PRENATAL CONTRACT

PLEASE READ THIS CAREFULLY. This agreement is an important part of our prenatal program. This contract briefly outlines our expectation of you as our patient. We want to make sure that you have the healthiest pregnancy and the best outcome possible.

APPOINTMENTS

To have the healthiest pregnancy possible, you must see your provider regularly. You are required to attend ALL prenatal visits as requested by your provider. It is important for you to keep us informed of your current address and phone number. Often, we need to reach you in between your appointments. If you do not show up for two appointments in a row without communicating with us, or a total of the appointments in your pregnancy, we will assume you have gone somewhere else for your care and we will dismiss you from our care. In this case, we will attempt to contact you by letter at your last known address.

TOBACCO, DRUGS AND ALCOHOL

We strongly discourage the use of tobacco at all times, but especially during pregnancy. If you are a smoker, we will expect you to make an effort to quit during your pregnancy. We will refer you to a smoking cessation program.

If you test positive for cocaine, crack, marijuana, speed, alcohol, or any other drugs at any time during your pregnancy, you are endangering your unborn child. ANY amount of these substances has the ability to cause birth defects, learning difficulties, and other long-term problems. By signing this contract, you agree to allow us to send your urine for drug testing at any time. If you test positive for drugs, we will expect you to pursue a drug treatment plan, which may include an in-patient drug treatment program, and of course, we will expect you to continue keeping your prenatal appointments. If you test positive at any time, you may be referred to the Office of Children's Services (OCS).

TEAM EFFORT

We are here to work in partnership with you for your health and the health of the baby. We want to provide you with quality health care and want you to be pleased with the care you receive. If you are not, please let us know so that we can correct any problems.

I have read and understand the contract. I agree to follow the policies, terms and expectation as set forth in this agreement. My questions have been answered satisfactorily.

Please sign:

Signed_____ Date_____

Patient Name:

35670 Kenai Spur Hwy., Ste 101 B, Soldotna, AK 99669 (907) 262-2615

OBSTETRICAL FEES

The fee for OB Care is approximately $10,740 ($5240 for prenatal care/ultrasounds and $5500 for a normal vaginal delivery). The initial exam is $550 and each return exam is $185. You will have approximately 14 visits with Dr. Behrens and/or Kathy Flores throughout your prenatal care. In the event that you require a Cesarean section, the cost is approximately $11,950 ($5240 for prenatal care/ultrasounds and $6710 for the Cesarean section). Please keep in mind, if you are a high-risk OB patient your cost will be based on the care provided to you as additional visits and/or tests may be necessary.

There are separate charges for lab work, ultrasounds, and fetal non-stress tests. At different stages during your pregnancy, Dr. Behrens or Kathy Flores will request lab work and possibly and ultrasound or fetal non-stress tests.

There are also separate charges for any services provided by the hospital, including your delivery. For details of those charges, please contact Central Peninsula Hospital at 714-4404. If you are referred to a specialist for a consult, you will have additional charges that will be billed by that facility.

At your initial visit, Dr. Behrens or Kathy Flores will order a prenatal panel, GC and chlamydia culture, and a Pap smear. At 16-18 weeks, and alpha-fetal protein test is offered, but not required At 24 weeks a CBC and Glucose test is ordered, and at 36 weeks another CBC is ordered. When lab tests are performed, you will receive a separate bill from the laboratory that performs the test. In most cases, your bill will come from Lab Corp.; we also use Central Peninsula Hospital Laboratory.

Regarding Ultrasounds:
If you desire an ultrasound for gender the cost is $435 and is not covered by Medicaid or some insurances, as it is not a medically necessary procedure. This is best done between 24-26 weeks. This ultrasound may or may not be conclusive. If it is not conclusive and you desire another ultrasound for gender it will be charged out at the same rate of $435.

MISCELLANOUS OB FEES

Ultrasound:

Single Gestation, Initial, complete		$595	
Twin Gestation, Initial, complete	$980		
Anatomy screening 18-22 weeks		$1015	
Limited to Gender/position (Single gestation only)			$435
36 week position/weight	$645		
Biophysical Profile	$590		

INSURANCE INFORMATION

Once you have met your deductible we will bill your primary insurance for your OB care and delivery. You will need to pay for your co-pay at the time of your visit. If you have a secondary insurance you will need to submit your own claims. Balances left unpaid after 30 days will need to be paid in full and you can work out reimbursement with your insurance company. Most insurance companies require notification of your upcoming anticipated delivery date and we suggest that you contact them and give them this information. If they need any additional information they can contact our office.
*prices subject to change

Signed_____ Date_____

Patient Name:

Cystic Fibrosis Informed Consent/Decline

You should be certain you understand the six items listed below. If you are not certain about any of them, please ask your healthcare provider to explain them further before signing this form accepting or declining CF carrier testing.

1. I understand that the decision to be tested for CF carrier status is completely mine.
2. I understand that 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 chance is 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. I understand that if the baby has inherited a changed CF gene from each parent, the only way to avoid the birth of a baby with CF is by terminating the pregnancy.

I have read and understand the information in the pamphlet entitled "Cystic Fibrosis Carrier Screening" and:

_____ I do not want CF carrier testing

_____ I want CF carrier testing**

** This test is a screening test only, if you are not at a high risk your insurance may deny your claim. If insurance denies the claim, you are responsible for the out of pocket cost for the laboratory fee.

Signed: _____ Date: _____

Patient Name:

Maternal Serum Quad Screen Informed Consent/Decline

This test is available the first trimester between 15-20 weeks of pregnancy which tests for Downs Syndrome, Trisomy 18 and open neural tube defects.

You should be certain you understand the 3 items listed below. If you are not certain about any of them, please ask your healthcare provider to explain them further before signing this form accepting or declining Maternal Serum Quad Screen.

1. I understand that the decision to have the Maternal Serum Quad Screen is completely mine.
2. I understand that a POSITIVE test result does NOT mean that the baby will have an abnormality.
3. I understand that with a NEGATIVE test result, there is still the chance that the baby could have the listed abnormalities.

I have read and understand the information in the pamphlet entitled “Maternal Serum Quad Screen” and:

_____ I do not want Quad screen

_____ I want Quad screen**

** This test is a screening test only, if you are not at a high risk your insurance may deny your claim. If insurance denies the claim, you are responsible for the out of pocket cost for the laboratory fee.

Signed: _____ Date: _____

Patient Name:

GENETIC QUESTIONNAIRE

Patient Name: «FirstName» «LastName» **Date:** _____

	YES	NO
1. Will you be 35 years or older when the baby is due?	_____	_____
2. Have you had two or more pregnancies that ended in miscarriage or a child that died around time of delivery?	_____	_____
3. Have you or the baby's father had a stillborn baby?	_____	_____
4. Have you or the baby's father had a child with a birth defect or genetic condition?	_____	_____
5. Do you or the baby's father have a birth defect or genetic condition?	_____	_____
6. Does your family or the baby's father's family have children with birth defects or a condition that has been diagnosed as genetic or inherited?	_____	_____
7. Are you or the baby's father from any of the ethnic backgrounds listed? Jewish____ Black____ Asian____ Mediterranean (Greek/Italian) ____	_____	_____
8. Have you or the baby's father ever been screened for any of the disorders listed below? Tay-Sachs___ Sickle Cell Anemia___ Thalassemia___ If yes, Results: _____	_____	_____
9. Do you have any health problems such as insulin-dependent diabetes mellitus or epilepsy?	_____	_____
10. Have you taken any drugs during this pregnancy?	_____	_____
11. Have you had a fever greater than 101 F at any time during the first 2 months of your pregnancy?	_____	_____
12. Do you think you are at a greater risk than average to have a child with a birth defect or genetic disorder?	_____	_____
13. Do you or the baby's father, or either of your families, have any history of the following? Hemophilia___ Cystic Fibrosis___ Short Stature___	_____	_____