revised 11/11

PERINATAL ASSOCIATES OF CENTRAL
CALIFORNIA MEDICAL GROUP, INC.
2210 E ILLINOIS AVE STE 308, FRESNO, CA 93701-2184
2273 E BEECHWOOD AVE, FRESNO, CA 93720-0329
(559)-268-8307

Douglas A. Helm, M.D.

Patient # _____

## REGISTRATION - REGISTRACION

PATIENT - PACIENTE

NAME - NOMBRE

ADDRESS-DIRECCION

CITY - CIUDAD STATE - ESTADO ZIP - ZONA POSTAL

HOME PHONE - TELE DE CASA NOTE - NOTA

2ND PHONE - OTRO TELE NOTE - NOTA

SSN - NUM DE SEGURO SOCIAL

DRIVER'S LICENSE - LICENCIA DE MANEJAR

OCCUPATION - OCUPACION

EMPLOYER - PATRON

ADDRESS - DIRECCION DEL PATRON

DATE OF BIRTH - FECHA DE NACIM IENTO

MARITAL STATUS - SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____
ESTADO MARITAL - SOLTERA ____ CASADA ____ VIUDA ____ DIVORCIADA ____

EMERGENCY CONTACT - NAME PHONE
CONTACTO DE EMERGENCIA - NOMBRE TELE

PHARMACY - FARMACIA

ALLERGY - ALLERGIA

REASON FOR TODAY'S VISIT
RAZON POR LA CITA HOY

RESPONSIBLE PARTY - PERSONA RESPONSABLE

NAME - NOMBRE

ADDRESS-DIRECCION

CITY - CIUDAD STATE - ESTADO ZIP - ZONA POSTAL

HOME PHONE - TELE DE CASA NOTE - NOTA

2ND PHONE - OTRO TELE NOTE - NOTA

SSN - NUM DE SEGURO SOCIAL

OCCUPATION - OCUPACION

EMPLOYER - PATRON

ADDRESS - DIRECCION DEL PATRON

DATE OF BIRTH - FECHA DE NACIMIENTO

MARITAL STATUS - SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____
ESTADO MARITAL - SOLTERA ____ CASADA ____ VIUDA ____ DIVORCIADA ____

INSURANCE - ASEGURANZA

NAME OF INSURED - NOMBRE DE ASEGURADO

EMPLOYER/SCHOOL - PATRON/ESCUELA

ID # - NUM GROUP # - GRUPO PLAN # - PLAN

BIRTHDATE - FECHA DE NACIMIENTO AGE - EDAD SEX - SEXO

PATIENT IS - INSURED ____ SPOUSE ____ CHILD ____ OTHER ____
PACIENTE ES - ASEGURADA ____ ESPOSA ____ NINA ____ OTRA ____

2ND INSURANCE - ASEGURANZA SEGUNDA

NAME OF INSURED - NOMBRE DE ASEGURADO

EMPLOYER/SCHOOL - PATRON/ESCUELA

ID # - NUM GROUP # - GRUPO PLAN # - PLAN

BIRTHDATE - FECHA DE NACIMIENTO AGE - EDAD SEX - SEXO

PACIENTE ES - ASEGURADA ____ ESPOSA ____ NINA ____ OTRA ____

ASSIGNMENT OF BENEFITS - I HEREBY ASSIGNALL MEDICAL AND SURGICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING GOVERNMENT PROGRAMS, PRIVATE INSURANCE, MAJOR MEDICAL BENEFITS, AND ANY OTHER HEALTH PLAN, TO PERINATAL ASSOCIATES OF CENTRAL CALIFORNIA MEDICAL GROUP, INC. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

ASIGNACION DE BENEFICIOS - POR ESTE ACTO ASIGNO TODOS LOS BENEFICIOS MEDICOS Y SURGICOS QUE SOY AUTORIZADA, INCLUSIVO DE PROGRAMAS DEL GOBIERNO, DE ASEGURANZA PRIVADA, DE BENEFICIOS MEDICOS, O DEL OTRO PLAN DE SALUD A PERINATAL ASSOCIATES OF CENTRAL CALIFORNIA MEDICAL GROUP, INC. ESTA ASIGNACION CONTINUARA HASTA QUE LA REVOQUE POR CARTA ESCRITA. UNA COPIA DE ESTA ASGIANACION ES TAN VALIDA COMO SI FUERA LA ORIGINAL. COMPRENDO QUE SOY RESPONSABLE FINANCIALMENTE POR TODOS LOS COBROS SI PAGADOS O NO PAGADOS POR ESTAS ASEGURANZAS. POR ESTE ACTO AUTORIZO ESTE ASIGNADOR QUE RELEVE TODA LA INFORMACION PARA ASEGURAR EL PAGO.

**SIGNATURE - FIRMA** _____ **DATE - FECHA**_____

## Acknowledgement of Receipt of Notice of Privacy Practices

Perinatal Associates of Central California Medical Group, Inc

2210 E Illinois Ave Ste 308, Fresno, CA 93701-2184

2273 E Beechwood Ave, Fresno, CA 93720-0329

Privacy Officer 559-268-8307

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

## Acknowledgement of Receipt of Notice of Prenatal Genetic Counseling

I hereby acknowledge that I received a copy of this medical practice's notice of Prenatal Genetic Counseling.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

# PERINATAL ASSOCIATES OF CENTRAL CALIFORNIA MEDICAL GROUP, INC.

2210 E Illinois Ave Ste 308, Fresno, CA 93701-2184
2273 E Beechwood Ave, Fresno, CA 93720-0329

(559) 268-8307

## FINANCIAL POLICY

Dear Patient:

We would like to take this opportunity to welcome you to our practice and to thank you for choosing us to provide a portion of your health care. We appreciate your trust in us and we look forward to keeping both you and your baby healthy. As part of our service we try to contain the ever-rising cost of health care. Over the past 15 years our average charge has increased less than 40%, far less than the rate of inflation. In order to try to limit increases in our fees we have implemented a financial policy.

Our financial policy was designed to give you a number of payment options to choose from in order to make your health care payment as easy on you as we can. You will receive important forms that must be completed prior to seeing a doctor. In order to provide the highest quality of care, please complete these forms as accurately as you can.

Regarding insurance, we require certain co-payment or pre-payment amounts depending upon the type of insurance and the insurance carrier. You may use cash, check, or credit card to make your payments. If the insurance claim has not been paid within 90 days we require that **you pay the balance**. You may use one of the above mentioned payment methods. We bill your insurance company solely as a courtesy to you and we expect **YOUR** help in obtaining payment from **YOUR** insurance company. Your insurance carrier should be mailing the payment for the treatment that you received directly to our office. If by some mistake the payment is mailed to you, we expect you to immediately notify our office and to forward the payment to us. That money was meant to pay for the treatment that you received at our office. Failure to immediately forward this payment to us may force us to refer your account to a collection agency for settlement.

Following is a list of some of the insurances that we accept and the amount of payment that will be required at the time of today's visit. All co-payments, co-insurance payments or deductible payments are due at the time services are rendered.

| Type of Insurance | Amount of Payment Required |
|---|---|
| Medi-Cal | No payment with current card unless a non-covered Medi-Cal service or Medi-Cal co-payment (share of cost). |
| Kaiser | No payment unless a non-covered Kaiser service. |
| Medicare | 20% of the approved charge. |

| | |
|---|---|
| Private Insurance | 20% to 50% of the charge depending upon the type of insurance, insurance plan, etc. |
| Champus | No payment unless a non-covered Champus service or Champus required co-payment |
| Other HMO or contracted insurance | Co-payment or percentage will vary depending upon your insurance plan. |
| Cash paying or no current insurance card | 50% of the charge. |

Your signature at the bottom of this page indicates that:

1. You have read, understand and agree to the provisions of this financial policy.
2. You agree to forward to this office immediately any payment by your insurance company sent to you.
3. You agree to notify this office if your insurance changes during the course of your treatment.
4. You have had the opportunity prior to your visit with the doctor to find out what the expected charges are for today's visit.
5. You understand that you are responsible for payment of your bill and will be asked to do so **if your insurance has not paid within 90 days.**
6. You agree to inform us now if you have a second insurance, if you are eligible for a second insurance, or if you plan to apply for a second insurance (such as Medi-Cal).

I prefer to settle my account by (please circle one):

Cash Check VISA Card Master Card Discover Card

SIGNATURE OF PATIENT_____DATE_____

WITNESS_____DATE_____

Rev 2016-03-07

# Prenatal genetic counseling

Prenatal genetic counselors work with individuals, couples, or families who have an increased chance of having a child with a birth defect or genetic condition. Those who are already pregnant or are considering having a child in the future can meet with a prenatal genetic counselor to learn more about the condition in question, understand their risks more clearly, and discuss options for prenatal screening, testing, and/or assisted reproduction techniques such as sperm and egg donation. During pregnancy, if a baby is found to have a birth defect or genetic condition you may be referred to a prenatal genetic counselor. The counselor will help the expecting couple understand the medical information, what to expect, and how to prepare for the birth of a child with special needs, as well as discuss options such as pregnancy termination or adoption. Prenatal counselors also help many families who do not have an increased chance of having a child with a birth defect or genetic condition understand prenatal screening and testing options. Procedures such as blood tests and ultrasounds may be able to give a better idea if a developing baby has a chance of having birth defects or a genetic condition.

# Why see a prenatal genetic counselor?

**You and/or your partner:**

• Are worried about a genetic condition or a disease that runs in your family
• Have a child who is affected with a genetic condition and are thinking about having another child in the future
• Have family members with mental retardation or birth defects
• Have a history of infertility or pregnancy losses (miscarriages or stillbirths)
• Are concerned that your health or lifestyle poses a risk to the pregnancy
• Are concerned about risks to the pregnancy associated with increasing parental age
• Receive abnormal prenatal screening or ultrasound results
• Are concerned that you are at increased risk of being a carrier of a genetic condition because of your ethnic background (some diseases are more common in certain ethnicities)
• Are pregnant and the baby has been diagnosed with a birth defect or genetic condition
• Have taken a medication or drug during pregnancy or have been exposed to a chemical and are concerned that it might cause a problem for the baby

# What will happen during my appointment?

Depending on the reason on the reason for the visit, some things a genetic counselor may do during an appointment are:

• Go over your family and medical history with you. The team will take a family history of at least three generations, documenting all genetic conditions or health problems in each family member.
• Figure out and explain your chances of having a child with specific genetic conditions
• Help you explore and make decisions about your options for screening and testing before and during pregnancy
• Help you interpret screening or testing results
• Help you understand medical and genetic information

• Provide you with any information about any problems detected during pregnancy and help you understand your options
• Provide supportive counseling and information about resources and support networks
• Explain the diagnosis and any issues about the condition, including how the condition is expected to progress, the management of the condition, treatment options, whether genetic testing is available, and the chances of the condition being present in future pregnancies.

This may be done all in one counseling session or over the course of numerous sessions. The healthcare team may ask you to come back for follow-up appointments.

Specialized Deliveries
PERINATAL ASSOCIATES
OF CENTRAL CALIFORNIA, MEDICAL GROUP INC.
Douglas A. Helm, M.D., FACOG

**Downtown Fresno**
2210 E Illinois Ave
Suite 308
Fresno, CA 93701

**North Fresno**
2273 E Beechwood Ave.
Fresno, CA 93720

(559) 268-8307

**Payment Authorization Form**

## Payment Authorization Form

Authorize your payment to be deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

**Payments Options That Will Make Your Life Easier:**

- It's convenient (saving you time and postage)
- If you have a balance on your account, you can quickly pay it online at: http://www.fresnohighriskob.com All you need is your account number that is listed on any statement. Or simply call us and we would be happy to look it up for you!
- Call us and let us know what method of payment you want to use and your account number

**Here's How It Works:**

List the payment type(s) you would like to use and we will create an account for you in our system. Anytime you wish to make a payment, just let us know the amount and which method of payment. A receipt for each payment can be mailed or emailed to you. Checking account payments will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us prior to the payment being collected. If you would like to pay by checking at a later date, send us a VOIDed check so we can get the information from your check entered into our system.

**Please complete the information below:**

I _____ authorize Perinatal Associates of Central California Medical Group, Inc. to process my payments with the following information.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____
(Optional)

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Perinatal Associates of Central California Medical Group, Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the request is made. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Perinatal Associates of Central California Medical Group, Inc. may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized payment. I acknowledge that any checks mailed into the office will be considered a reference for us to create the eCheck/ACH transaction and should be marked VOID. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.