WELCOME TO PERINATAL SPECIALISTS OF KANSAS CITY

Welcome to Cecily A Clark-Ganheart, M.D., P.A., d/b/a Perinatal Specialists of Kansas City.

Perinatology, also commonly known as maternal-fetal medicine, is the study and care of complicated and high-risk pregnancies. At Perinatal Specialists of Kansas City, we see and treat patients for a variety of reasons.

What to bring to your appointment: Please have your insurance card, a photo ID, and any applicable co-pay when you check-in. Having these items helps to complete the filing of insurance claims. Failure to bring these items in may result in a reschedule of your appointment. You may be asked to sign some additional paperwork depending on the type of insurance plan you have and/or the services requested.

Please complete the new patient paperwork prior to your visit. **Sections to complete prior to the visit include: Medical History Form, Patient Registration and Consent to Treat, Financial Consent, and HIPPA Acknowledgement and Consent. The Rights and Responsibilities and Notice of Privacy and Non-Discrimination are for your review, however, printing is optional.**

Your appointment: Please arrive 15 minutes prior to your scheduled appointment to allow for registration. We will do our best to accommodate your schedule when scheduling an appointment. Please contact our office at least 24 hours prior to your appointment when rescheduling or cancelling appointments. Failure to do so, may incur a $50 service charge. This charge is not covered by an insurance carrier.

Sonograms: We perform ultrasound for diagnostic purposes. While our sonographers will do their best to provide you with a "keepsake" photo over the course of your pregnancy, the purpose for your visit is medical.

Please feel free to ask us any questions which you may have!

Best regards,

Cecily A. Clark-Ganheart, MD, FACOG
Maternal-Fetal Medicine
President & CEO
Perinatal Specialists of Kansas City

Medical History Form Today's date: _____

Perinatal Specialists of Kansas City

Name: _____ Date of birth: _____ Age: _____

Baby's father's name: _____ Age: _____

Referring Physician: _____

In your own words, why have you been referred to us? _____

Your height: _____ Your weight prior to pregnancy: _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:

Are you allergic to latex? ☐ Yes ☐ No _____

Menstrual history: When was the first day of your last menstrual period? _____

Are you certain of this date? ☐ Yes ☐ No

Do you have regular (28-30 day) cycles? ☐ Yes ☐ No

Were you breastfeeding when you became pregnant? ☐ Yes ☐ No

Did you use ART (assisted reproductive therapy) to become pregnant? ☐ Yes ☐ No

When is your due date? _____ This is based on Last menstrual period ☐ Early ultrasound ☐ ART ☐

Pregnancy history: Please list all pregnancies from first to last (not including your current pregnancy).

Year	Live Birth Fetal loss after 20 weeks Miscarriage Termination	Type of delivery: Vaginal Cesarean Assisted	Weeks of gestation at delivery	Infant's birth weight	Gender	Pregnancy complications?	Newborn complications?

Gynecologic history: Have you had any of the following? If yes, provide date and additional information.

☐ Yes ☐ No	Laser, cryotherapy of the cervix		
☐ Yes ☐ No	Sexually transmitted infection		
☐ Yes ☐ No	Abnormal Pap smear		
☐ Yes ☐ No	LEEP		
☐ Yes ☐ No	Cold knife conization of the cervix		
☐ Yes ☐ No	Myomectomy		
Other:			

Medications: Please list your current medications (prescription, over-the-counter, herbal preparations, supplements, inhalers).

Medication	Dose	How often taken	Reason

Medical History: Have you had any of the following conditions? **If so, include the date of onset and any other information.**

□ Diabetes	□ Respiratory disease
□ Thyroid disorder	□ Blood clots
□ Polycystic ovarian syndrome (PCOS)	□ Clotting disorder
□ High blood pressure	□ Seizure disorder
□ Heart disease/defect	□ Migraine headaches
□ Kidney disease	□ Mental health problems
□ Recurrent urinary/kidney infections	□ Lupus, or other auto-immune disorders
□ Hepatitis	□ Other
□ Other liver disease:	

Surgical History: Have you had any of the following procedures? If so, please include dates.

□ Yes □ No	Tonsils removed	□ Yes □ No	Cesarean delivery
□ Yes □ No	Gall bladder removed	□ Yes □ No	D&C
□ Yes □ No	Appendix removed	Other:	

Prior hospitalizations: Please list dates and reason of prior hospitalizations (not including childbirth).

Social history:

Marital status: □ Married □ Single □ Divorced □ Cohabiting □ Widowed

Is the father of the baby involved: □ Yes □ No

Do you feel safe at home: □ Yes □ No, if no explain _____

Tobacco use: □ Yes □ No If yes, how many packs per day?_____

Alcohol use: □ Yes □ No If yes, how many drinks per day_____, per week_____

Drug use: □ Yes □ No If yes, which drugs _____, frequency _____

Physical activity: □ Yes □ No If yes, how many times a week do you work out? _____
What is the activity?_____

Review of systems: Please check if you have experience any of the following during this pregnancy. If you have, please include additional information.

☐ Headache	☐ Flu-like symptoms	☐ Abdominal pain
☐ Vision disturbances	☐ Depression, anxiety	☐ Lower back pain
☐ Blurred vision	☐ Numbness	☐ Pelvic pressure
☐ Black spots in vision fields	☐ Loss of sensation	☐ Leaking of fluid from the vagina
☐ Fever	☐ Chest pain	☐ Diarrhea/constipation
☐ Rash	☐ Shortness of breath	☐ Nausea/vomiting

Family history: Please indicate if any of these conditions have occurred in you, your family, the baby's father, or the baby's father's family, and to whom (you, baby's father, grandparents, parents, children, sister, brother, nieces or nephews) either living or deceased.

	Mother's side	Father's side
☐ Miscarriages/Infertility		
☐ Stillbirth, infant or childhood death		
☐ Diabetes		
☐ Obesity		
☐ Heart disease/Stroke		
☐ High blood pressure		
☐ Autoimmune disease		
☐ Cancer and type		
☐ Death before age 70		
☐ Thyroid disorders		
☐ Mental health issue		
☐ Other		

Genetics/Family History:

Are you and the baby's father blood relatives? ☐ Yes ☐ No , if yes how are you related?

_____

Have either you or the baby's father every had a bone marrow or stem cell transplant? ☐ Yes ☐ No

Have either you or the baby's father ever had a stillborn infant? ☐ Yes ☐ No

Have either you or the baby's father ever had a chromosome study? ☐ Yes ☐ No

If yes, what were the results?_____ or ☐ Unsure

Have you had genetic screening done during or prior to this pregnancy? ☐ Yes ☐ No
Examples include screening for sickle cell disease, cystic fibrosis, fragile X or SMA: pregnancy screening such as first trimester screening, QUAD screen, or non-invasive prenatal screening.

If yes, what were the results? _____

Ethnic Background:

How would you describe your racial/ethnic background (examples include, but are not limited to Caucasian, Black, LatinX, Jewish, Asian, etc. Individuals often identify with more than one racial or ethnic group)

	Mother (patient)	Father (father of baby)
How would you describe your race?	_____	_____
How would you describe your ethnicity?	_____	_____

Do you have any additional concerns or questions not already covered? _____

Patient's signature: _____ Date: _____

Reviewer's signature: _____ Date: _____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Name: (Last) _____ (First) _____ (MI) _____
Preferred Full Name (if different from above): _____
Date of Birth: _____ Social Security Number: _____
Address: _____
City, State, Zip: _____
Home Phone Number: _____ Cell Number: _____ Work Number: _____
Email address: _____
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Legally Separated □ Other _____
Gender Identity: □ Female □ Male □ Transgender Female to Male □ Transgender Male to Female
□ Genderqueer □ Choose not to disclose
□ Additional Gender category not listed _____
Race: □ American Indian/Alaska Native □ Asian □Native Hawaiian/Pacific Islander
□ Black/African American □ White □ Hispanic □ Choose not to disclose
□ Other not listed: _____
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Choose not to disclose
Preferred Language: □ English □ Spanish □ ASL □ Japanese □ Mandarin □ Korean □ French □ Swahili
□ Indian: Hindi, Tamil, Gujarati etc. □ Russian □ Arabic □ Vietnamese □ Haitian Creole
□ Bosnian/Croatian/Serbian/Serbo-Croatian □ Albanian □ Burmese □ Tagalog □ Portuguese
□ Farsi-Iranian/Persian □ Cambodian □ Other not listed: _____
Employment: □ Employed □ Unemployed □ Self-employed □ Full-time Student □ Part-time student □ Retired
Employer name: _____ Occupation: _____
Referring Provider Name: _____

RESPONSIBLE PARTY INFORMATION (*if not patient*)

Responsible Party: □ Guarantor □ Self □ Check here if address and telephone information is same as patient
Responsible Party Name: (Last) _____ (First) _____ (MI) _____
Date of Birth: _____ Social Security Number: _____
Address: _____
City, State, Zip: _____
Home Phone Number: _____ Cell Number: _____ Work Number: _____
Email address: _____
Employment: □ Employed □ Unemployed □ Self-employed □ Full-time Student □ Part-time student □ Retired
Employer name: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION:

Policy Holder's Name: (Last) _____ (First) _____ (MI) _____
Policy Holder's Date of Birth: _____ Social Security Number: _____
Relationship to patient: _____ Employer: _____
Insurance Company: _____
Address: _____
City, State, Zip: _____
Phone Number: _____ Policy Effective Date: _____
Subscriber ID: _____ Group Number: _____ Copay Amount: _____

SECONDARY INSURANCE INFORMATION (*if applicable*):

Policy Holder's Name: (Last) _____ (First) _____ (MI) _____
Policy Holder's Date of Birth: _____ Social Security Number: _____
Relationship to patient: _____ Employer: _____
Insurance Company: _____
Address: _____
City, State, Zip: _____
Phone Number: _____ Policy Effective Date: _____

Subscriber ID: _____ Group Number: _____ Copay Amount: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last) _____ (First) _____ (MI) _____
Phone number: _____
Relationship to patient: _____
Address: _____
City, State, Zip: _____

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk s and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides Perinatal Specialists of Kansas City with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services with Perinatal Specialists of Kansas City.

You have the right to discuss the treatment plan with your physician and the purpose and potential risks and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommend by Perinatal Specialists of Kansas City, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform, reasonable and necessary medical examinations, testing, and treatment for the condition which has brought me to seek care at Perinatal Specialists of Kansas City. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative: _____
Date: _____
Print Name of Patient or Personal Representative: _____
Relationship to Patient: _____

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Patient's Legal Name: (Last) _____ (First) _____ (MI) _____
Preferred Full Name (if different from above): _____
Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

_____ (Patient/Representative Initials) I acknowledge that I have received Perinatal Specialists of Kansas City's Notice of Privacy Practices, which describes the ways in which the clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the clinic and/or the clinic's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in Perinatal Specialists of Kansas City's Notice of Privacy Practice/clinics.

DISCLOSURES FOR FRIENDS AND/OR FAMILY MEMBERS

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below. I understand I may revote or modify this specific authorization for disclosure at any time and that any revocation or modification must be in writing :

	Name	Relationship	Contact Number
1.			
2.			
3.			

COMMUNICATION ABOUT MY HEALTHCARE

I agree Perinatal Specialists of Kansas City may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes, and/or Perinatal Specialists of Kansas City's health care operations purposes (e.g., quality improvement activities). I understand that Perinatal Specialists of Kansas City retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the clinic without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

CONSENT TO EMAIL, CELLULAR TELEPHONE, OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or Perinatal Specialists of Kansas City or its Extended Business Office (EBO) Servicers have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: appointment reminders, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. Perinatal Specialists of Kansas City does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative: _____
Date: _____
Print Name of Patient or Personal Representative: _____
Relationship to Patient: _____

FINANCIAL POLICY AND AGREEMENT

FINANCIAL AGREEMENT

I acknowledge and agree that the insurance information provided at intake is accurate. If my insurance changes, I will notify practice immediately.

I agree to pay for services that are not covered, or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. All co-payments, co-insurance, and/or deductibles must be paid at the time of service.

I understand there is a fee for returned checks.

INSURANCE INFORMATION & COVERAGE

I understand that my insurance plan may require that I have a pre-authorized referral(s) for office visits, testing, and lab services from my primary care physician or Perinatal Specialists of Kansas City. Without an authorized referral, I understand that my appointment may need to be rescheduled. If I choose to keep the appointment without a referral, I understand that payment in full will be necessary prior to my visit. If my insurance plan requires that I use specific ancillary facilities for additional medical services ordered by a physician, I understand that it is my responsibility to inform the office staff of that requirement. Perinatal Specialists of Kansas City can discuss your proposed treatment and cost of those services upon request.

COLLECTION ACTION

I understand that all charges for services are my responsibility at time of service and I understand that any balance on my account after 90 days will result in collection action. Perinatal Specialists of Kansas City recognizes that emergencies do arise and may affect timely payment of account balances. If such extreme cases occur, please contact our office promptly for assistance in management of accounts. I acknowledge the practice may use the services of a third-party business associate or affiliated entity as an Extended Business Office (EBO) Servicer for medical account billing and servicing.

ASSIGNMENT OF BENEFITS

I hereby assign to Perinatal Specialists of Kansas City any insurance or other third-party benefits available for health care services provided to me. I understand the clinic has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the clinic, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

MEDICARE PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFIT

I certify that any information I provide, if any, in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice by the Medicare or Medicaid program.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

I agree that, in order for the Perinatal Specialists of Kansas City, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that the clinic or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or the clinic or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

If you have any questions regarding the above policy and agreement or any uncertainties regarding insurance coverage or request for payment, please do not hesitate to ask. A photocopy of this consent shall be considered as valid as the original.

I understand and agree to Perinatal Specialists of Kansas City's Financial Policy and Agreement.

Signature of patient or personal representative: _____
Date: _____
Print Name of patient or personal representative: _____
Relationship to patient: _____

16240 Foster Street
Overland Park, KS 66085

Perinatal Specialists of Kansas City

Phone: 913-291-0069
Fax: 913-291-0070

PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

I consent for photographs and/or video images to be taken of me and my pregnancy by Cecily A. Clark-Ganheart, M.D., P.A. dba Perinatal Specialists of Kansas City or a representative.

I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below) ___ YES ___ NO

For educational purposes (medical teaching or training), _____ YES _____ NO

For marketing and advertising purposes (website, print, digital, or social media), _____ YES _____ NO

At my request, my photographs and/or video images will only be used as part of my medical record. I hereby release Cecily A. Clark-Ganheart, M.D., P.A. dba Perinatal Specialists of Kansas City its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation. By signing this form, I confirm understanding of this consent.

If I wish to withdraw my consent in the future, I may do so via written request submitted to Cecily A. Clark-Ganheart, M.D., P.A. dba Perinatal Specialists of Kansas City or by completion of a new form.

Patient Signature: _____ Date: _____

Perinatal
SPECIALISTS
OF KANSAS CITY