

AAMG Annapolis OB-GYN

2000 Medical Parkway, Suite 304

Annapolis, MD 21401

Phone: 410-573-9530

Appointment Reminders...

- **COMPLETE AND SIGN ALL OF THE ENCLOSED PAPERWORK. SEND COMPLETED PAPERWORK TO OUR PRE-REGISTRATION DEPARTMENT PREFERABLY TWO WEEKS PRIOR TO YOUR VISIT, OR ONE WEEK AT THE LATEST. PLEASE BRING YOUR ORIGINALS TO YOUR VISIT.**

Fax: 667-204-7241 or email: AOGpreregistration@aaahs.org

- If you picked up these forms from one of our offices, or received them in the mail, due to inability to print or access our website, you may drop them off at any one of our locations or mail them back to our Annapolis office. You can also submit them via the fax number or email address above. However, they must be received within the timeframe mentioned above to avoid cancellation.
If your pre-registration forms have not been received by 2 days prior to your appointment time, your appointment will be cancelled.
- You may be asked to reschedule your appointment if you arrive late and/or you do not have your completed paperwork in hand 30 minutes prior to your appointment time! To avoid cancellation, you must advise our pre-registration coordinator no later than 2 days in advance of your appointment at 410-573-9530 Ext. 7851168, if you need to arrive early with your completed forms.
- All patients MUST bring their current insurance card, a photo ID and copay to the visit.
- Your enrollment into your patient portal, MyChart, will serve as your electronic chart and a way to view your lab results and your medical records after your initial appointment. Please ask for a token at the time of your visit, to enable you to enroll.
- Be prepared to give us the name, address and phone number of your primary care physician.
- If you are being referred to us by another physician please bring a copy of your referral to the visit. If your insurance requires a referral for your visit, you must present the referral at the time of your visit.
- Bring all lab results, radiology results and records relative to your visit.
- If you are currently pregnant and transferring from another practice, it is important to have your prenatal records sent to us prior to your initial visit. Please be sure to include a copy of your last pap smear result. Without these important documents, you may not be seen.
- You must arrive 15 minutes prior to the time of your appointment.
- If your visit is at the Annapolis office, allow at least 15 additional minutes to park
- **YOU WILL BE CHARGED A "NO SHOW" FEE IF YOUR APPOINTMENT IS NOT CANCELLED WITHIN 24 HOURS.**

Updated 08/14/2020

PATIENT REGISTRATION FORM

Last Name (Print) _____ (First) _____ (MI) _____ (Previous/Maiden) _____

DOB _____ Marital Status: _____ Single _____ Married _____ Divorced _____ Sep. _____ Widow _____

Address _____ City _____ State _____ Zip _____

Home# _____ Work# _____ Ext _____ Cell# _____

Circle best way to reach you

E-Mail _____ Employer _____ Occupation _____

Race: () White () Black/African American () Hispanic () Other: _____

Ethnicity: () Hispanic or Latino () Not Hispanic or Latino () Decline Language: () English () Spanish () Other: _____

ARE YOU CURRENTLY PREGNANT: _____ Yes _____ No

I have been seen by Annapolis OB-GYN within the past 12 months _____ Yes _____ No
NOTE: If you checked "Yes", do NOT complete the rest of the form unless your information has changed. If you checked "No", please continue to complete the rest of the form below this box. YOU MUST SIGN AT THE BOTTOM.

PRIMARY CARE DOCTOR(Other than at this practice) _____ Phone _____

PHARMACY _____ LOCATION _____ Pharm Phone: _____

EMERGENCY CONTACT _____ Relationship _____

Emergency Contact's Home # _____ Work# _____ Cell# _____

YOUR PARTNER'S INFORMATION (SPOUSE /PARTNER/BABY'S OTHER PARENT) (Please circle one)

Name (Last) _____ (First) _____ (MI) _____ DOB _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home# _____ Work# _____ Cell# _____

PRIMARY INSURANCE: Insurance Co. _____ Phone# _____

Name of Insured _____ Patient Relationship to Insured _____ DOB _____

Insurance Address _____ Employer _____

Subscriber ID# _____ Group ID# _____ Co-Pay Amount _____

SECONDARY INSURANCE: Insurance Co. _____ Phone# _____

Name of Insured _____ Patient Relationship to Insured _____ DOB _____

Insurance Address _____ Employer _____

Subscriber ID# _____ Group ID# _____ Co-Pay Amount _____

I declare I have listed all the medical/health insurance plans from which I may receive benefits. I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I also understand that I am responsible for contacting AAMG Annapolis Ob-Gyn, in a timely manner, with any future changes in the above information, especially those that may affect the processing of my insurance claims.

Patient Signature _____ Date _____

Parent or Guardian _____ Relationship _____ Date _____

For office use only
FD _____ CL _____

HISTORY AND PHYSICAL RECORD

Print Name: _____ Date: _____ DOB: _____

Marital Status: (circle one) S Sep M D W Previously divorced? ____ Previously widowed? ____ Where were you born: _____

Place of Employment: _____ Occupation: _____

YOUR MEDICAL HISTORY: (Check off if you have had this illness, and write what type if applicable)

Disease	√	Type	Disease	√	Type	Disease	√	Type
Asthma			Kidney Dis/Infections			Epilepsy/Seizures		
Pulmonary Disease			High Blood Pressure			Hepatitis /Liver Disease		
Diabetes			Gastrointestinal Prob.			STD/HPV (list kind)		
Cancer			Depression/Anxiety			Herpes (list kind)		
Heart Disease			Chronic Bladder Infec.			Thyroid Disorder		
Hyperlipidemia			Osteoporosis			Blood Clotting Disorder		
Migraines			Addiction			Other:		

YOUR PAST SURGICAL/INJURY HISTORY: (List a D&C for a miscarriage in the OBSTETRICAL HISTORY below.)

Disease/Diagnosis/Injury	Procedure or Surgery Type	Date	Physician/Surgeon	Hospital

GYN HISTORY:

Menstrual Cycle:	Response	Menopause/Gyn:	Response
Age when period started?		Are you having peri-menopausal symptoms?	
Last menstrual period?		What are your symptoms?	
Periods are how many days apart?		Are you post-menopausal?	
How long does your period last?		Your age at menopause?	
Pain with menstrual period?		Type: Natural, Surgical, Premature, Chemo, Other?	
Do you bleed in between periods?		Pain with intercourse?	
Is your flow heavy, moderate or light?		Vaginal Dryness?	
Do you have pain between periods?		Bleeding with intercourse?	
Do you have a vaginal discharge?		Vaginal itching or odor?	
Is this normal for you?		Are you sexually active?	
Color and consistency of discharge?		Sexual orientation?	
		State method of contraception:	

RECENT SCREENINGS:

Screening	Date	Result	Screening	Date	Result	Screening	Date	Result
Bone Density			Colonoscopy			Pap		
Chest X-Ray			Cholesterol			Mammogram		

SOCIAL HISTORY:

SMOKING:	Response	CAFFEINE	Response	DRUGS:	Response
Do you smoke?		Do you drink caffeine?		Do you use drugs?	
How much do you smoke?		Amount/frequency?		Recovering from addiction	
Did you quit smoking?		Type of caffeine?		What type of addiction?	
How many years did you smoke?		EXERCISE/SAFETY			
		Do you exercise?		MISC:	
ALCOHOL		Exercise frequency?		Have you traveled outside of the US in the past year?	
Do you drink alcohol?		Wear seat belts?		Where did you visit?	
Amount/frequency?		Have a Living Will?			
Recovering from addiction?		Do you feel safe at home?			

OBSTETRICAL HISTORY:

Patient's Name: _____

Date of Delivery	Weeks of gest.	Type of Delivery	Physician	Sex	Wt.	Abortion (Elective)	Miscarriage	List other problems/complications, outcome, and/or infertility history.
TOTALS: Enter totals below:								
Total Pregnancies	# of Full Term	# of Premature	Elective Abortions	Miscarriages	Ectopic Pregnancy	Live Children		

ALLERGIES:

Allergy	Reaction	Allergy	Reaction

MEDICATIONS: (Include medications, birth control, vitamins & herbal supplements)

Name	Strength	Dosage	Reason	Name	Strength	Dosage	Reason

CHECK BELOW ANY DISEASE A BLOOD RELATIVE OF YOURS MAY HAVE, OR HAD: (Please write maternal or paternal side)

Disease	Relative	Outcome	Disease	Relative	Age of Diagnosis
Addiction (list type)			Alzheimer's		
Blood Disorder			Mental Illness (list type)		
Pulmonary			Epilepsy		
Depression			Cancer:		
Diabetes			Breast		
Osteoporosis			Colon		
Thyroid Disease			Ovarian		
High Blood Pressure			Uterine		
High Cholesterol			Skin		
Heart Disease (list type)			Other:		

PRENATAL QUESTIONNAIRE

DATE: _____

NAME: _____ DOB: _____ AGE: _____

1. When was your last menstrual period? _____ Was it normal? Yes No
2. How many total pregnancies have you had? _____ (including this pregnancy)
3. How many pregnancies ended in miscarriage, ectopic or therapeutic abortions?
Therapeutic abortions _____ Miscarriages _____ Ectopic _____
4. How many pregnancies were full term? _____ How many living children do you have? _____
5. Please check any of the following problems that you are currently experiencing:
Nausea _____ Vomiting _____ Bleeding _____ Breast tenderness _____ Frequent urination _____
Bladder pressure _____ Cramping _____
6. Have you had an X-ray since you have been pregnant? Yes No
If yes, what did you have X-rayed? _____
7. Have you taken any prescribed or over-the-counter medications since you have been pregnant? Yes No
If yes, what were the medications? _____
8. Have either you or the baby's father had herpes? Yes No
If yes, circle: Mother of baby Father of baby
9. Do you or the baby's father use drugs? Yes No
If yes, circle: Mother of baby Father of baby
10. Have you been treated for an eating disorder? Yes No
11. Do you have a history of diabetes? Yes No
If yes, circle one: while pregnant while not pregnant
12. Have you ever tested positive for Hepatitis B? Yes No
13. Have either you or the baby's father ever tested positive for HIV (AIDS)? Yes No
If yes, circle: Mother of baby Father of baby
14. Is there a history of twins or other multiple births in your family? Yes No
If yes, circle: Mother of baby Father of baby
15. Have you or the baby's father in a previous pregnancy had a stillborn child or three or more first trimester spontaneous pregnancy losses? Yes No
If yes, circle: Mother of baby Father of baby
16. What is your ethnicity? _____ Father of the baby's ethnicity? _____
17. Are you or the baby's father black? Yes No
If yes, circle one or both: Mother of baby Father of baby
Was this person or persons tested for sickle cell trait? Yes No
Mother's results _____ Father's results _____
18. Are you or the baby's father of Jewish ancestry? Yes No
If yes, circle one or both: Mother of baby Father of baby
19. Have you been tested for Tay Sachs? Yes No
Mother's results _____ Father's results _____

PATIENT'S NAME: _____

DOB: _____

20. Are you or the father of Italian, Greek or Mediterranean background? Yes No
 If so, have either of you been tested for B-Thalassemia? Yes No
 If yes, circle one or both: Mother of baby Father of baby
 and indicate the results _____
21. Are you or the baby's father of Filipino or Southeast Asian ancestry? Yes No
 If yes, have either of you been tested for A-Thalassemia?
 If yes, circle one or both: Mother of baby Father of baby
 and indicate the results _____
22. Was anyone in your family or the baby's father's family live born or stillborn with birth defects, mental retardation or any disease which you think might be inherited? Yes No
 If yes, please circle the disease or problem below and state the family relation.

DISORDER

FAMILY RELATION

- | | |
|--|-------|
| Any mental retardation | _____ |
| Down syndrome or other chromosomal defect | _____ |
| Hemophilia | _____ |
| Hydrocephalus | _____ |
| Huntington's chorea | _____ |
| Neural Tube Defect (Spina Bifida, Anencephaly) | _____ |
| Muscular Dystrophy | _____ |
| Duchenne's muscular dystrophy | _____ |
| Cystic Fibrosis | _____ |
| Congenital Heart Disease | _____ |
| Cleft Lip/Cleft Palate | _____ |
| Adult onset Polycystic Disease | _____ |
| Other _____ | _____ |

23. Do you have any medical conditions that may affect your pregnancy? Yes No
 If yes, please state: _____
24. Do you have a child with Autism, Asperger's or a related Syndrome? Yes No
25. If "yes" would you be interested in being tested for Fragile X Syndrome? Yes No
26. Are you interested in genetic testing? Yes No
27. Do you have a history of hypertension? Yes No

Place a check in the box to indicate your answer:

Over the last 2 weeks, how often have you been Bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on the edge				
2. Not being able to stop or control worrying				
3. Little interest or pleasure in doing things				
4. Feeling down, depressed, or hopeless				

28. Do you have any physical, emotional or sexual abuse in your life? Yes No

AAMG ANNAPOLIS OB-GYN

Information for Obstetrical Patients

We offer complete obstetrical care including prenatal, delivery, and post- partum care.

We rotate our delivery room coverage and feel it is important for you to meet each of us during your pregnancy. This will occur through scheduling of your prenatal visits. On some of these visits you may schedule with our obstetricians: Drs. Claudia Hays, Frederick Guckes, Suleika Michel, Ifeyinwa Stitt, Benjamin Solomon, Laura Merkel, Victoria Moore, Julia Lubsky and Janelle Cooper, along with our advanced practice providers - Rene Smit, CNM, Tara Pomponio, PA-C, Wenda Collien, CRNP, Julie Viera, PA-C, Marianne Eggerl, WHNP-BC/CNM, Aileen Landis, CRNP, and Emma Garey, PA-C. We encourage scheduling visits with our advanced practice providers; however, they do not deliver.

We do not practice general medicine, but we wish to be informed of any problems occurring during your pregnancy. We will work with your family doctor, internist, surgeon, etc., for problems outside the obstetrical bounds.

We encourage full participation of the baby's father or your support person in your prenatal care, childbirth classes, labor, delivery, and subsequent care of your infant. We do encourage and support the philosophy of prepared childbirth classes. We feel this is a most helpful and extremely beneficial way for you to prepare for your pregnancy, labor and delivery.

Our fee includes your initial complete physical examination, all routine prenatal visits, the management of labor and vaginal delivery, post-partum visits during your hospital stay, and your six week post-partum checkup in the office.

When you come into the office for your initial visit and registration, blood will be drawn and sent to the appropriate laboratory for your insurance. You may receive a bill from the lab for their service. Special medications, i.e. injections and medicines which must be obtained from a pharmacy, are not included in our fee. It is important to have insurance identification information with you at all times in case we are able to bill insurance directly for certain tests or procedures.

Should a cesarean section be required for delivery, there will be an additional charge. This procedure requires a surgical assistant. Since AAMC is not a teaching hospital, the assistant will be a licensed surgeon in private practice and you will receive a bill from his/her office. A vaginal birth after cesarean section (VBAC) may also involve an additional fee.

The hospital has no staff anesthesiologists, therefore, you will be billed separately for his/her service should you either desire or require anesthesia.

It is up to you to make arrangements for a Pediatrician to take care of your new baby. If you do not already have one and are not sure who to contact, ask one of us to recommend one or more for you to consider. Again, you will be billed separately for his/her service.

Sometimes during a pregnancy we may deem it necessary to order a sonogram or non-stress test. If this is the case, those procedures will be scheduled for you in our office. The charges for these tests are not included in your obstetrical fee. As soon as you receive notice from your insurance company that they have paid their portion, you are responsible for remitting the balance. Please carefully read our Advanced Beneficiary Notice (ABN) regarding your financial responsibility on certain tests that may not be covered by your insurance. There will be additional charges for the management of unlikely, but possible complications.

DANGER SIGNS DURING PREGNANCY:

Throughout your pregnancy, we will be discussing many of the common complaints and possible complications that occur. In the meantime, we would like you to familiarize yourself with the following danger signs:

- Vaginal bleeding
- Severe swelling in your face, hands or feet
- Pain, redness, swelling or heat in the calf of your leg
- Shortness of breath or difficulty breathing
- Blurring of vision or spots before your eyes
- Severe or constant headaches
- Fever and chills
- Burning and pain during urination
- Sharp, constant abdominal pain

Call us at (410)573-9530 should you notice any of these symptoms.

PAYMENT:

Upon confirmation of pregnancy, our billing department will confirm the level of benefits available for Global Maternity Care with your insurance company.

For patients whose plans involve deductible and/or coinsurance amounts, an Explanation of Delivery Fees will be sent to you specifically outlining your maternity benefits, including the amount estimated to be the portion of patient responsibility collectible during the prenatal months of care. Each Explanation of Delivery Fees acts as a contract between you and our office with balances payable in accordance with your payment plan selection. Specific questions regarding information contained in an Explanation of Delivery Fees should be directed to our OB billing coordinator at the number listed below.

Patients whose insurance plan issues benefits at a level that indicates limited patient responsibility will NOT be issued an Explanation of Delivery Fees. ALL balances assessed to your account are payable upon receipt of statements.

It is extremely important to advise our office immediately of any insurance changes to ensure appropriate billing.

If you have any questions regarding our obstetrical payment policies, please contact our OB billing coordinator. She can be reached at 443-837-1226, Monday thru Friday from 8:00 am to 4:00 pm.

AAMG Annapolis OB-GYN Advanced Beneficiary Notice (Signature required by ALL OB Patients) Managed Care Organization Enrollment

The information contained in this document applies to the following patient demographic:

- Any obstetrics patient applying for insurance through the Maryland Health Exchange whose eligibility qualifies them for enrollment in the Maryland Medical Assistance Program.
- Any obstetrics patient applying for Maryland Medical Assistance to help offset the cost of maternity care due to the large deductibles and/or co-insurance amounts of their current commercial insurance policies.
- Dependant children who either do not have maternity coverage under their parents' insurance plan or those who are looking to ensure automatic coverage for the baby from date of birth.

This document stands as notification that AAMG Annapolis OB-GYN only participates with Priority Partners, University Healthplan (Riverside), United Healthcare MCO (including AmeriChoice)

Important Information you need to know:

Who can apply?

- Uninsured patients (NOTE: In some instances, having health insurance will not prevent eligibility for MCHP. *Even if you have health insurance, it's best to apply and let the case manager assigned to your application determine whether your health insurance will affect your eligibility for MCHP.*)
- Dependant children with or without maternity coverage under their parents' policy.
- Children under age 19, who are not eligible for Medicaid, and whose countable income is at or below 200% of the federal poverty level (FPL).
- Pregnant women of any age, whose countable income is at or below 250% FPL.

Selecting Priority Partners, United Healthcare Community Plan, AmeriGroup, Aetna Better Health, University of Maryland Health Partners as your MCO:

Upon approval for the Maryland Medical Assistance Program (MA), **you are required to select the MCO in which you wish to be enrolled...PLEASE NOTE: SELECTING YOUR MCO IS A TIME SENSITIVE PROCESS.** Failure to comply with the enrollment process will result in you being auto enrolled in an MCO picked for you by the state of Maryland.

There are two ways to enroll for an MCO:

- Upon approval for Medical Assistance (MA), immediately contact your local County Health Department with your Medical Assistance number. Advise them that you have recently been approved for Medical Assistance, and need to enroll in one of the above plans. Request the effective date of coverage for your records. Usually 7-10 days from calling. **(RECOMMENDED)**
- Within 7 to 10 days from being approved for Medical Assistance, you will be sent a packet of information by mail describing all available MCO's. Phone numbers are provided for you to call to enroll in the MCO with which we participate. (THIS PROCESS CAN TAKE UP TO 3 WEEKS LONGER...and exposes you to auto enrollment if you miss the deadline.)

IMPORTANT NOTICE: At the present time, Priority Partners is open to **new** enrollment for all Maryland residents. If at some point they close enrollment to a county, you can enroll under one of the following conditions:

- If you were previously enrolled in Priority Partners within the last 180 days, your enrollment is reinstated.
- If you have a dependant or are the sibling of a dependant who is currently enrolled with Priority Partners, you can enroll under the Family Unity Program

BE ADVISED: Patients who do not comply with enrollment procedures and end up enrolled in an MCO with which we do not participate, may be subject to the following:

- **Transfer of care.** Obstetrics services may no longer be rendered to you by AAMG Annapolis OB-GYN You will need to find a provider that participates with your current MCO insurance, and facilitate a transfer of care immediately.
- **Financial responsibility.** Services rendered to you while you were covered by an insurance this office DOES NOT participate with will be reduced to our office cash pay fee schedule and become your patient responsibility.

******I have read the above information, and understand that should I have need to enroll in a Managed Care Organization (MCO), I must enroll with one of the plans listed above to maintain status as an obstetric patient at AAMG Annapolis OB-GYN. Additionally, I accept financial responsibility for any services rendered to me while I am covered by an MCO with whom AAMG Annapolis OB-GYN does NOT participate.**

AAMG ANNAPOLIS OB-GYN

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read this form carefully. You will be asked to sign this form electronically upon arrival to your appointment. There is no need to bring this form to your visit.

I hereby give my consent for AAMG Annapolis OB-GYN to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (AAMG Annapolis OB-GYN Notice of Privacy Practices provides a more complete description of such disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. AAMG Annapolis OB-GYN reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to AAMG Annapolis OB-GYN Privacy Official at **2000 Medical Parkway Ste. 304, Annapolis, MD 21401**.

With this consent, AAMG Annapolis OB-GYN may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, AAMG Annapolis OB-GYN may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that AAMG Annapolis OB-GYN restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to AAMG Annapolis OB-GYN use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, AAMG Annapolis OB-GYN may decline to provide treatment to me.

NOTE: If you would like anyone else (spouse, partner, parent, etc.) to have access to your health information please ask for the appropriate form.



AAMG
Annapolis OB-GYN

Our Locations



The Belcher Pavilion
2000 Medical Parkway,
Ste. 304
Annapolis, MD 21401



AAMC Health Services Bldg.
1630 Main Street, Ste. 211
Chester, MD 21619



AAMC Health Services
Bldg.
2401 Brandermill Blvd,
Ste. 350
Gambrills, MD 21054



Pasadena Office
18 Magothy Beach Rd.,
Ste. A
Pasadena, MD 21122