Luminis Health
Annapolis OB GYN
2000 Medical Parkway, Suite 304
Annapolis, MD 21401
410.573.9530

Pre-Registration & Appointment Guidelines

- Please fill out **ALL** forms in the enclosed Pre-Registration Packet and return to the Pre-Registration Department as soon as possible. Completed forms should be returned in PDF format along with a copy of the front and back of your insurance card through any of the following confidential and secure ways:

  Email: ***AOGpreregistration@aahs.org*** or to ***awagner@aahs.org***
  Fax: 667.204.7241
  US Postal: 2000 Medical Parkway, Suite 304 Annapolis, MD 21401
  In person: dropped off at any of our 4 office locations

- **PLEASE NOTE THAT ALL COMPLETED FORMS MUST BE RECEIVED AT LEAST 1 WEEK PRIOR TO YOUR APPOINTMENT OR THE APPOINTMENT WILL BE CANCELLED AND YOU WILL NEED TO RESCHEDULE.** If you are a pregnant patient coming from Shady Grove or another Reproductive Endocrinologist Specialist, ***please be sure to turn in your Graduate Packet with your new patient paperwork.***

- **If your insurance requires a referral, it is your responsibility to present the referral at the time of your visit – failure to do so may result in needing to reschedule the appointment – or your insurance may leave you responsible for the visit charges.**

- You are expected to arrive ***15 minutes before your appointment time.*** Allow additional time for parking when scheduled at the Annapolis office, the garage can get quite busy. **You may be asked to reschedule your appointment if you arrive late at any office!**

- Items you ***must*** bring to your appointment: photo id, current insurance card, and copay. We will also need the name/address/phone number of your primary care physician. Additionally, any labs/radiology/other records relative to your visit with Annapolis OB GYN.

- Enrollment with the patient portal, **MyChart**, will serve as your electronic chart – allowing you to view lab results, medical records, and correspond with office staff and providers after your initial visit.

- **PLEASE NOTE - A "NO SHOW" FEE IS CHARGED FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS.**

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_____

FAX TO: 443-837-2791 or E-MAIL TO: AOGpreregistration@aahs.org updated 03/11/2020

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?			
Amount/frequency?		Have a Living Will?		Where did you visit?	
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)			Alzheimers		
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 <u>positive</u> for Hepatitis B? Yes No**

13. **Have either you or the baby's father ever tested <u>positive</u> 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 and Aileen Landis, CRNP. 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, University Healthplan (Riverside), United Healthcare MCO (including AmeriChoice) 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.**

(For questions or assistance, please call our billing office at 443-837-1226 or 410-573-9564) **11/21/17**

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
(Park in Garage E)

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

8/2/17