HIGH RISK PREGNANCY DOCTORS

Maternal-Fetal Medicine Specialist & Board Certified OB/GYN located in Frisco, TX

PATIENT INFORMATION:

Today's Date_____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I.____ Last Name_____

Sex: ❑ Male ❑ Female Birth Date_____ Age____ Soc. Sec. #_____ E-mail_____

Street_____ Apt.____ City_____ State____ Zip____

Home Tel.(____)_____ Cell.(____)_____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Did you find our practice online? ❑ Yes ❑ No Referred By_____ (FIRST NAME) _____ (LAST NAME)

Preferred Pharmacy_____ Tel. (____)_____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Has a family member ever been a patient of our practice? ❑ Yes ❑ No Driver's Licence Number_____

Nearest relative not living with you_____ (FIRST NAME) _____ (LAST NAME) Tel.(____)_____

Employer_____ Occupation_____ Bus. Tel.(____)_____

In case of emergency, please contact_____ Tel. (____)_____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name_____ (FIRST NAME) _____ (LAST NAME) S.S.#_____ Birth Date_____ Age____

Tel.(____)_____ Cell. (____)_____ E-mail_____

Street_____ Apt.____ City_____ State____ Zip____

Driver's Lic.#_____ Employer_____ Bus. Tel.(____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ (FIRST NAME) _____ (LAST NAME) Relation_____ S.S.#_____ Birth Date_____

Street_____ Apt.____ City_____ State____ Zip____

Tel. (____)_____ Employer_____ Bus. Tel.(____)_____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address_____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not . . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Business Address_____ City_____ State____ Zip____

Business Telephone (____)_____ Plan_____

Insurance Company Name_____ I.D. #_____

Address_____ City_____ State____ Zip____

Telephone (____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME) Relation_____

Birth Date_____ Sex: ❑ M ❑ F S.S. #_____ Telelphone (____)_____

Address_____ City_____ State____ Zip____

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Business Address_____ City_____ State____ Zip____

Business Telephone (____)_____ Plan_____

Insurance Company Name_____ I.D. #_____

Address_____ City_____ State____ Zip____

Telephone (____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME) Relation_____

Birth Date_____ Sex: ❑ M ❑ F S.S. #_____ Telelphone (____)_____

Address_____ City_____ State____ Zip____

HEALTH HISTORY:

To our patients: *Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		

GENETIC SCREENING:

Does anyone in the family have any of the following (includes patient, father of baby, and anyone in either family):

		Yes	No
5.	Is the patient's age over 35 years as of estimated date of delivery?	❑	❑
6.	Thalassemia (Italian, Greek, Mediterrean, or Asian background) MCV<80?	❑	❑
7.	Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)?	❑	❑
8.	Congenital Heart Defect?	❑	❑
9.	Tay-Sachs (Jewish, Cajun, French Canadian)?	❑	❑
10.	Sickle Cell Disease or Trait (African American)?	❑	❑
11.	Hemophilia or other Blood Disorder?	❑	❑
12.	Muscular Dystrophy?	❑	❑
13.	Cystic Fibrosis?	❑	❑
14.	Down Syndrome?	❑	❑
15.	Intellectual Disability / Autism?	❑	❑
16.	Other Inherited Genetic or Chromosomal Disorder?	❑	❑

FAMILY HISTORY:

		Yes	No
17.	Have you or has the father of the baby had a child with a birth defect (spina bifida, hole in the heart, down syndrome, cleft lip)?	❑	❑
	If so, describe _____		
18.	Did you or the father of the baby have a birth defect?	❑	❑
	If so, describe _____		
19.	Please describe any abnormalities that have occured in children of your family or the father of the baby's family (metal retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis?	❑	❑
	How is the child / person related to you _____		
	_____		
20.	Is the father of the baby over the age of 50?	❑	❑
21.	Do you, or the father of the baby, have a history of pregnancy losses (miscarriages or stillbirths)?	❑	❑
	If so, describe _____		

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
22. Rheumatic fever?			
23. Damaged heart valves / mitral valve prolapse?			
24. Heart murmur?			
25. High blood pressure?			
26. Low blood pressure?			
27. Chest pain / angina?			
28. Heart attack(s)?			
29. Irregular heart beat?			
30. Cardiac pacemaker?			
31. Heart surgery?			
32. Pneumonia, bronchitis, chronic cough?			
33. Asthma?			
34. Hay fever / sinus problems?			
35. Snoring?			
36. Sleep apnea / CPAP?			
37. Difficult breathing / other lung trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Tuberculosis?			
39. Emphysema?			
40. Do you smoke or vape? If so, how much a day			
41. Do you use chewing tobacco?			
42. Blood transfusion?			
43. Blood disorder such as anemia?			
44. Bruise easily?			
45. Bleeding tendency / abnormal bleed?			
46. Hepatitis, jaundice, or liver disease?			
47. Infectious mononucleosis?			
48. Gallbladder trouble?			
49. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Acid reflux?			
51. Stomach / GI troubles / ulcers / IBS / colitis?			
52. Contagious diseases?			
53. Sexually transmitted diseases?			
54. Problems with immune system? Possibly from medication / surgery, etc.			
55. Delay in healing?			
56. A tumor or growth?			
57. Cancer / radiation therapy / chemotherapy?			
58. Chronic fatigue / night sweats?			
59. Are you on a diet?			
60. A history of alcohol abuse?			
61. A history of marijuana or other drug use?			
62. Contact lenses?			
63. Eye disease / glaucoma?			
64. Mental health problems / anxiety / depression?			
65. A removable dental appliance?			
66. Pain or clicking of jaws when eating?			

ARE YOU NOW TAKING:	YES	NO	NOTES
67. Any kind of medication, drug, pills?			

68. Please list any medications you are currently taking:

Medication	Dosage	Frequency

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
69. Local anesthetic (numbing meds.)?			
70. Penicillin?			
71. Other antibiotics?			
72. Sulfa drugs?			
73. Sodium pentothal / Valium / other tranquilizers?			
74. Aspirin?			
75. Amoxicillin?			
76. Codeine or other narcotics?			
77. Other medications?			
78. Latex?			
79. Soy?			
80. Eggs / yolk?			
81. Sulfites?			
82. Do you have any known allergies?			

83. Please list any allergies other than drug allergies:

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

PREGNANCY INFORMATION:

Due Date _____ First Day of Last Menstrual Period _____

Please check if ❑ Dated by Ultrasound ❑ Dated by Last Menstrual Period

PREGNANCY HISTORY: *(INCLUDING MISCARRIAGES, TERMINATIONS, AND/OR ECTOPIC PREGNANCIES)*

DATE MONTH / YEAR	GESTATIONAL AGE (WEEKS)	BIRTH WEIGHT	SEX (M / F)	TYPE OF DELIVERY (VAGINAL / C-SECTION)	PRETERM LABOR (Y / N)	COMMENTS / COMPLICATIONS

GYNECOLOGICAL HISTORY:

Current Weight _____ Height _____ Date of Last Pap Smear _____

Have you ever had an abnormal pap smear? ❑ Yes ❑ No; it Yes, when _____

Any procedures on your cervix (biopsy, LEEP, CRYO surgery, colposcopy)? ❑ Yes ❑ No; it Yes, describe _____

_____

Any uterine abnormality? ❑ Yes ❑ No Fibroids? ❑ Yes ❑ No Bicornuate uterus? ❑ Yes ❑ No

Any infertility problems? ❑ Yes ❑ No; if Yes, describe _____

Is this pregnency? ❑ IVF (invitro fertilization) ❑ IUI (intrauterine insemination)

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Reviewed by** X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)* X _____ **Date**

AUTHORIZATION

I authorize my doctor and his / her designated staff, to perform an examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize ultrasound to be performed as a necessary part of this visit or future visit. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointment.

❑ I permit the office to communicate with me via text message on my cell phone.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Witness** X _____ **Doctor** X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

You will be seeing a High Risk Pregnancy Specialist during your appointment. We will do our best to keep your appointment as close as possible to the scheduled time. However, please be aware if there is a patient in front of you who has been diagnosed with fetal anomaly or complicated maternal condition, we may not be able to stay with the scheduled time parameters because this is a terribly difficult and emotional issue for both the patients and the staff. Extra time might be needed for that patient. If your time does not permit waiting please notify our staff. We will try to accommodate your schedule as much as possible and will reschedule your appointment if needed. Also note, that if the Doctor is not available to discuss your immediate ultrasound results, she will call you on the same day to address your visit and findings.

In addition, please note the Doctor will discuss with you the results of your ultrasound and your condition with a more detailed review being undertaken with you after OFFICE hours are over. There is a small possibility that ultrasound finding might be amended based on the additional review of images and/or consultation with other specialists.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

HIGH-RISK
PREGNANCY DOCTORS
Complete Pregnancy Care

13052 Dallas Parkway
Ste 230
Frisco, TX 75034
Phone: (972) 668-BABY
Fax: (877) 862-5660
www.highrisk-pregnancy.com

FINANCIAL POLICY

Patient Name_____DOB:_____Social Security#_____

Address: _____ _____ _____ _____
(street) (City) (State) (Zip)

Responsible Party Name_____DOB:_____Social Security #_____

Address: _____ _____ _____ _____
(street) (City) (State) (Zip)

Thank you for choosing us as your healthcare provider. The following is our Financial Policy, If you have any questions or concerns about our payment policies, please do not hesitate to ask.

Definition of Terms:

- Date of Service: The Date of Medical Service is Provided.
- Account Balance: the total amount due.
- **Where "Patient" is referred to in the below policies, "Responsible Party" is also included jointly, severally, universally, and unconditionally as a guarantor of liability and co-obligor for performance for all purposes.**

Guarantee of Payment:
Patient is responsible for the payment of all charges for services rendered to the Patient indicated above.

_____ It is the Patient's responsibility to prepay any portion of the physician's fee that will not be / is not covered by the insurance company. This includes any deductible, coinsurance, or items not covered by Patient's insurance plan.

_____ Patient understands that this office will be filing a claim with Patient's insurance company or other third-party payer as a courtesy only. Under no circumstance, does the filing/disposition of a claim relieve Patient from Patient's responsibility for the payment of all charges for any services rendered.

_____Patient understands that this office will not bill to the insurance for claims when the insurance was active. This office will not bill for the past claims.

_____ It is Patient's responsibility to NOTIFY HRPD's front desk of any changes in Patient's insurance provider and coverage. It is Patient's responsibility to disclose Patient's Primary. Failure to do so will result in a charge for claims re-submission fee or $250.00, whichever is greater.

_____ All lab services are provided as a courtesy. Lab work, including genetic testing, will be billed by another company. Should Patient receive a bill from the third-party Lab, it is Patient's responsibility to pay such bill. Self-pay fees DO NOT include lab tests by the third-party provider.

_____ Patient personally guarantees the payment of all charges for medical services rendered. These include, without limitation, claims filed for Workman's Compensation and/or claims due to personal injury accidents/illnesses. Patient agrees that this authorization shall be valid for all Dates of Services.

_____ Patient agrees that to pay $25.00 for FMLA form signed by HRPD

_____Patient agrees to pay $400 for Iron Infusion as a self pay rate in case your insurance does not cover it.

_____ If Patient chooses to change doctor and transfer Patient's records to another office, there will be a $15.00 Transfer of Records fee. Similarly, if a letter must be signed by HRPD, there will be a $15.00 Letter fee.

_____ It is Patient's responsibility to **cancel any appointments at least 24 hours in advance**, otherwise Patient will be charged a $75 cancellation/no show fee. Missing an appointment for long scans (basic, detailed anatomy or echo), will result in a $100 cancellation/no show fee. Upon a second no-show/cancellation occurrence in violation of the foregoing, there will be a $100/$200 charge. After three consecutive no-show occurrences, the practice may elect to terminate its relationship with Patient.

Collection of Delinquent Account Terms

Failure to pay Patient's balance within 30 days from any Date of Service is considered a delinquent account and may result in fees and interest being added to Patient's account Balance listed below.

_____ Outstanding patient account balances must be paid in full prior to being seen at scheduled and unscheduled appointment.

_____ If there a balance on the patient's account, the funds from Advanced Deposit will be used to cover remaining balance on the account.

_____ A delinquent account balance that is 30 days past due will accrue interest at rate at the maximum lawful interest rate or 18% per annum, whichever is higher, until paid in full.

_____ An account that is delinquent with any outstanding balances for 60 days will be forwarded and assigned to a collection agency at the patient's expense.

_____ Any delinquent account assigned to any collection agency will be charged a collection fee, which upon assignment becomes the due and owing Account Balance. COLLECTION FEE is 50% of THE BALANCE OWING AS OF THE DATE OF SERVICE AND WILL BE ADDED TO THE OUTSTANDING ACCOUNT BALANCE WITH OR WITHOUT SUIT.

_____ If litigation is required to collect this account, in addition to any Account Balance, Patient agrees to pay interest as set forth herein, plus all costs associated with such collection activity, including but not limited to all collection agency fees as set forth herein as part of the Account Balance, plus any and all attorney fees, court fees, skip tracing fees and costs in addition to any miscellaneous fees the court or jurisdiction may award. Collection exception and Exemptions: allowed charges under Medicare Title XIX (Texas Medicaid) contracts.

_____ Patient hereby irrevocably waives, to the fullest extent permitted by applicable law, any and all right to trial by jury in any legal proceeding arising out of or relating to this Agreement or the transactions contemplated hereby.

Returned Checks or Disputed Credit Card Payment:

_____ There is a fee of $50.00 for any returned check for insufficient funds. If a credit card payment is disputed and payment is wrongfully charged back from High Risk Pregnancy Doctors by Patient's credit card company, a $50.00 fee will be added to Patient's account. These amounts may change at any time.

Assignment:

_____ If Patient's account becomes delinquent, HRPD may assign this account and/or to release any necessary information to any third-party collection agency. Additionally, if Patient's account is assigned to any collection agency, Patient hereby authorizes the collection agency the right to report this account as delinquent to all the Credit Bureaus in accordance with applicable state and federal law.

If Advance Deposit was collected, it will be returned to the patient within thirty (30) days after all insurance claims are processed and the remaining balance of the patient account is covered. Should there be any balance in patient's account, the funds from the Advance Deposit will be used to cover the balance before refund (if any) is issued.

Signature of Understanding: I have read and understand the entire Financial Policy document. By signing this form, I consent to all the terms and conditions contained herein and all of the terms and conditions of treatment and understand that it is my responsibility for assuring that the financial obligation of Patient's care is fulfilled. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage.

I have reviewed this contract and having understood its terms and conditions, I accept the terms and conditions contained herein.

X_____ _____

Signature of Patient or Parent/Guardian if Patient is under 18 years of age **Date**

_____

Print name

HRPD Payment Plan Guidelines

Patient is responsible to pay outstanding balance on the day of the appointment and before being seen by the doctor. HRPD reserves a right to refuse a service to any patient who is not prepared to pay the outstanding balance without prior arrangement with the management office.

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD

High Risk Pregnancy Doctors
13052 Dallas Parkway, Ste 230
Frisco, TX 75034
Tel: (972) 668-2229
Fax: 877-862-5660

ADVANCE DEPOSIT AND CREDIT CARD AUTHORIZATION FORM

HRPD requires an Advance Deposit of $300.00 to be paid for all patients using their insurance. This Advance Deposit is fully refundable within 30 days once the services rendered to you at HRPD are completed and all claims are successfully processed. Please refer to Financial Policy you are signing for more information.

Amount collected: $_____

Patient/Guardian sign _____ Date ____/____/____

HRPD officer sign _____ Date____/____/____

FOR COMMERCIAL INSURNCE CARRIERS ONLY:

HRPD requires second form of Payment (CC) to pay outstanding balances (deductible/co-insurance) after your Insurance provider is done processing all your claims and COB is complete. You will be notified in advance should you have outstanding balance and when your card will be charged.

Card Type (Circle): Visa / MasterCard / American Express / Discover

Name on Card: _____

Card Number: _____ _____ _____ _____

Expiration Date: ____/____/____ CVV Code (Security Code): _____ ZIP _____

Cardholder Signature: _____

Please list anyone other than the cardholder that is authorized to use this credit card.

Name: _____Date: ____/____/_____

Cardholder Signature: _____

I hereby authorize High Risk Pregnancy Doctors to charge the credit card listed above for the payment of all services and fees. This credit card will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may revoke this credit card on file by submitting a written request to the address at the top of this form. A new form must be submitted if any information such as credit card expirations or authorized users is changed. Applicants agree to pay the cost for any returned or challenged payments. A service fee of 3.5% will be added to all credit card transactions. Please refer to the Financial Policy Form for more information.

Patient Signature:_____ Date: ____/____/____

HIGH RISK PREGNANCY DOCTORS

INFORMED PATIENT CONSENT FOR TRANSVAGINAL SCAN

Name _____ **DOB** _____

Address _____

Patient Information

Your doctor has requested us to perform a transvaginal ultrasound. It is important that you understand the procedures that is associated with this examination:

- The ultrasound transducer will be placed in the vagina (the probe is sterilised)
- The transducer will be introduced with a latex / non latex type covering
  - Do you have an allergy to latex? YES / NO
- It will be necessary to move the transducer from side to side, up and down and may be swiveled to obtain images
- If you prefer, you may insert the transducer yourself, otherwise the person conducting the examination will do this
- A third person may be present during the examination acting as a chaperone, if required by the sonographer or yourself
- You may request the examination to be stopped at any time during the examination

Patient Consent

- I acknowledge that the examining doctor / clinician has explained the proposed procedure
- I have been provided with information regarding the proposed procedure
- I understand the risks and complications involved in the procedure
- I understand I have the right to change my mind at any time including after I have signed this form but, preferably following discussion with my doctor
- I have been provided the opportunity to have any questions answered
- I therefore give my consent for the transvaginal examination to be performed

_____	_____	_____
Patient Name (Print)	Signature	Date
_____	_____	_____
Sonographer (Print)	Signature	Date
_____	_____	_____
Chaperone (Print)	Signature	Date

OR

HIGH RISK
PREGNANCY DOCTORS

Declined consent for Transvaginal scan

I _____ understand the benefits of a transvaginal scan but on this occasion I have chosen to decline to undertake the procedure and wish to have the opportunity to discuss further with my referring practitioner.

_____	_____	_____
Patient Name (Print)	Signature	Date
_____	_____	_____
Sonographer (Print)	Signature	Date

Office Use: (Trans-vaginal examination did not proceed as determined by sonographer)

- ☐ *Patient was less than 18 years of age*
- ☐ *Appropriate informed consent was not satisfactorily obtained due to language barrier*
- ☐ *Other (Reason)* _____

HIGH RISK PREGNANCY DOCTORS

ACKNOWLEDGEMNT OF NON-DELIVERING PHYSICIAN

NAME _____

ADDRESS _____

PATIENT CONSENT

- I acknowledge that it is my personal responsibility to find an Ob/Gyn of my choice who will be delivering my baby.
- I acknowledge that Dr. Lozovyy is not my primary Ob/Gyn and will not be my delivering physician.
- I acknowledge that Dr. Lozovyy will not bear responsibility of attending my care in the hospital during my delivery.
- I understand what while HRPD office may share Ob/Gyn physicians' names with me, it is my right to choose any doctor of my liking.

_____.	_____.	____/____/____
Patient Name (Print)	Signature	Date

HIGH-RISK
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13052 Dallas Parkway
Ste 230
Frisco, TX 75034
Phone: (972) 668-BABY
Fax: (877) 862-5660
www.highrisk-pregnancy.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your medical information and are required by law to do so. Under HIPAA, your medical information is referred to protected health information or PHI. This notice describes how we may use your PHI at High Risk Pregnancy Doctors (HRPD) and how we may disclose it to others outside of HRPD. This notice also describes the rights you have concerning your own PHI. Please review this notice carefully and let us know if you have questions.

Permissible Uses and Disclosures without Your Written Authorization

Treatment: We may use your PHI to provide you with medical services and supplies. We may also disclose your PHI to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care. For example, we will allow other physicians treating you to have access to your medical record. To assure that your other treatment providers have quick access to your latest health information, we may participate in a community-based electronic health information exchange. We also may use and disclose your PHI to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you, or to perform follow-up calls to monitor your care experience.
Family Members and Others Involved in Your Care: We may disclose your PHI to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your PHI to disaster relief organizations to help locate a family member or friend in a disaster. During visits with family members and other visitors, let your physician and Practice personnel know if you do not want them to disclose your PHI during the visit.

Payment: We may use and disclose your PHI to get paid for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may ask to see parts of your medical record before they will pay us for your treatment.

Practice Operations: We may use and disclose your PHI if it is necessary to improve the quality of care we provide to patients or to run the Practice. We may use your PHI to conduct quality improvement activities, to obtain audit, accounting, or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate the care provided by Practice personnel, your doctors, or other health care professionals.

Health Information Organizations: Your PHI may be used and disclosed with other health care providers or other health care entities for treatment, payment, and health care operations purposes, as permitted by law, through a Health Information Organization. For example, information about your past medical care and current medical conditions and medications can be available to other primary care physicians or hospitals, if they participate in the Health Information Organization. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions. You may opt out of the Health Information Organization and prevent providers from being able to search for your information through the exchange. You may opt out and prevent your PHI from being searched through the Health Information Organization by completing and submitting an Opt-Out Form to the registration desk at the Practice office.

Research: We may use or disclose your PHI for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your PHI.

Required by Law: Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device. We also are required to give information to the State Workers' Compensation Program for work-related injuries.
Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA or may notify patients of recalls of products they are using.

Public Safety: We may disclose PHI for public safety purposes in limited circumstances. We may disclose PHI to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose PHI to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct at the Practice. We also may disclose your PHI to law enforcement officials and others to prevent a serious threat to health or safety.

Health Oversight Activities: We may disclose PHI to a government agency that oversees the Practice or its personnel, such as the State Department of Health, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor the Practice's compliance with state and federal laws.

Coroners, Medical Examiners and Funeral Directors: We may disclose PHI concerning deceased patients to coroners, medical examiners, and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose PHI to organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your PHI as required by military command authorities or to the Department of Veterans Affairs. The Practice may also disclose PHI to federal officials for intelligence and national security purposes, or for presidential Protective Services.

Judicial Proceedings: The Practice may disclose PHI if the Practice is ordered to do so by a court or if the Practice receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your PHI.

Uses and Disclosures for Which Your Authorization is Required: With limited exceptions, the Practice must obtain your written authorization before it may disclose your PHI in the following circumstances: (1) to disclose psychotherapy notes, (2) to conduct marketing activities, or (3) to sell your medical information to a third party.

Information with Additional Protection: Certain types of PHI have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of PHI. For those types of information, the Practice is required to get your permission before disclosing that information to others in many circumstances.

Other Uses and Disclosures Requiring Authorization: If the Practice wishes to use or disclose your PHI for a purpose that is not discussed in this Notice, the Practice will seek your written authorization. If you give your authorization to the Practice, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose the information. If you ever would like to revoke your authorization, please notify the Practice Manager in writing.

WHAT ARE YOUR RIGHTS?

Right to Request Your PHI: You have the right to look at your own PHI and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your PHI, write to the Practice Office. Federal and state laws permit a reasonable cost-based fee to be charged for the copying of patient records. You will be notified in advance what this copying will cost. You can look at your record at no cost.

Right to Request Amendment of PHI You Believe Is Erroneous or Incomplete: If you examine your PHI and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your PHI, write to the Practice Manager.

Right to Get a List of Disclosures of Your PHI: You have the right to request a list of the disclosures we make of your PHI. If you would like to receive such a list, write to the Practice Manager. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How the Practice Will Use or Disclose Your PHI for Treatment, Payment, or Health Care Operations: You have the right to request the Practice from making uses or disclosures of your PHI to treat you, to seek payment for care, or to operate the Practice. In many cases, the Practice is not required to agree to your request for restriction, but if we do agree, we will comply with that agreement. However, the Practice must agree to your request not to disclose to your health plan any PHI about items or services for which you have paid in full, unless such disclosure is required for treatment or by law. If you do not want the practice to notify your health plan, you must notify us at the time of your registration as well as make immediate arrangements to pay in full for your treatment or visit.

Right to Revoke Your Authorization: You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Practice and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Practice Office.

Right to Request Confidential Communications: You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the Practice Manager. At your request, you can also ask to speak with your health care providers in private outside the presence of other patients or family.

Right to a Paper Copy: If you have received this notice electronically, you have the right to a paper copy at any time. You may obtain a paper copy of the notice from the Practice Manager.

DUTIES OF THE PRACTICE

The Practice is required by law to protect the privacy of your PHI, give you this Notice of Privacy Practices, and follow the terms of the Notice that is currently in effect. The Practice is also required to notify you if there is a breach of your unsecured PHI.

WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE?

This Notice of Privacy Practices applies to HRPD and its personnel, volunteers, and trainees.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient PHI, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all PHIwe maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current notice of Privacy Practices at any time by contacting the Practice Manager.

DO YOU HAVE CONCERNS OR COMPLAINTS?

Please tell us about any problems or concerns you have with your privacy rights or how the Practice uses or discloses your PHI. If you have a concern, please contact the Ethics Action Line at 1-800-8-ETHICS. If for some reason the Practice cannot resolve your concern, you may also file a complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy and Security Office will provide you with the correct address for the Director. We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

PRIVACY OFFICIAL CONTACT INFORMATION

Corporate Compliance & Privacy Office: 13052 Dallas Parkway, Ste. 230, Frisco TEXAS 75033

By my signature below, I acknowledge that I have received the Notice of Privacy Practices. I understand that the organization reserves the right to change their notice and practices and before implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

PATIENT/PARENT/GUARDIAN SIGNATURE NAME (PLEASE PRINT)

_____

PATIENT NAME (PLEASE PRINT) DATE

PLEASE COMPLETE THE FOLLOWING INFORMATION:

I, _____ , hereby give my consent to High Risk Pregnancy Doctors
(Patient Name)

Pregnancy Doctors to disclose any medical information including, genetic information, lab results, ultrasound results and diagnostic testing results, and/or billing information to the following:

☐ Referring Physician _____ (billing information not applicable)
(Name)

☐ Spouse / Significant Other _____
(Name)

☐ Other _____
(Name)

I give permission to leave NORMAL RESULTS on my voicemail / answering machine / e-mail ❑Yes ❑NO

If the person tested is unable to sign, please indicate the reason here:_____

_____ _____
Patient Signature or Legal Representative Date

HIGH RISK PREGNANCY DOCTORS

Dr. Violetta Lozovyy
13052 Dallas Parkway, Suite 230
Frisco, TX 75034
(P) 972-668-BABY (F) 1-877-862-5660

Non-Disparagement Clause

For purposes of this agreement, the Legal definition of disparagement; the publication of false and injurious statements that are derogatory of another's property, business, or product. Any negative statement, in any form of communication whether written or oral.

At High Risk Pregnancy Doctors, we pride ourselves in the highest quality of care and are dedicated to a highly accessible, patient-care experience. Should you have any concerns, we ask that you escalate them directly within our management:

High Risk Pregnancy Doctors
Director of Operations
13052 Dallas Parkway Suite 230
Frisco, Texas 75034
(O) (214) 618-0023

As our Patient, you agree that you shall not engage in any pattern of conduct that involves the making or publishing of disparaging written or oral statements or remarks, including, without limitation; publish, or communicate to any person or entity or in any public forum such as Google, Facebook, or Yelp, any defamatory comments, or statements which are disparaging, deleterious or damaging to the integrity, reputation or good will of High Risk Pregnancy Doctors, its management, its affiliates or any of their respective employees, existing and prospective patients, suppliers, investors and other associated third parties.

_____ _____

Patient Signature Date

HIGH-RISK
PREGNANCY DOCTORS
Complete Pregnancy Care

13052 Dallas Parkway
Ste 230
Frisco, TX 75034
Phone: (972) 668-BABY
Fax: (877) 862-5660
www.highrisk-pregnancy.com

THINGS TO KNOW BEFORE YOUR APOINTMENT.

1. Please be prepared to pay any fees and outstanding balance before your appointment!
2. When checked in, you have to use bathroom BEFORE you are taken to the Ultrasound room! Failure to do so, may cause significant delays for other clients who are coming after you.
3. Please note: At your appointment, you will NOT see the doctor in person if you come for the following Ultrasound scans:
   a. NT Scan (12-13 weeks/30 min long);
   b. Basic Anatomy (18 weeks/ 60 min long);
   c. Detailed Anatomy (18 weeks/60 min long);
   d. Echo (22 weeks/60 min long)

   Your Doctor will still read and analyze your ultrasound! If abnormality is discovered, the Doctor will come to see you in person.
4. In the event of unforeseen circumstances may arise in HRPD, please be prepared for prolonged wait times due to Emergencies and other internal factors!
5. If there is any change at any time in your insurance coverage, you have to notify the front desk to avoid penalties. If you have secondary insurance, please let our office know immediately as it may cause HRPD to rebill all your claims from scratch!
6. If you have to cancel or reschedule your appointment, you have to notify the office 24 hours in advance to avoid penalties
7. If you have a question about your Genetic Test with ***NATERA***, please contact **Matthew Jennings at *NATERA* to discuss the results any billing questions: tel: (918) 833-1634**
8. **If you need to reach our nurse, please call her direct line: (972) 668-6262. PLEASE DO NOT CALL OUR MAIN LINE TO REACH THE NURSE!**

HRPD Fee Schedule:

- If appointment is canceled or rescheduled in less than 24 hours prior your appointed time, $50 fee will be added to the patient's balance or $100 for the extensive 1 hour-long scans, as outlined above.
- FMLA letter - $25.00
- Doctor's Signed Letter - $15.00
- Release of Records - $15.00
- Detailed Claim Records - $25.00.
- Failure to disclose all current insurance coverage and changes in my policy will result in claims re-submission fee or $250.00, whichever is greater.
- All deductibles must be paid in full by 26 weeks of pregnancy.
- All concierge payment plans will be collected in accordance with the signed concierge contract
- In office circumcision fee: $400. We will NOT bill your insurance for this cosmetic procedure!