Birth & Women's CENTER

3100 Swiss Avenue | Dallas, Texas 75204 | 214-821-8190
www.birthcenter.net

CLIENT REGISTRATION AND PERSONAL DATA

Please fill out this form in its entirety prior to your initial visit. This information is essential to your birth certificate and to be able to contact you throughout your pregnancy.

Mother's Name:_____	Maiden Name: _____
Street Address: _____	Date of Birth:_____/____/_____Race:_____
City:_____State:_____ Zip:_____	State of Birth:_____
Inside city limits? ☐ yes ☐ no	Religion:_____Marital Status:_____
How long at this address? Years_____Months_____	Years Education:_____Occupation:_____
Home phone:_____	Social Security Number:_____
Cell phone:_____	Best time to call:_____
Work phone:_____	Do you check messages? ☐ yes ☐ no
Email:_____	May we text your cell phone? ☐ yes ☐ no
Father's Name:_____	Date of Birth:_____/____/_____ Race:_____
Street Address: _____	State of Birth:_____
City:_____State:_____ Zip:_____	Religion:_____Marital Status:_____
Home phone:_____	Years Education:_____Occupation:_____
Cell phone:_____	Social Security Number:_____
Work phone:_____	Best time to call:_____
Email:_____	Do you check messages? ☐ yes ☐ no
OTHER INFORMATION	
Referred by:_____	Primary Support Person:_____
Emergency contact:	Method of payment: Cash ☐ Insurance ☐
Name:_____	Insurance Company:_____
Phone:_____Relationship:_____	ID:_____Group:_____
Tour date:_____	Phone No._____Policy Holder:_____

Pregnancy Forms Checklist *(Please check off)*	**Classes** *(Please check off if completed)*	**Birth Center Orientation** *(Please enquire and check off as needed)*
Consents Signed (4) ☐	Bradley Classes: ☐	Tour of the Center: ☐
Terms of Payment: ☐	BWC Saturday Class: ☐	After Hours Contact: ☐
Food Diary: ☐	CPR Class: ☐	

Birth & Women's CENTER

PERSONAL QUESTIONNAIRE

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In the event your medical records are copied for another healthcare provider,
this page WILL NOT be copied and will be kept confidential.

yes ☐ no ☐ Are you and the FOB related by blood (for example, cousins)?

yes ☐ no ☐ Are you and the FOB from any of the following ethnic groups? If yes, check which ones.

☐ Jewish ☐ Black ☐ Asian ☐ Mediterranean ☐ Eskimo ☐ Haitian

yes ☐ no ☐ Have you or the FOB ever had hepatitis or jaundice?

yes ☐ no ☐ Have you ever used any drug intravenously (IV) or had a blood transfusion?

yes ☐ no ☐ Have you ever had a sexual partner who used drugs IV, had a blood transfusion or had bisexual relations?

yes ☐ no ☐ Have you had more than 5 sexual partners in the last five years?

yes ☐ no ☐ Do you think you are at an increased risk of having a baby with a birth defect or genetic problem?

yes ☐ no ☐ Do you think you are at an increased risk for hepatitis?

yes ☐ no ☐ Do you think you are at an increased risk of having HIV/AIDS?

yes ☐ no ☐ Have you ever experienced dramatic fluctuations in your weight?

yes ☐ no ☐ Have you ever had anorexia, bulimia or eating problems?

yes ☐ no ☐ Is there anything in the development of your sexuality you'd like to discuss?

yes ☐ no ☐ Are you now or have you ever been in a physically, emotionally or sexually abusive relationship?

yes ☐ no ☐ Have you ever been forced to take part in sexual activities against your will?

yes ☐ no ☐ Have you ever had severe emotional problems?

yes ☐ no ☐ Have you ever been on any medication for psychological problems?

yes ☐ no ☐ Has anyone ever told you, or do you think you use or have used drugs or alcohol excessively?

Do you have any particular ethnic, cultural or religious preferences for your care during this pregnancy and birth?

Please detail any concerns or questions you may have about this pregnancy and your care.

MEDICAL HISTORY

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Name:_____Birthdate:_____/_____/_____Today's date:_____/_____/_____

Family History: Please indicate if anyone in your immediate family has ever had one of these conditions. If so, who and when.

- ☐ High blood pressure:_____
- ☐ Cancer:_____
- ☐ Diabetes:_____
- ☐ Twins:_____
- ☐ Severe emotional problems:_____
- ☐ Alcohol/drug abuse:_____
- ☐ Other medical conditions:_____

Father's History: Indicate if the father of the baby (FOB) has ever had any of these conditions. If so, when.

- ☐ Urethritis:_____
- ☐ Alcohol/drug abuse:_____
- ☐ Tobacco use:_____
- ☐ Alcohol/drug abuse:_____
- ☐ Sexually transmitted disease:_____
- ☐ Severe emotional problems:_____
- ☐ Other medical conditions:_____

Your Mother's History: Please answer these questions about your mother.

- ☐ Number of pregnancies:_____
- ☐ Number of live births:_____
- ☐ Miscarriages:_____
- ☐ Any complications:_____
- ☐ Your weight at birth:_____
- ☐ Did she take DES with you:_____

Genetic History:

☐ Yes ☐ No Have either you or the FOB ever had a baby with birth defects? If yes, describe:_____

☐ Yes ☐ No Did you or the FOB have a birth defect yourselves? If yes, describe:_____

☐ Yes ☐ No Do either you or the FOB have a history of pregnancy losses (miscarriages or stillborn)? If yes, describe:_____

☐ Yes ☐ No If you answered yes to the last question, have either of you had genetic counseling?

☐ Yes ☐ No If you answered yes to the last question, have either of you had chromosomal studies? If yes, where and when:_____

☐ Yes ☐ No Are you or the FOB of Jewish ancestry?

☐ Yes ☐ No If you answered yes to the last question, have either of you had a Tay-Sachs screening test? If yes, give date and results._____

☐ Yes ☐ No Are you or the FOB black?

☐ Yes ☐ No If you answered yes to the last question, have either of you had a Sickle Cell screening test? If yes, give date and results:_____

☐ Yes ☐ No Please describe any abnormalities that have occurred in the children in your or the FOB's family such as mental retardation, birth defects, deformities or inherited diseases like hemophilia, muscular dystrophy, or cystic fibrosis._____

☐ Yes ☐ No Will you be 35 or older when the baby is born?

☐ Yes ☐ No Will the FOB be 50 or older when the baby is born?

☐ Yes ☐ No Do you have any objections to receiving blood or blood products?

Signature: _____Date:_____/_____/_____

Healthcare Provider's Notes

Do you have any other concerns about birth defects or inherited disorders?

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MEDICAL HISTORY

Your History: *Indicate if you have ever had any of these conditions and when. Attach additional information if necessary.*

- ☐ Severe headaches:_____
- ☐ Eye/vision problems:_____
- ☐ Ear/hearing problems:_____
- ☐ Dental problems:_____
- ☐ Thyroid problems:_____
- ☐ Hemorrhages:_____
- ☐ High blood pressure:_____
- ☐ Varicose veins:_____
- ☐ Hemorrhoids:_____
- ☐ Tuberculosis:_____
- ☐ Asthma:_____
- ☐ Stomach problems:_____
- ☐ Ulcers:_____
- ☐ Bowel problems:_____
- ☐ Colitis:_____
- ☐ Blood in stool:_____
- ☐ Gall bladder problems:_____
- ☐ Liver problems:_____
- ☐ Hepatitis:_____
- ☐ Diabetes:_____
- ☐ Hypoglycemia:_____
- ☐ Bladder infections:_____
- ☐ Kidney infections:_____
- ☐ Urinary surgery:_____
- ☐ Urethral dilation:_____
- ☐ Aching joints:_____
- ☐ Pelvic/back injuries:_____
- ☐ Seizures:_____
- ☐ Hospitalizations:_____
- ☐ Surgeries:_____
- ☐ Allergies (drug or other):_____
- ☐ Other medical conditions:_____
- ☐ _____

Gynecologic History: *Please answer these questions about yourself.*

Age at first period:_____
Length of cycle (days):_____
Duration:_____
Date of last Pap smear:_____
Have you ever had an adnormal Pap? ☐ No ☐ Yes, detail when and results:_____
_____

Past Pregnancies (from earliest to latest)

Date	Weeks	Outcome	Problems

Please indicate if you have ever had any of the following conditions and when.

- ☐ Yeast infections:_____
- ☐ Trichomonas:_____
- ☐ Gardnerella:_____
- ☐ Bacterial vaginosis:_____
- ☐ Chlamydia:_____
- ☐ Gonorrhea:_____
- ☐ Syphilis:_____
- ☐ Other:_____
- ☐ PID:_____
- ☐ Genital sores:_____
- ☐ Oral Herpes:_____
- ☐ Genital Herpes:_____
- ☐ Condyloma (warts):_____
- ☐ Cervicitis:_____
- ☐ Cervical surgery:_____
- ☐ Cervical polyp:_____
- ☐ Ovarian cysts:_____
- ☐ Fibroids:_____
- ☐ Endometriosis:_____
- ☐ Abnormal bleeding:_____
- ☐ Uterine surgery:_____
- ☐ Breast lumps:_____
- ☐ Breast surgery:_____
- ☐ Infertility:_____

Present Pregnancy: *Please answer these questions about your current pregnancy.*

First day of your last period: _____Was it normal? ☐ Yes ☐ No If no, give date of last normal period:_____
Suspected date of conception:_____Date of pregnancy test:_____Was this pregnancy planned? ☐ Yes ☐ No
Your feelings about this pregnancy:_____
Father's feelings about this pregnancy:_____
Most recent birth control used:_____ Other birth control used in the past:_____
Any complications?_____

Please indicate if you have had any of the following problems during this pregnancy:

- ☐ Nausea:_____
- ☐ Vomiting:_____
- ☐ Fever:_____
- ☐ Headache:_____
- ☐ Dizziness:_____
- ☐ Indigestion:_____
- ☐ Leg cramps:_____
- ☐ Rash:_____
- ☐ Backache:_____
- ☐ Swelling:_____
- ☐ Constipation:_____
- ☐ Diarrhea:_____
- ☐ Urinary complaints:_____
- ☐ Abdominal/pelvic pain:_____
- ☐ Vaginal bleeding/spotting:_____
- ☐ Vaginal discharge:_____
- ☐ Bleeding gums:_____
- ☐ Varicose veins:_____
- ☐ Hemorrhoids:_____
- ☐ Loneliness:_____
- ☐ Depression:_____
- ☐ Family/relationship problems:_____
- ☐ Work problems:_____
- ☐ Other:_____
_____

Please indicate if you have been exposed to any of the following during this pregnancy:

- ☐ Tobacco:_____
- ☐ Alcohol:_____
- ☐ Caffeine:_____
- ☐ Marijuana:_____
- ☐ Cocaine:_____
- ☐ Street drugs:_____
- ☐ Prescription drugs:_____
- ☐ Non-prescription drugs:_____
- ☐ Vitamins:_____
- ☐ Herbs:_____
- ☐ Fumes/sprays:_____
- ☐ X-rays:_____
- ☐ Ultrasound:_____
- ☐ Measles:_____
- ☐ Viruses:_____
- ☐ Vaccinations:_____
- ☐ Cats:_____
- ☐ Other:_____

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CONSENT FORM

Being in approximately the _____ month of pregnancy and being _____ years of age, I hereby request enrollment in the Birth Center program with the following understandings. (Headnotes are merely for convenience).

1. Physical Examinations

I engage and authorize any member of the Medical Team Staff to perform physical examinations on my person to confirm general health and pregnancy status, obtain the usual specimens, and perform the usual diagnostic procedures, including but not limited to the following:

A. Drawing blood for type and Rh factor, serology, HIV, and other tests, including drug screen if indicated
B. Pregnancy test,
C. Urinalysis, including drug screen if indicated,
D. Blood pressure,
E. Internal examination, including collection of both vaginal and cervical specimens, including a Pap smear.

It has been explained to my satisfaction that even when the above are properly and correctly done there is a potential for infection, tissue damage and other unpredictable medical conditions. I agree that the Medical Team Staff shall be responsible for the performance of their own professional acts only. The test results shall be the responsibility of those who perform them.

2. Authority to Treat

I engage and authorize any member of the Medical Team Staff to treat, administer and provide as necessary or available to me and my baby:

A. Health care, including prenatal education and instruction,
B. Physical examinations as necessary,
C. Obtaining of blood or other specimens for laboratory tests,
D. Oral medications,
E. Intramuscular, subcutaneous and intravenous injections and local anesthesia,
F. Intravenous infusions,
G. Delivery of my baby,
H. Episiotomy and repair,
I. Postpartum care including family planning,
J. In-house newborn care,
K. A follow up home visit, and
L. Other procedures related to childbearing as may be deemed necessary.

The administration and performance of such care may be at Birth & Women's Center and elsewhere, including an ambulance. I grant to the personnel of Birth & Women's Center and to its subcontractors and their personnel full authority to administer and perform any and all drugs, treatments, tests, diagnostic procedures, examinations, and care to or upon me and my baby.

In case of emergencies, I authorize any member of the Medical Staff Team to take appropriate measures; when specialized equipment or hospitalization is believed required, to transfer me or my baby to a local hospital.

3. Early Transfer
I understand that if you recognize signs which indicate that the course of my pregnancy may deviate significantly from the normal (even though such deviation may not necessarily adversely affect the outcome of the pregnancy), you will discuss my condition with me in terms of the Center's management criteria. Further, if after such discussion, it is the decision of the Medical Team Staff that the management of my pregnancy shall be transferred to a physician and/or hospital; I/we agree to abide by this decision regarding transfer at any stage of the pregnancy.

Please initial. I agree. _____

4. Informed Consent
While pregnancy and childbearing are normal human functions, it has been explained to me, and I understand that there are hazards and stresses of childbearing to the mother and other hazards and stresses of being born to the baby which may arise or become aggravated suddenly and unpredictably. These include the possibilities of excessive blood loss, infection, convulsions, coma, allergic reaction and respiratory distress. The following are some other medical problems affecting the mother that could occur: placental abruption, hemorrhage, amniotic fluid embolism, uterine rupture, cardiac arrest, and anaphylactic shock. Some other problems affecting the fetus and newborn that could occur are: prolapse and other problems relating to the umbilical cord, congenital anomalies, fetal distress, malpresentation, immaturity and postmaturity, birth injuries, stillbirth and amnionitis, necessitating vacuum or forceps delivery. I understand also that certain conditions affecting the newborn such as the effects of hyperbilirubinemia, blood incompatibility, precipitous labor and respiratory distress syndrome, some congenital anomalies, allergies and infections and brain damage with or without mental retardation are difficult to recognize or are unrecognizable within 6 hours of birth at which time families will usually be discharged.

I have been informed with regard to all of the foregoing and advised that I may have more detailed and complete explanations of each condition described and other even more remote risks, consequences and conditions. (Please initial or ask for further explanations.)

I do not desire such further explanation at this time. _____

I am aware that the practice of medicine, nursing, and midwifery are not exact sciences and I acknowledge that no guarantees or assurances have been made to me concerning the results of the treatments, examinations, and procedures to be performed nor of the outcome of pregnancy.

5. Patient History and Right To Withdraw
In view of all of the above, I understand that in my selection and treatment at the Birth & Women's Center you will rely on medical history and the information about myself which I provide. I affirm that such information is and will be correct and accurate to the best of my knowledge. In addition, I agree to follow all the rules, regulations, and policies of the Birth & Women's Center with the understanding that I may voluntarily withdraw from enrollment at any time I wish upon written notice to you.

6. Disposition of Specimens: (Please initial one of the following)

A._____I hereby authorize the Birth & Women's Center Medical Team Staff to dispose the placenta (after birth)

B._____I will be fully responsible for making other disposition arrangements for the placenta (after birth). Failure to remove within two days after it is obtained will constitute approval of disposition under A.

7. Transfer Consent:
I understand that in the event of a transfer, Baylor University Medical Center, its employees and consulting physicians assume no responsibility or liability to events or management of labor that have occurred prior to my arrival at the hospital.

I understand that in the event of a transfer to the hospital I am no longer considered a low risk pregnancy, and I may require intervention. I agree to accept the treatment recommendation of the transferring physicians which may include but is not limited to: intravenous fluids and medications, use of Pitocin, electronic fetal monitoring, possible forceps or vacuum extraction, possible cesarean section.

8. Malpractice Coverage:
All Certified Nurse Midwives and Birth & Women's Center are covered with professional liability.

The undersigned have read and understand the above statement and have had the opportunity to ask questions. It is entirely acceptable.

Signature_____ Date ____/_____/_____

Signature of Partner_____ Date ____/_____/_____

Witness_____ Date ____/_____/_____

Birth & Women's CENTER

DISCLOSURE FORM

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The Birth & Women's Center is an alternative approach to normal childbearing. It may appeal to and be desired by some people and not others. For this reason, we feel you must be fully informed.

You have participated in the orientation conducted by our professional staff, which includes:

1. Your personal inspection of our maternity facilities,
2. Orientation to our procedures, methods, and services, as well as our mutual expectations,
3. Frank discussions of how hospital delivery and delivery out of a hospital differs,
4. The potential risks of childbearing to the mother and her baby and their management in the Birth Center,
5. The criteria for management are available for your inspection should you care to see them.

We have taken every reasonable precaution to ensure your safety, comfort, and satisfaction. We are a State licensed freestanding childbirth facility. **WE ARE NOT A HOSPITAL**. The Birth & Women's Center has on hand the medications and equipment we think necessary for normal childbearing in a homelike setting. We do not have an operating room or intensive care unit for mother or baby, nor the highly specialized services and equipment which such units contain. Also, blood or blood fractions and general anesthesia are not administered here. The services of an anesthesiologist are not available. All are available at the Center's referral hospital in our service area.

Our Medical Team Staff consists of Certified Nurse Midwives, Consulting Obstetricians, and other qualified nurses and assistants. At any time it may be the judgment of the Medical Team Staff, based on the accepted management criteria, that your care is better provided in
another setting. Should transfer to physician or hospital become necessary, your records will be made available to the receiving care provider.

Referral or transfer from the Birth & Women's Center may be needed for you or your baby during your pregnancy, labor, delivery, or after the birth. Transfer will be made as follows:

For you:
To a consulting physician if insurance or financial arrangements are completed.

For baby:
Pediatrician on call or your private Pediatrician if time permits.

Although one of our staff members is likely to accompany you, hospital rules require that upon admission, the hospital staff and not ours, will have direct and exclusive responsibility for your care. All hospital, ambulance, and/or physician expenses incurred at such time or any other time shall be your obligation and are not included in our financial arrangements.

For those families delivering at the Center we will provide all normal postpartum care including one ten-day and one six-week follow-up office visit, scheduled after delivery. Home visits are available upon request for an additional fee.

It is the philosophy of the Birth & Women's Center that whenever possible, decisions about your care will be arrived at in consultation with you. Do not hesitate at any time to ask questions you have about our Childbirth Center and the functions as well as anything that concerns you, your baby, or your family.

Because of the nature of our Center, enrollment shall be at our exclusive discretion. Applicants will be notified about acceptance after all records and the physical examination are completed and laboratory reports received, generally at the second visit.

If you have any complaints about The Birth & Women's Center you may write or call:

Director, Health Facility Licensure and Certification Division
Texas Department of Health
1100 W. 49th Street | Austin, TX 78756 | (512) 834-6650

The undersigned have read and understand the above statements and have had the opportunity to ask questions.
It is entirely acceptable.

*Client's Signature*_____ *Date*_____

*Witness Signature*_____ *Date*_____

Client has been given her copy.

Birth & Women's CENTER

OBSTETRICAL HISTORY

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Name of Client:_____ **Current Due Date:**____/____/_____

Live Births_____ Stillbirths_____ Miscarriages_____ Abortions_____ Premature Births_____

Number of Pregnancy	1st	2nd	3rd	4th	5th	6th
Year						
Weeks Gestation						
Delivery Outcome: Normal Vaginal, C-Section, Forceps, Miscarriage						
Sex						
Birth Weight						
Apgars						
Length of Labor/ Second Stage						
Anesthesia/Analgesia						
Episiotomy/ Laceration						
Where Delivered?						
With Whom?						
Problems during pregnancy (anemia, diabetes, hypertension)						
Total weight gained						
Vaginal infections/ UTIs / STDs						
Complications						
Status of baby now						
Breastfed / Bottlefed How long?						

PHOTO CONSENT

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In an effort to foster and promote family-centered maternity care and alternative birthing services for all childbearing families, I consent to the following:

- Use of my name and biographical material or transcripts written by me, about me, my pregnancy, and my children.
- Use of my picture and/or photographs and names of my child/children.
- Use of information from my record regarding my care while a maternity patient at Birth & Women's Center for statistical reporting and publication as long as the Birth & Women's Center ensures the confidentiality of my records.

I understand that there is no money or other form of payment due now or in the future to me or my children for the use of photographs and/or written materials.

I understand that the use of photographs and/or written material may be used to promote birth centers and the midwifery model of care on the Internet and other publications.

I hereby give my full release to Birth & Women's Center for the above described use of my photographs and/or written materials.

Mother's Name:_____

Mother's Signature:_____ Date:_____

Father's Name:_____

Father's Signature:_____ Date:_____

Address:_____City:_____Zip:_____

Witness:_____ Date:_____

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PRENATAL NUTRITION & EXERCISE HISTORY

Name of Client:_____ **Date:**____/____/_____

1. How would you describe your eating habits? ☐ Good ☐ Fair ☐ Poor

2. Since conception, have you had any of the following?
   ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Hemorrhoids ☐ Heartburn

3. Before this pregnancy, what was your usual weight? _____
   What is the most and least you ever weighed as a non-pregnant adult?
   Most:_____ Least:_____
   If you were pregnant before, how much weight did you gain during your pegnancy _____
   How much do you expect to gain this pregnancy?_____

4. Are you on any of these specific diets?
   ☐ Low Salt ☐ Vegetarian ☐ Diabetic ☐ Low Fat ☐ Weight Loss ☐ Other:

5. Do you crave anything (including non-food items)?_____

6. Are there any foods you avoid eating which you think we will say you should be eating?_____
_____

7. How many cups of the following liquids do you drink a day?

_____Water	_____Sodas with sugar	_____Coffee
_____Juice	_____Diet sodas, beverages	_____Tea
_____Milk	_____Punch/Kool-aid	_____Other

8. How many times a week do you usually eat:
   _____Breakfast _____Lunch _____Dinner _____Snacks

9. Who does the following in your household?
   Plans meals_____ Buys food_____ Prepares food_____

10. Which best describes the type & amount of food in your home?_____
    ☐ Enough of the kind wanted ☐ Sometimes not enough
    ☐ Enough, but not always the kind wanted ☐ Often not enough

11. Prior to pregnancy (in the last 2 years), did you exercise regularly? (Besides housework and childcare) ☐ Yes ☐ No
    If yes, how often?_____ What type?_____

    Have you continued to exercise? ☐ Yes ☐ No

12. What plans do you have for exercise during this pregnancy?_____
_____
_____

RN/CNM COMMENTS: _____
_____
_____
_____
_____
_____
_____

Birth & Women's CENTER

MEAL CHART

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Name of Client:_____**Current Due Date:**____/____/_____

DATE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							
Protein							
Water							

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Ackowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ **Birthdate:**_____/_____/_____

Date: _____

Signature:_____

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PATIENT RECORD OF DISCLOSURES

Name of Client:_____**Date:**____/____/_____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____
☐ O.K. to leave messages with detailed information
☐ Leave message with call-back number only

Work Telephone

☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Written Communication
☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to this number

☐ Other _____
_____

Patient Signature_____ Date _____

Print Name_____ Birthdate _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)
		☐				
		☐				
		☐				
		☐				
		☐				
		☐				
		☐				

1. Check this box if the disclosure is authorized 2. Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
3. Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

#21122 – Medical Arts Press* 1-800-328-2179

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TERMS OF PAYMENT FOR INSURED CLIENT

Birth & Women's Center accepts many major insurance plans. We will contact your insurance company, verify your benefits and calculate your estimated out-of-pocket expenses. To receive a personalized quote of benefits, please go to www.birthcenter.net, click "Fees and Costs" and complete the Insurance Request Form. Your prenatal care, labor, birth and postpartum care are typically covered by your insurance, unless there is a specific exclusion for a certified nurse-midwife (advanced nurse-practitioner) and/or the birthing center facility. You are responsible for paying your deductible and co-insurance amounts in full, one month prior to delivery. We require a $300 deposit that MUST BE PAID at your first prenatal visit and will be applied to your out of pocket expense.

This covers the following services

- **24-hour availability of a nurse-midwife**
- **All Prenatal Visits**
  - Initial visit, (may include physical exam, Pap smear, health history, nutritional counseling and review of records, as applicable), routine prenatal visits and consultations.
- **Labor and Delivery at the Birth Center**
  Care and support during labor, delivery, and the immediate postpartum period, including use of the birth center's facility from admission to discharge.
- **Postpartum Follow-up**
  - Newborn care, including labs and the required Newborn Screen.
  - When applicable, a home visit is provided.
  - Ten-day and six-week follow-up office visits scheduled after delivery.
- **Birth Center Preparation Class**
  The **mandatory** birth-center preparation session at Birth & Women's Center (Please note: This is not a Childbirth Education Class).
- **Standard labs, which are:**
  - Comprehensive obstetric panel
  - Urine culture x 1
  - HIV test
  - One-hour glucose test
  - Group B Strep culture
  - Urine checks at each appointment (in-office)
- **What is NOT billed through Birth & Women's Center:**
  - Physician consultation, if necessary
  - Sonograms
  - Childbirth education classes (required for first-time mothers)
  - Hospital delivery
- **Hospital Deliveries**
  Should complications develop during labor that necessitate a transfer of your care for physician management at the hospital, your prepaid out-of-pocket expenses cover your prenatal care, managing your labor at the Birth & Women's Center, MD and/or hospital consultation for transfer of care and support. The physician and the hospital will submit claims to your health insurer independently of the Birth & Women's Center. Services not covered by your insurer are your responsibility.

Birth & Women's CENTER

3100 Swiss Avenue | Dallas, Texas 75204 | 214-821-8190
www.birthcenter.net

FEES AND COST FOR SELF PAY CLIENT

Our Fees:
The fee for prenatal care, delivery and postpartum care is $5,450. This includes the following services for a normal pregnancy and delivery:

- **24-hour availability of a nurse-midwife**
- **All Prenatal Visits**
  - Initial visit, (may include physical exam, Pap smear, health history, nutritional counseling and review of records, as applicable), routine prenatal visits and consultations.
- **Labor and Delivery at the Birth Center**
  - Care and support during labor, delivery, and the immediate postpartum period, including use of the birth center's facility from admission to discharge.
- **Postpartum Follow-up**
  - Newborn care, including labs and the required Newborn Screen.
  - Ten-day and six-week follow-up office visits scheduled after delivery.
- **Birth Center Preparation Class**
  - The **mandatory** birth-center preparation session at Birth & Women's Center a month before your due date (Please note: This is not a Childbirth Education Class).
- **Standard labs, which are:**
  - Comprehensive obstetric panel
  - Urine culture x 1
  - HIV test
  - One-hour glucose test
  - Group B Strep culture
  - Urine checks at each appointment (in-office)
- **WHAT IS NOT INCLUDED:**
  - Additional labs not indicated above
  - Medications if necessary
  - Emergency supplies if necessary
  - Physician consultation if necessary
  - Sonograms
  - Childbirth education classes (required for first-time mothers)
  - Hospital delivery
- **Hospital Deliveries**

  Should complications develop during labor that necessitate a transfer of care for physician management at the hospital, the physician and the hospital will bill independently of the Birth & Women's Center. Payment of outside services is the responsibility of the client and/or insurance as applicable. Physician fees of $2,400.00 are due in full at the time of service.