GENETICS CENTER

INSURANCE AND PAYMENT INFORMATION

PATIENT INFORMATION

Patient Name (Last, First, Middle): | Maiden Name: | **Date of Birth (MM-DD-YYYY):**

Social Security #: | Driver's License #: | **Phone Number:**

Home Address: | **City:** | **State:** | **ZIP Code:**

First time here? ◯ Yes ◯ No | Communication Preference: ◯ Mail ◯ Phone ◯ No Preference

Smoking Status: ☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Former Smoker
☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Never Smoker

Employer: | Work Address: | Work Phone:

Name of Nearest Relative (other than spouse/partner): | **Relationship to Patient:** | **Phone Number:**

SPOUSE/PARTNER INFORMATION

Spouse/Partner Name (Last, First, Middle): | **Date of Birth (MM-DD-YYYY):**

Social Security #: | Driver's License #: | Work Phone:

Employer: | Work Address:

INSURANCE INFORMATION

Primary Insurance:

Address:

Policy Number: | Subscriber Name:

Secondary Insurance:

Address:

Policy Number: | Subscriber Name:

Your signature below confirms that the information submitted above is true and correct to your knowledge and that you have read, understood, and accept our Insurance, Payment, and Other Terms on a separate page.

Patient's Signature: Date:

GENETICS CENTER

GENETIC SCREENING QUESTIONNAIRE

Name: _____ DOB: _____ Ethnic Origin: _____

Partner's Name: _____ DOB: _____ Ethnic Origin: _____

Family and Patient History

1. Is your family or your partner's family…

		Maternal	Paternal
a. Southeast Asian, Taiwanese, Chinese, or Filipino?	☐ No	☐ Yes	☐ Yes
b. Italian, Greek, Middle Eastern, East Indian, or Pakistani	☐ No	☐ Yes	☐ Yes
c. African or African-American (Black)?	☐ No	☐ Yes	☐ Yes
d. Jewish?	☐ No	☐ Yes	☐ Yes
e. Cajun or French Canadian?	☐ No	☐ Yes	☐ Yes

2. Have you, your partner, or anyone in either of your families ever had any of the following disorders?

	No	Yes		No	Yes
a. Down syndrome	☐	☐	k. Bone or skeletal disorder (e.g. dwarfism)	☐	☐
b. Other chromosomal abnormalities	☐	☐	l. Polycystic kidney disease/kidney abnormalities.	☐	☐
c. Neural tube defect (such as spina bifida, anencephaly)	☐	☐	m. Heart defect (at birth)	☐	☐
			n. Cleft lip/palate	☐	☐
d. Cystic fibrosis (a lung disease)	☐	☐	o. Developmental delay, mental retardation, or autism	☐	☐
e. Bleeding disorder (hemophilia)	☐	☐			
f. Sickle cell/Thalassemia	☐	☐	p. Any birth defect or genetic condition not listed above	☐	☐
g. Tay-Sachs/Canavan	☐	☐	q. Needed surgery before age 1 year	☐	☐
h. Neurofibromatosis	☐	☐	r. Cancer in childhood or young adulthood	☐	☐
i. Muscular dystrophy	☐	☐	s. Non-age-related blindness or deafness	☐	☐
j. Other nerve or muscle disorder	☐	☐			

	No	Yes
3. Are you and your partner related by blood (such as cousins)?	☐	☐
4. Have you, your partner, or anyone in either of your families had a baby who died shortly after birth or in childhood?	☐	☐
5. Have you, your partner, or anyone in either of your families had a stillbirth or two or more pregnancy losses?	☐	☐
6. Have you or your partner had any genetic tests (such as chromosomes, cystic fibrosis, Tay-Sachs, or sickle cell screening)? Other: _____	☐	☐
7. Have you ever been diagnosed with diabetes, cancer, another serious medical condition, or genetic condition?	☐	☐
8. Do you or your partner have a history of infertility?	☐	☐

If so, specify the cause, if known: _____

9. If yes to any question above, please explain:

Pregnancy History

	No	Yes
1. Was this pregnancy achieved through in-vitro fertilization (IVF) or other assisted reproductive methods?	☐	☐

If yes, was there: ☐ Sperm donor ☐ Egg donor ☐ ICSI ☐ Preimplantation genetic diagnosis (PGD)
☐ Other: _____

2. Have you had the California Prenatal Screening Program blood test? If yes, when? _____	☐	☐
3. Have you had Non-invasive Prenatal Testing (NIPT)? If yes, when? _____	☐	☐

4. During *this* pregnancy, have you had any of the following? (If "yes", please describe, including dates, if known):

	No	Yes		No	Yes
a. Cramping, vaginal bleeding or vaginal leakage of fluid	☐	☐	e. Ultrasound ("sonogram")	☐	☐
b. Infections, rashes, or other illness, fever over 101°	☐	☐	f. Occupational, chemical, or other exposures	☐	☐
c. X-rays, hospitalizations, or surgery	☐	☐	g. Prescription or non-prescription medication	☐	☐
d. Cigarettes, alcoholic beverages, or "street" drugs	☐	☐	h. Prenatal vitamins	☐	☐

My signature below indicates that the above family and pregnancy history information provided is complete and correct.

Completed by: _____ Date: _____

Reviewed by: _____ Date: _____

GENETICS CENTER

Recommended Prenatal Genetic Screening Tests

Patient Name: _____ **Date of Birth:** _____
(MM-DD-YYYY)

The following tests are recommended to be offered to every patient who is planning a pregnancy or who is already pregnant. The testing can determine if the pregnancy is at a higher risk than the general population of having these conditions. Currently, there is not a cure for these conditions prior to or after birth. If the risk of these conditions is higher, you would be offered further diagnostic testing. The purpose of having this information about your developing baby is so that you can prepare yourself to care for a child with special health care needs or choose to not continue an affected pregnancy. Please review the basic information regarding these conditions. If you would like more information or have further questions, your genetic counselor can answer them for you. We can also verify insurance coverage for this testing.

Cystic Fibrosis	• CF is a life long illness that causes problems with digestion and breathing. CF does not affect intelligence or appearance. In California, all infants are tested for this condition at birth through the State Newborn Screening Program. • CF is most common in individuals of European, Caucasian, or Jewish descent. However, CF has been reported in other populations as well. • To have a child with CF, both parents must carry a genetic change or mutation. • CF carrier screening does not detect all CF carriers. The detection rate varies by specific ethnic group.
I would like more information regarding this testing: ☐ Yes ☐ No	
Spinal Muscular Atrophy (SMA)	• SMA is a serious condition that causes progressive muscle weakness and paralysis. Children with SMA type 1 usually die from respiratory failure by 2 years of age. Other types of SMA are less severe, but are also disabling. • SMA affects all ethnic groups equally. The chance of being a carrier is approximately 1/50 in the general population. • To have a child with SMA, both parents must carry a genetic change or mutation. • SMA carrier screening does not detect all SMA carriers. 6-9% of carriers of SMA are not detected by current technology. • The severity of SMA cannot be predicted by genetic testing.
I would like more information regarding this testing: ☐ Yes ☐ No	

Continued on next page

GENETICS CENTER

Recommended Prenatal Genetic Screening Tests

Continued from previous page

Fragile X syndrome	• This condition is the most common cause of inherited mental retardation and developmental delay in males. Behavioral abnormalities, including autism spectrum disorder, are also common. • Only females can carry the genetic mutation that causes Fragile X syndrome. Males with Fragile X syndrome are more severely affected than females with this condition. • The incidence in the general population is approximately 1/2000 to 1/4000 live births.
I would like more information regarding this testing: ☐ Yes ☐ No	

Patient's Signature: _____ **Date:** _____

**I acknowledge that the values and limitations of DNA testing have been explained to me, and I give my consent for testing.*

FOR COUNSELOR USE ONLY

I have received and understand the information on Spinal Muscular Atrophy & Fragile X syndrome.

☐ I do not want Fragile X carrier testing.
☐ I want Fragile X carrier testing. *

☐ I do not want Spinal Muscular Atrophy carrier testing.
☐ I want Spinal Muscular Atrophy carrier testing. *

GENETICS CENTER

REQUEST FOR MEDICAL INFORMATION BY

GENETICS CENTER
211 SOUTH MAIN STREET, SUITE E, ORANGE, CALIFORNIA 92868
TEL. 714.288.3500 FAX 714.288.3510

GENETICS CENTER is currently treating the patient identified below, and we are requesting that medical information for that patient be released to **GENE**TICS CENTER and forwarded to us at the above address.

Patient's Full Name: _____
(Last, First, Middle)

Date of Birth: _____

Information Requested: **Screening Results from The California Prenatal Screening Program**

*I hereby authorize release of the above records to **GENE**TICS CENTER.*

Patient's Signature: **X** _____ **Date:** **X** _____

OR

Signing for Patient: _____ **Date:** _____

Relationship to Patient: _____

Witness' Signature: _____ **Date:** _____

GENETICS CENTER'S **Signature:** _____

Date: _____

FOR OFFICE USE ONLY
Medical Information being requested from:

Physician or Facility: California Department of Public Health - Genetic Disease Screening Program

Address: _____

City, ZIP code: _____

Phone Number: _____

Fax Number: _____

Please return a copy of this form with the records. Thank you.

GENETICS CENTER

Notice of Separate Fee From the California Prenatal Screening Program

The California Prenatal Screening Program has a ***separate fee* of $221.60** for enrollment in their program. This single program fee covers both the first and/or second blood test and any authorized follow up services (this does not cover the nuchal translucency ultrasound). Please see page 18 of the blue California Prenatal Screening Program booklet for further details.

For any questions regarding this $221.60 fee, please directly call the State at 510-412-1613, as Genetics Center is not involved in this billing.

I acknowledge that I have read this form and am aware of the separate State fee:

Signature: _____ Date: _____

The State is out-of-network with all insurance companies and you may receive a separate bill from the State. If so, fill out their insurance form and return it along with the bill directly to the State.

GENETICS CENTER

Insurance, Payment, and Other Terms

Patient Name:_____ Date of Birth:_____
(MM-DD-YYYY)

AUTHORIZATION TO RELEASE INFORMATION FOR BILLING

I authorize the Genetics Center and its medical affiliates to release any information acquired in the course of my examination and treatment to my insurance company for billing purposes.

AUTHORIZATION TO RELEASE PAYMENT(S) TO GENETICS CENTER

I irrevocably assign and transfer insurance payment(s) directly to the Genetics Center.

INSURANCE ELIGIBILITY

I certify that I am eligible with my insurance company. I understand that if this is not true or if I am not eligible for some or all of the Genetics Center services under the terms of my insurance contract, I am liable for any and all charges for services rendered. Also, if I am not eligible, I agree to pay in full for all services rendered within thirty days of receiving a bill from the Genetics Center.

INSURANCE AND PAYMENT TERMS

I acknowledge that all medical bills are due and payable at the time services are rendered. However, as a courtesy to me the patient, Genetics Center will submit my claim to my insurance company for me. I understand that my insurance coverage is a contract between me and my insurance carrier. If it is my desire to have Genetics Center bill my insurance carrier for these services, I will present my insurance card.

I also acknowledge that **all co-pays and unmet deductibles are due and must be paid at the time of service.** In certain cases, Genetics Center may also require some deposit in advance. If my insurance company pays more than was collected, Genetics Center will promptly reimburse me that amount of the deposit. In some cases, my insurance will only cover a portion of the fees. If I have made an initial payment, it will then be applied to my balance. **If Genetics Center does not receive payment from my insurance carrier within 60 days from the date of my service, Genetics Center may look to me for payment in full.** A monthly 1.5% service charge will be added to balances over 30 days old, and a $10 statement fee will be added to balances over 60 days old. **The charges for Genetics Center services are ultimately my responsibility.**

BENEFITS AND COVERAGE CHECK IS SUBJECT TO CHANGE

Genetics Center cannot accept responsibility for any differences between what was quoted to them by my insurance during their courtesy benefits and coverage check (copay, deductible, etc), and the final benefit determination performed by my insurance when my claim is processed. Therefore, I may owe a different amount than what was quoted to me prior to services.

ACKNOWLEDGEMENT OF INDEPENDENT CONTRACTORS

I acknowledge that some providers involved here are not employees, but are independent contractors, specifically including the NT practitioners, sonographers, and perinatologists.

ACKNOWLEDGEMENT OF POTENTIAL BILLING BY OTHER PROVIDERS

I acknowledge that there could be other providers involved, such as ultrasound, hospital, perinatologist, etc., which will have their own billing.

AUTHORIZATION TO RECEIVE VOICE MESSAGES

I authorize the doctor and/or facility and/or staff to identify themselves as being from Genetics Center when calling to leave a message regarding my appointment, results, or other medical information on any answering device or with another person answering the phone

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Genetics Center's Notice of Privacy Practices.

My signature confirms that I have read, understand, and accept these terms.

Signature of Patient:_____ Date:_____
(or parent if minor)