis, MD, FACOG
Maternal Fetal Medicine

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