Maternal-Fetal
Associates of Kansas

A WESLEYCARE CLINIC

We want to take this opportunity to remind you of your upcoming appointment and welcome you to our practice. We have been serving this region for more than 18 years and pride ourselves on providing world class healthcare right here in your community. We know pregnancy can be an anxious time for you and your family so we strive to make your experience with us as inviting as possible. To help us accomplish this, we'd like to ask you to complete the enclosed forms and bring them with you to your appointment. This will save you time and allows us to get a snapshot of your health history. You will find some basic information about our practice below and please, if you have **any** questions, feel free to ask one of our staff members.

Location: Our office is located at 551 N Hillside, Suite 330, Wichita, KS 67214. If you want specific directions, you can contact our office during regular business hours, 8 AM to 5 PM, at 316-962-7188. You can also go to our website, www.mfmkansas.com.

What to Bring: Please have your insurance card, a photo ID and any applicable co-pay when you check-in. Having these items at check-in allows us to send accurate claims to your insurance provider. You may be asked to sign some additional paperwork depending on the type of insurance plan you have and/or the services requested.

Sonograms: We perform a sonogram on all new patients. In order to obtain the highest quality images, we have to be able to look "through" your bladder and into the uterus. If you are less than 16 weeks along in your pregnancy, drinking 20-30 ounces of water 1 hour before your sonogram will help your bladder expand enough to create the "window" our techs look through. If you are more than 16 weeks along, drink 15-20 ounces before your sonogram. We recognize this is a family event and can accommodate up to 3 additional people in our sonography rooms. Please bring another adult with you if you plan on bringing children. Childcare is available in our building. You can go to healthstaretgiesfitness.com or call 316-962-8015 for more information.

Amniocentesis: This is a procedure we perform in our office to test for fetal anomalies; however, not all women are candidates for this test. If you prefer to talk with us before deciding which route to go, we are happy to oblige. Dependent on the patient volume when you are here, we may be able to perform the amniocentesis the same day of your appointment. If not, we will schedule it at a more convenient time. We understand your time is no less valuable than ours. We do our very best to stay on schedule. Please be aware there are times in our office where patients may be delayed longer than expected. Occasionally, unforeseen circumstances arise that require extra time and we want to give each patient the time necessary to address their individual situation. We sincerely appreciate your understanding during these instances.

Thank you for allowing us to participate in your healthcare.
We look forward to meeting you!
Warmest Regards,
Margaret O'Hara, MD

Welcome to Maternal~Fetal Associates of Kansas

- Please contact our office at least 24 hours prior to your appointment if interpreter services will be required.

- We appreciate your arrival 15 minutes prior to your appointment time. This allows plenty of time for any additional paperwork and/or any insurance issues to be resolved. You may be asked to reschedule if you are more than 15 minutes late for your appointment.

- It is important to us that your wait time in the lobby not be extensive. If you have waited more than 15 minutes past your scheduled appointment time, please notify one of our receptionists. Some appointments will take longer than expected due to unforeseen circumstances. We will make every effort to inform you if there is a delay. Each patient is given the same attention and time during their appointment.

- Please plan on spending 1-2 hours in our office for your appointment and sonogram. Sonograms are thirty to sixty minutes long and most exams last an hour. Occasionally, the need for additional testing arises. Unfortunately, we are not always able to determine this ahead of time and it can increase the length of time you spend with us.

- Insurance card and Photo ID are required at check-in. Failure to bring them may result in a reschedule of your appointment. Be prepared to pay any co-payments and applicable deductibles that are required by your insurance. If we are unable to verify your insurance, you may be asked to sign a waiver of benefits and/or pay for your visit at the time of service.

I acknowledge that I have read and understand this form:

Patient Signature: _____ Date: _____

Maternal Fetal Associates of Kansas

Patient Registration Form

Patient's Last Name: _____ First Name: _____ MI: _____
Also Known as, Last Name: _____First Name _____
Married _____ Single _____ Divorced _____ Widowed _____ Legally Separated _____ Other_____
Social Security Number_____-____-_____ Female _____Male _____ Date of Birth _____-_____-_____
Email Address: _____
Address: _____
City, State, ZIP: _____
Home Phone: (____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____
Emergency Contact Name: _____ Phone Number: (_____)_____
Relationship to the patient:_____
Employed: ____ Unemployed: ____ Self-employed: ____ Full-time Student: ____ Part-time student: ____ Retired: ____
Employer _____ Occupation: _____
Referring Provider Name: _____

Responsible Party Information (if not patient)

Last Name: _____ First Name: _____ MI: _____
Also Know as, Last Name: _____ First Name: _____
Social Security Number: _____-____-_____ Female: _____ Male: _____ Date Of Birth: _____-_____-_____
E-mail: _____
Address: _____
City, State, ZIP: _____
Home Phone: (_____)_____ Cell Phone: (_____)_____ Work: (_____)_____
Employed: ____ Self-employed: ____ Unemployed: ____ Full-time student: ____ Part-time student: ____ Retired: ____
Employer: _____ Occupation: _____
Emergency Contact Name: _____ Phone Number: (_____)_____
Relationship to patient: _____

Primary Insurance Information

Policy Holder's Last Name: _____ First Name: _____ MI: _____
Policy Holder's Date Of Birth: _____-_____-_____ Social Security Number: _____-____-_____ Female: ____ Male: ____
Relationship to patient: _____ Employer: _____
Insurance Company: _____ Address: _____
Insurance Company Phone Number: (_____)_____ Policy Effective Date: ____-____-____
Subscriber ID: _____ Group Number: _____ Copay Amount: _____

Secondary Insurance Information (if applicable)

Policy Holder's Last Name: _____ First Name: _____ MI: _____
Policy Holder's Date Of Birth: _____-_____-_____ Social Security Number: _____-____-_____ Female: ____ Male: ____
Relationship to patient: _____ Employer: _____
Insurance Company: _____ Address: _____
Insurance Company Phone Number: (_____)_____ Policy Effective Date: ____-____-____
Subscriber ID: _____ Group Number: _____ Copay Amount: _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient or Responsible Party Signature: _____ Date: _____

Maternal~Fetal Associates of Kansas
551 N Hillside Ste: 330 Wichita Ks 67214
Ph: 316-962-7188

Patient Name: _____ Age: _____

Gynecologic History:

What date was the first day of your last menstrual period? _____
Was it normal for you? _____ if no, why?_____
Do you have monthly periods every 28 days? _____
How old were you when you started having periods? _____
***Were you using any form of contraception (birth control) when you got pregnant? _____
***(Note: This includes abstinence, withdrawal, vasectomy, tubal ligation, natural family planning, etc.)
Have you had any sonograms during this pregnancy? _____ If yes, when and where?
_____

Pregnancy History

(List all starting with your 1st pregnancy to the current pregnancy, including miscarriages or abortions)

Date	Type*	Gender	Birth Weight	Problems	Epidural	Length of Labor	Facility of Delivery
		M or F			Y or N		
		M or F			Y or N		
		M or F			Y or N		
		M or F			Y or N		
		M or F			Y or N		
		M or F			Y or N		
		M or F			Y or N		
		M or F			Y or N		

*(vaginal, vacuum, forceps, cesarean, abortion or miscarriage)

Past Medical History

Please indicate, if you or a family member have or has had any of the following conditions?

Condition	You	Family	If family, who?	Condition	You	Family	If family, who?
Diabetes				Thyroid Problems			
High Blood Pressure				Blood Transfusion			
Heart Disease				Asthma/Lung problems			
Kidney Problems				Infertility			
Seizures/Neurology Problems				Cancer			
Stroke				Chicken Pox			
Documented Psychiatric Problems							
Hepatitis							
Blood Clots							

What was your weight prior to pregnancy?_____ Height_____
Do you have seasonal allergies? _____
Are you allergic to Latex? _____
Are you allergic to any medications? _____ if so, what? _____

List Your Current Medication (Include Over-The-Counter)

_____ _____ _____ _____

_____ _____ _____ _____

List Prior Surgeries

_____
_____

Maternal Fetal Associates of Kansas
551 N. Hillside – Suite 303
Wichita, Kansas 67214

FINANCIAL POLICY

As your physician, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

All co-payments, deductibles and previous balances due must be paid at time of service. If you have insurance, please present your insurance card for verification. If your insurance changes, please notify us immediately.

Your insurance plan may require that you have a pre-authorized referral(s) for office visits, testing and lab services from our office and/or ancillary facilities as ordered by our physician. Without an authorized referral, the appointment will need to be rescheduled. If you choose to keep the appointment without a referral, payment in full will be necessary prior to visit. If your insurance plan requires that you use specific ancillary facilities for additional medical services ordered by the physician, it is your responsibility to inform the office staff of that requirement.

We will be pleased to discuss your proposed treatment and cost of those services. If you have questions regarding coverage of a medical service by your insurance company, we will assist you in finding the information. Your insurance is a contract between you, your employer and the insurance company and we may not be able to receive specific coverage information for you contract.

We must emphasize that as your physician, our relationship and concern is with you and your health, not with your insurance company. **All charges for services are your responsibility at time of service.** Any balance on your account after 90 days will result in collection action. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in management of your account.

Consent to Telephone Calls for Financial Communications.
_____(Patient initials) I agree that, in order for **Maternal Fetal Associates of Kansas**, 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 **Maternal Fetal Associates of Kansas** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Maternal Fetal Associates of Kansas** 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 or any uncertainties regarding insurance coverage or request for payment, please do not hesitate to ask. We are here to help you.

I understand and agree to the Maternal Fetal Associates of Kansas Financial Policy.

Signature _____ Date:_____

Witness:_____ Date: _____