

**Northeast Women's Healthcare
Obstetrics and Gynecology
Miles E. Mahan, MD, Board Certified
David Bonilla, MD, Board Certified
Penny Landers, RNC-WHNP**

PATIENT INFORMATION
(please print)

DATE: _____

PATIENT'S LEGAL NAME: _____

SOCIAL SECURITY #: _____ BIRTHDAY _____ AGE _____

MAILING ADDRESS: _____

E-Mail ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ MARITAL STATUS _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____

NAME OF SPOUSE/GUARDIAN: _____

SOCIAL SECURITY # OF SPOUSE/GUARDIAN: _____ D.O.B. _____

EMPLOYER OF SPOUSE/GUARDIAN: _____ WORK#: _____

NAME OF CLOSEST LIVING RELATIVE: _____ PHONE: _____

IN CASE OF EMERGENCY, NOTIFY: _____ PHONE: _____

*Lifetime Insurance Authorization: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the Social Security Administration or its intermediaries or carriers involved in processing and collection of a claim. I understand that I am financially responsible for the charges not covered by this authorization.

X _____
Signed patient, or parent, if minor _____ Date _____

IF PATIENT IS A MINOR, PLEASE COMPLETE:

I, _____, give permission to Dr. Mahan, Dr. Biscette or the Nurse Practitioner to examine my daughter _____.

Parent or Guardian _____ Witness _____ Date _____

Northeast Women's Healthcare
Obstetrics and Gynecology
Miles E. Mahan, MD, Board Certified
David Bonilla, MD, Board Certified
Penny Landers, RNC-WHNP

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ~ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ~ Obtain payment from third-party payers.
- ~ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices. I may request a copy of the Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

~~~~~  
**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below:

| Date | Initials | Reason |
|------|----------|--------|
|      |          |        |

**Northeast Women's Healthcare  
Obstetrics and Gynecology  
Miles E. Mahan, MD, Board Certified  
David Bonilla, MD, Board Certified  
Penny Landers, RNC-WHNP**

**Consent for Patient Care Provided by a Nurse  
Practitioner**

Northeast Women's Healthcare employs a highly qualified Nurse Practitioner. A Nurse Practitioner is a registered nurse with additional specialized training in diagnosing and treating illnesses and providing healthcare maintenance.

Penny Landers, RNC-WHCNP

Penny received her training at The University of Texas-Southwestern Medical School and specializes in Women's Health.

You can schedule your appointment with Dr. Mahan, Dr. Bonilla or Penny Landers and every effort will be made to ensure that you see the provider of your choice. However, occasionally the doctors are called from the office for or delivery or an emergency. In those instances, you will be offered to wait, reschedule, or have a Nurse Practitioner see you at that time.

By signing below, you consent for care and treatment provided by Penny Landers, RNC-WHNP.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**Prenatal Information Form**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 When was the first day of your last period? \_\_\_\_\_  
 How old were you when you first started your period? (Menarche) \_\_\_\_\_  
 Menstrual Frequency:  regular  irregular/every \_\_\_\_\_ days/ Duration: \_\_\_\_\_ days  
 What is your ethnicity? \_\_\_\_\_  
 Father of this Baby's Name: \_\_\_\_\_ Age \_\_\_\_\_ Ethnicity \_\_\_\_\_

**Obstetrical History:**

|                                    | Number |                   | Number |                  | Number |
|------------------------------------|--------|-------------------|--------|------------------|--------|
| <b>Pregnancies</b>                 |        | <b>Live Birth</b> |        | <b>Abortions</b> |        |
| Preterm birth (less than 37 weeks) |        | Miscarriages      |        | Living Children  |        |

| No | Delivery Date | # weeks Pregnant | Type and Anesthesia (Vaginal, c-section, miscarriage or abortion) | # Hours in Labor | Place of Birth | Birth weight | Gender | Complications (During pregnancy or delivery) |
|----|---------------|------------------|-------------------------------------------------------------------|------------------|----------------|--------------|--------|----------------------------------------------|
| 1  |               |                  |                                                                   |                  |                |              |        |                                              |
| 2  |               |                  |                                                                   |                  |                |              |        |                                              |
| 3  |               |                  |                                                                   |                  |                |              |        |                                              |
| 4  |               |                  |                                                                   |                  |                |              |        |                                              |
| 5  |               |                  |                                                                   |                  |                |              |        |                                              |
| 6  |               |                  |                                                                   |                  |                |              |        |                                              |

**Medical History:**

|                      | Yes/No |                             | Yes/No | Surgery (date and type of surgery) | Hospitalization (date and reason) |
|----------------------|--------|-----------------------------|--------|------------------------------------|-----------------------------------|
| Allergic Rhinitis    |        | Liver Disease               |        |                                    |                                   |
| Anemia               |        | Neurologic Disorder         |        |                                    |                                   |
| Asthma               |        | Renal Disease               |        |                                    |                                   |
| Autoimmune Disorder  |        | (Rh) Sensitized             |        |                                    |                                   |
| Abnormal Pap smear   |        | Thyroid Disorder            |        |                                    |                                   |
| Blood Transfusion    |        | Trauma History              |        |                                    |                                   |
| Breast Disorder      |        | Uterine Abnormalities       |        |                                    |                                   |
| Depression           |        | Varicosities/DVT            |        |                                    |                                   |
| Psychiatric Disorder |        | Anesthetic Complications    |        |                                    |                                   |
| Diabetes             |        | Tattoos (if yes, how many?) |        |                                    |                                   |
| Heart Disease        |        | Cats at home                |        |                                    |                                   |
| Hypertension         |        | Tobacco / Alcohol           |        |                                    |                                   |
| Infertility          |        | Illicit Drugs               |        |                                    |                                   |

**Genetic & Exposure Screening**

|                                                | Yes/No |                                                               | Yes/No |                                                  | Yes/No |
|------------------------------------------------|--------|---------------------------------------------------------------|--------|--------------------------------------------------|--------|
| Are you 35 or older?                           |        | Autism (If yes, was person tested for Fragile X?)             |        | Patient or partner has history of Genital Herpes |        |
| Neural Tube Defect (Spina Bifida, Anencephaly) |        | Mental Retardation (If yes, was person tested for Fragile X?) |        | Exposure to TB                                   |        |
| Trisomy 21 (Down Syndrome)                     |        | Muscular Dystrophy                                            |        | Rash or Viral Illness since last period          |        |
| Congenital Heart Defect                        |        | Sickle Cell Disease or Trait                                  |        | History of any Sexually Transmitted Disease      |        |
| Cystic Fibrosis                                |        | Other inherited Genetic or Chromosomal Disorder               |        | Possible Varicella Susceptibility                |        |
| Tay-Sachs                                      |        | Maternal Metabolic Disorder (Type 1 Diabetes, PKU)            |        | Other Exposure or History of Infection           |        |
| Thalassemia                                    |        | Recurrent Pregnancy Loss, or A Stillbirth                     |        |                                                  |        |
| Canavan Syndrome                               |        | Other Birth Defects                                           |        |                                                  |        |
| Hemophilia                                     |        | Other Genetic Screening                                       |        |                                                  |        |
| Huntington's Chorea                            |        | Partner has history of HIV                                    |        |                                                  |        |

**Northeast Women's Healthcare  
Obstetrics and Gynecology  
Miles E. Mahan, MD, Board Certified  
David Bonilla, MD, Board Certified  
Penny Landers, RNC-WHNP**

Release of Information to another party.

I \_\_\_\_\_ give permission for any medical information regarding myself including lab results to be released to the following individual/s.

|      |              |
|------|--------------|
| Name | Relationship |
| Name | Relationship |
| Name | Relationship |
| Name | Relationship |

I am aware that this note is valid until I terminate my authorization in writing.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

**Northeast Women's Healthcare  
Obstetrics and Gynecology  
Miles E. Mahan, MD, Board Certified  
David Bonilla, MD, Board Certified  
Penny Landers, RNC-WHNP**

### **Antepartum Testing**

We would like to take this opportunity to welcome you to our practice. In order to give the best quality care to our patients we will perform several different tests during your pregnancy. These tests include but are not limited to the following:

|                             |                        |
|-----------------------------|------------------------|
| Complete Blood Count        | Hepatitis B            |
| ABO and RH (Blood Type)     | Hepatitis C            |
| Thyroid Stimulating Hormone | Gonorrhea              |
| Antibody Screen             | Chlamydia              |
| Urine Culture               | HIV                    |
| Urine Drug Screen           | RPR (Syphilis)         |
| Sickle Cell Screening       | Glucose Tolerance Test |
| Pap Smear                   | Rubella Antibodies     |
| Group B Strep Colonization  | Ultrasound             |
| AFP/Tetra (optional)        |                        |
| Cystic Fibrosis (optional)  |                        |

Non-Stress Testing is done during some but not all pregnancies.

Some test will be done more than once. If you have any questions or concerns regarding any of the above tests, please discuss this with your nurse and/or doctor.

I acknowledge that I have been informed and consent to all antepartum testing done during my pregnancy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**All blood testing is billed to your insurance and/or you by the laboratory, and is not included in your payments at our office.**

**In addition to our office/delivery charge you should expect charges for the following:**

|                   |                         |                                      |                  |                  |
|-------------------|-------------------------|--------------------------------------|------------------|------------------|
| <b>Facility</b>   | <b>Laboratory</b>       | <b>Pediatrician</b>                  | <b>Radiology</b> | <b>Pathology</b> |
| <b>Anesthesia</b> | <b>Other Physicians</b> | <b>Medications</b>                   | <b>Pharmacy</b>  | <b>Nursery</b>   |
| <b>Procedures</b> | <b>Operating room</b>   | <b>Assistant Surgeon(c-sections)</b> |                  |                  |

**We attempt to inform you of all charges that will incur during your pregnancy, however, any physician that you and/or your baby encounter may order testing or procedures that are billed separately.**

Northeast Women's Healthcare  
Miles E. Mahan, MD, Board Certified  
David Bonilla, MD, Board Certified  
Penny Landers, RNC-WHNP  
Obstetrics and Gynecology

## Attention: All Obstetrical Patients

Congratulations on your pregnancy!

### Insurance:

During your pregnancy it is very important that we bill the correct insurance company. In order to achieve this we need cooperation from you.

Please inform us of ALL insurance policies you may have, also of any insurance changes. We must bill insurance in a specific order:

- 1<sup>st</sup> Your insurance through your employer.
- 2<sup>nd</sup> Your insurance through your spouse's employer.
- 3<sup>rd</sup> Medicaid

We cannot bill out of order for any reason, unless you are on Medicaid because you have no maternity coverage through your policy.

Your insurance benefits will be verified and reviewed with you. Any deductibles and co-insurance are collected prior to the 27<sup>th</sup> week of pregnancy. We can set up a payment plan for you during the time leading up to your 27<sup>th</sup> week, after this payment is due in full. Failure to pay in a timely manner may result in termination of care. Occasionally because of the calendar year, you may owe a portion of deductible/co-insurance for both years. All payments plans are an estimate of benefits. Any balance will be billed; any credit after all visits have been paid by your insurance will be refunded.

I have read and understand the policies on insurance.

---

Signature of Patient/Guardian

Date

Northeast Women's Healthcare  
Miles E. Mahan, MD, Board Certified  
David Bonilla, MD, Board Certified  
Penny Landers, RNC-WHNP  
Obstetrics and Gynecology

## What is First Trimester Screening?

Ultra-Screen consists of a combination of an ultrasound exam and a blood test. The ultrasound exam is performed between 11 weeks and 13 weeks and the blood test is performed at the same time we do your ultrasound. The ultrasound demonstrates a fetal heartbeat and gestational age. Then the amount of fluid accumulation behind the neck of the baby, call nuchal translucency (NT), is measured. The blood specimen is analyzed for two chemicals called free Beta human chorionic gonadotropin (free Beta), and pregnancy associated plasma protein-A (PAPP-A) which are normally found in the blood of all pregnant women. The results of the ultrasound exam will be combined with the results of the blood test to estimate a specific risk for Downs syndrome and trisomies 18 and 13.

**\* This is NOT an amniocentesis \***

\_\_\_\_\_ I have chosen TO HAVE the Ultra-Screen test performed.

\_\_\_\_\_ I have chosen NOT TO HAVE the Ultra-Screen test performed.

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

**Northeast Women's Healthcare**  
**Miles E. Mahan, MD, Board Certified**  
**David Bonilla, MD, Board Certified**  
**Penny Landers, RNC-WHNP**  
**Obstetrics and Gynecology**

## **Attention: Obstetrical Patients**

The following list of services are billed separately from your total OB Care and delivery. Some of these services may not apply to your individual care.

1. Ultrasounds
2. Non- Stress Tests
3. Injections
4. Any office visits other than routine care
5. Laboratory services  
Please be aware that any lab tests ordered and sent to the laboratory are billed by the lab. Depending on your insurance coverage, fees can be upwards of \$3500.00 for labs that are ordered in the office.
6. Hospital Services
7. Anesthesia Services
8. Assistant surgeon for cesarean sections
9. Nursery services for your newborn
10. Referrals to specialists are billed by their office

**Please note: All cesarean sections are required to have an assistant surgeon present at the time of delivery. If you have a conflict of interest with another OB/GYN in the area please inform us so we will be sure not to ask them to assist with your surgery.**

We share call with Dr. Bonilla and Dr. Schettler.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Northeast Women's Healthcare**  
**Miles E. Mahan, MD, Board Certified**  
**David Bonilla, MD, Board Certified**  
**Penny Landers, RNC-WHNP**  
**Obstetrics and Gynecology**

## Leave Of Absence:

At some point during your pregnancy you may be required to discontinue working or decrease your work hours. At this point we can give you a letter stating that we have recommended this for your care. However, unless instructed by a physician to do this we cannot give you a letter. We must have a medical reason to take you off work or decrease your hours. This is the same when you are sick and miss work. We must have documentation in order to provide you with a letter.

---

I have read and understand the policies on Insurance and Leave off Work:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Northeast Women's Healthcare  
Obstetrics and Gynecology  
Miles E. Mahan, MD, Board Certified  
David Bonilla, MD, Board Certified  
Penny Landers, RNC-WHNP**

**Ultrasound Informed Consent**

I understand that during the course of my pregnancy I will get an ultrasound. I understand that ultrasounds may be performed to check fetal growth, verify dates, as well as other information that will be helpful in following my pregnancy. I understand that a routine ultrasound is not performed to detect congenital defects, although occasionally certain large defects may be identified. I also understand that ultrasounds are only about 75% accurate in determining the sex of my baby and are not specifically performed for this purpose.

By signing this form, I acknowledge that I have been given all the information I desire concerning this procedure and have had all my questions answered.

---

**Patient's Signature**

---

**Date**

## Cystic Fibrosis Testing

What is the purpose of cystic fibrosis carrier testing?

The purpose of CF carrier testing is to see if a couple is at increased risk for giving birth to a child who will have CF. Cystic Fibrosis carrier testing is a laboratory test done on a sample of blood or saliva. If testing shows that a couple is at high risk, additional testing can be done on the developing baby to see whether or not it will have CF. However, most women's test results are normal.

The chance of being a CF carrier depending on race/ethnicity:

|                                      |         |
|--------------------------------------|---------|
| European Caucasian, Ashkenazi Jewish | 1 in 29 |
| Hispanic American                    | 1 in 46 |
| African American                     | 1 in 65 |
| Asian American                       | 1 in 90 |

**REMEMBER:** Both parents must be carriers for the baby to develop CF.

1. I understand that the decision to be tested for CF status is completely mine.
2. I understand the test does not detect all CF carriers.
3. I understand that if I am a carrier, testing the baby's father will help me learn more about the chance that my baby could have CF.
4. I understand that if one parent is a carrier and the other is not, it is still possible that the baby will have CF, but that the chances of this are very small.
5. I understand that if both parents are carriers, additional testing can be done in order to know whether or not the baby will have CF.
6. The estimated cost of this test is \$1300.00. Please be aware you could be responsible for all or a portion of this depending on your insurance coverage.

I have read and understand the information and:

\_\_\_\_\_ I WANT CF carrier testing

\_\_\_\_\_ I DO NOT want CF carrier testing

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date