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: ____________________

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GENETIC SCREENING QUESTIONNAIRE

Name: ______________________ Pronouns (circle one) ☐ She/her ☐ He/him ☐ They/them ☐ Other: __________ DOB: ______________________

Partner's Name: ______________________ DOB: ______________________

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, Indian Subcontinent	☐ 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
f. White? If yes, what countries are your ancestors from? ______________________	☐ No	☐ Yes	☐ Yes
g. Hispanic? If yes, what countries are your ancestors from? ______________________	☐ No	☐ Yes	☐ Yes

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

	No	Yes
a. Chromosomal abnormalities (such as Down syndrome)	☐	☐
b. Neural tube defect (such as spina bifida, anencephaly)	☐	☐
c. Cystic fibrosis (a lung disease)	☐	☐
d. Blood disorder (such as hemophilia, sickle cell, thalassemia, clotting disorder)	☐	☐
e. Tay-Sachs/Canavan	☐	☐
f. Nerve or muscle disorder (such as neurofibromatosis, muscular dystrophy)	☐	☐
g. Bone or skeletal disorder (e.g. dwarfism)	☐	☐
h. Polycystic kidney disease/kidney abnormalities.	☐	☐
i. Heart defect (at birth)	☐	☐
j. Cleft lip/palate	☐	☐
k. Developmental delay, intellectual disability, or autism	☐	☐
l. Any birth defect or genetic condition not listed above	☐	☐
m. Needed surgery before age 1 year	☐	☐
n. Cancer in childhood or young adulthood	☐	☐
o. Non-age-related blindness or deafness	☐	☐

	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, seizures, 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: ______________________	☐	☐

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

Completed by: ______________________ Date: ______________________

Reviewed by: ______________________ Date: ______________________

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Insurance, Payment, and Other Terms

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
NOTICE OF OPEN PAYMENTS DATABASE
To comply with Assembly Bill (AB) 1278, I acknowledge receiving the required notice: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was offered a copy of the Genetics Center's Notice of Privacy Practices.
AUTHORIZATION TO RECEIVE TEXT MESSAGES
[Yes No] I expressly consent and authorize receipt of text messages from Genetics Center at the telephone number you provide for appointment reminders and general information related to my health care treatment, and I understand that I can opt-out at anytime.

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

Patient Name:______________________________ Date of Birth:______________

Patient Signature:______________________________ Date:______________
(or parent if minor)

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