Tennessee Maternal Fetal Medicine PLC

Dear _____

Your Tennessee Maternal Fetal Medicine appointment is scheduled for

_____ at _____.

Location: _____

We would like to take this opportunity to give you some information about our practice. We look forward to meeting you!

Our offices are staffed by four physicians: Dr. Breck Collins, Dr. Cornelia Graves, Dr. Audrey Kang, and Dr. Patricia Scott as well as nurse practitioners: Tracie Wilder, WHNP and Tracie Thibault, WHNP, CDE. During your visit with us, you may see any one of our physicians or nurse practitioners. We strive to provide comprehensive high-risk obstetric care and each one of our team members is committed to making your experience with our practice excellent. We understand that being referred to a specialist prior to or during your pregnancy may be overwhelming, and we want to assure you that we are prepared to care for your pregnancy concerns- ranging from routine to critical care. If you are being referred by your primary obstetrician, he or she will select the level of our involvement needed. This promotes a coordinated approach to evaluation and management of the pregnancy.

Our primary location is in Nashville at 300 20th Avenue North, Suite 702. We are open Monday through Friday from 8 a.m. until 4:30 p.m. We also have satellite offices in Murfreesboro at 1800 Medical Center Parkway, Suite 320 and in Franklin at 100 Covey Drive, Suite 207. We are open in Murfreesboro and Franklin Monday through Thursday, from 8 a.m. to 4:30 p.m. We ask that you arrive at your scheduled location at least 15 minutes prior to your appointment if you are a new patient.

Included with this letter, you will find patient information to be completed prior to your visit with us. **Please return the completed forms upon arrival. You will also find a copy of our "Office Policies." Please familiarize yourself with this information.** Our professional staff is happy to answer any questions you may have regarding these policies.

Sincerely,

Tennessee Maternal Fetal Medicine, PLC.

300 20th Avenue N., Suite 702
Nashville, TN 37203

1800 Medical Center Pkwy, Suite 320
Murfreesboro, TN 37129

100 Covey Drive, Suite 207
Franklin, TN 37067

(615) 284-8636 (TMFM) ▌Fax (615) 284-8637 ▌www.tnmfm.com

TMFM OFFICE POLICIES

Ultrasound Policy:

- We ask that no more than two people, other than the patient, attend your ultrasound.
- In order to provide the highest quality "level II specialty ultrasound," children under the age of 10 are not allowed in the ultrasound rooms. Children less than 10 must be accompanied by an adult, other than the patient, in the waiting room. If an accompanying adult is not available, you may be asked to reschedule your appointment.
- Cell phones, photography, and camcorders are not allowed in the exam room.
- Distractions to the sonographer may result in our inability to complete the scan and reduce diagnostic accuracy.

If you are scheduled for a **Chorionic Villi Sampling (CVS)** or **Nuchal Translucency Screening (NT Screen)/Ultrascreen** we ask that you come to your appointment with a **full bladder**, or your procedure may not be able to be completed.

Mobile Baby: At the time of the ultrasound anatomy scan, the "Mobile Baby" option may be offered. This may be purchased at the check-in desk for the appointment. Mobile Baby will allow the patient to obtain images of the baby by sending directly to their cell phone and/or email account. It substitutes less perfect media such as thermal print outs, CDs, and DVDs. Patients are then able to share these memories through email, text, and other social media if they choose to do so.

Payment and Collection Policy: We participate with many healthcare insurance plans. Please check with your plan to determine the individual coverage status regarding your healthcare plan and to verify that we participate. As a courtesy to our patients, we will file your insurance. In all cases, the patient is ultimately responsible for all services rendered. If your insurance refuses payment for any service, you are required to pay our office in a timely manner and negotiate with your insurance company for any payments they have refused. **We request that you present your insurance card, valid driver's license, or other approved U.S. picture I.D. and copayment at the time of each visit. If you do not have proof of insurance (insurance card) at the time of your visit, you may be asked to reschedule your appointment or remit payment in full before you are seen by our providers.** Please plan to pay your co-payment or deductible at the time of your visit as dictated by your insurance company. A member of the accounts receivable team is available to make arrangements prior to your visit. We accept cash, money order, debit card, personal checks, Visa, MasterCard, American Express or Discover. If you do not have healthcare insurance coverage, you are expected to pay in full at the time of the service. Also, it is the patient's responsibility to have any prior authorization or referral before your scheduled appointment. Failure to have a referral prior to service will result in reduced or denied benefits by your healthcare insurance carrier. Therefore, the patient is responsible for any balances not covered. Any unpaid patient balances not satisfied after 90 days are subject to collection activity, not limited to your account going to an outside collection agency and/or court costs.

Any unpaid or remaining account balances on the patient's account after insurance benefits have been applied, must be paid within 30 days unless prior payment arrangement have been made with our billing staff. If unpaid patient due balances exceed 30 days, they are subject to be turned over to our collection agency. The patient will be responsible for all collection fees. At that time, any subsequent and additional non-emergent services will be on a cash or credit basis only.

Late Policy: If you are more than 30 minutes late for an appointment, please be aware that you may be asked to reschedule your appointment. We feel this policy is necessary in order to provide each patient with the time and attention needed to address their needs. If you anticipate being late for your appointment, please call our office. Patients who do not arrive at the time of their appointment may experience a delay in patient care.

Forms and Letters Policy: We will complete forms and letters for patients whom we provide primary obstetric care. For all other patients, please consult your primary provider. We require a minimum of 7 days to complete disability forms or letters required by the patient's employer or insurance for maternity/sick leave. Fees will be charged in associated with any/all forms to be completed by the office staff/providers on behalf of the patient and at the patient request. The fee will depend up on type of form to be completed and time required to complete the form/s. The form completion fee must be paid in advance, prior to completion of the form.

TN MATERNAL FETAL MEDICINE, PLC

New Patient Information Form

Please fill in the following information as complete as possible.

Guarantor (Responsible Party) Information

Name_____Today's Date_____
Address_____
Zip Code_____City_____State_____
Telephone(_____)_____Marital Status_____
Social Security #_____Employer_____
Date of Birth_____Work Phone(_____)_____Advanced Directive: Yes___No___

Patient Information Relation to Guarantor: Self_____Spouse___ Child___Other___

Last Name_____First Name_____MI_____
Maiden Name_____ Social Security #_____
Address_____
Zip_____City_____State____ Email_____
Telephone(_____)_____**Referring Physician**_____
Date of Birth_____Age_____Employer_____
Marital Status_____Sex___ Work Phone_____Cell Phone_____
Race_____Ethnicity_____Language_____
Emergency Contact_____Relationship_____Telephone(___)_____
Student: Yes__No__Full-Time____Part-Time____Name of School_____
Is today's visit the result of an auto accident?Y___N____Work Injury?_____Date_____
Other Coverage?_____
Spouse Name_____Employer_____Telephone_____

Insured (Policy Holder) Information- Primary Carrier **Please Present your Insurance Card(s) to front counter)**

Ins Co Name_____Policy #_____
Address _____Group #_____
Address 2/City State Zip_____ _____
Patient Relation to Insured: Self___Spouse__ Child___Other_____
Policy Holder Name/Address 1_____
Address 2/City State Zip_____
Telephone(____)_____Date of Birth_____Sex_____
Employer_____

Insured(Policy Holder) Information –Secondary Carrier

Ins Co Name_____Policy #_____
Address _____Group #_____
Address 2/City State Zip_____ _____
Patient Relation to Insured: Self___Spouse__ Child___Other_____
Policy Holder Name/Address 1_____
Address 2/City State Zip_____
Telephone(____)_____Date of Birth_____Sex_____
Employer_____

I authorize the release of all medical records to referring physicians and my insurance company. I further authorize insurance payments to be made directly to TN MATERNAL FETAL MEDICINE, PLC. I understand payment is due at time of service.

Signature of Responsible Party_____ Date_____

PATIENT HISTORY FORM (Please Print)

Office Use Only: ID:

Last Name:

First Name:

Referring Doctor

Reason for visit:

☐ Pregnancy ☐ Preconceptual

PREGNANCY HISTORY

Due Date: ☐ Due Date Unknown

Number of Pregnancies:

Vag Deliveries # Preterm ☐ Miscarriages ☐

Full term ☐ Elec. Term. ☐

CSection # Preterm ☐

Full term ☐ # Living children ☐

DIABETES CARE (Check Yes (Y) or No (N))

Y	N		Y	N	
☐	☐	Medications	☐	☐	HgbA1C
☐	☐	DKA	☐	☐	Nutrition
☐	☐	Eye	☐	☐	Medical Alert ID
☐	☐	EKG	☐	☐	Hypoglyemic Unaware
☐	☐	ECHO	☐	☐	Glucagon
☐	☐	Nephropathy	☐	☐	Ketone Strips
☐	☐	Foot Exam	☐	☐	Meter
			☐	☐	Pump

SURGICAL HISTORY

Check all that apply:

☐ Appendectomy ☐ Gall Bladder

☐ Cervix Surgery ☐ Gastric Bypass

☐ C-Section ☐ Leep/Cone Biopsy

☐ D & C ☐ Other

☐ Myomectomy

MEDICAL/FAMILY HISTORY

Check problems you (P) or your family (F) have or had:

P	F		P	F	
☐	☐	Anemia	☐	☐	Irritable Bowel Syndrome
☐	☐	Arthritis	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Kidney Stones
☐	☐	Bladder Problems	☐	☐	Hepatitis
☐	☐	Clots in veins	☐	☐	Lung Disease
☐	☐	Blood Transfusion	☐	☐	Lupus
☐	☐	Diabetes; Pre-Existing	☐	☐	Seizure Disorder
☐	☐	Diabetes; Gestational	☐	☐	Reflux
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	High Blood Pressure	☐	☐	Thyroid Disorder
☐	☐	Intestinal Disease	☐	☐	Cancer
			☐	☐	Other

MEDICATIONS

☐ None ☐ Blood Pressure ☐ Heart

☐ Anti-Depressant ☐ Blood Thinners ☐ Thyroid

☐ Baby Aspirin ☐ Diabetes ☐ Other

☐ Prenatal Vitamins

DRUG ALLERGIES

☐ None ☐ Latex ☐ Shellfish

☐ Codeine ☐ Morphine ☐ Sulfa

☐ Iodine ☐ Penicillin ☐ Other

SOCIAL HISTORY

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employed inside/outside home ☐ Yes ☐ No

(Check if Yes)

Smoke ☐ Yes ☐ No Use of Illicit Substances ☐

Drink ☐ Yes ☐ No Seatbelt use ☐

Exercise ☐ Yes ☐ No Physical/Sexual Abuse ☐

INFECTION HISTORY

Herpes ☐ Hepatitis B, C ☐

HIV ☐ Chicken Pox ☐

GENETIC/FAMILY HISTORY (check if yes)

Previous Genetic Testing this Pregnancy ☐ Muscular Dystrophy ☐

Cystic Fibrosis ☐

Patient's age greater than 35 yrs at est date of deliv- ☐ Autism ☐

Italian, Greek, Mediterra-nean, or Southeast Asian ☐ Huntington's Chorea ☐

Neural Tube Defect ☐ Mental Retardation ☐

Congenital Heart Defect ☐ Other genetic or chromosomal disorder ☐

Down Syndrome ☐ Maternal metabolic disorder ☐

Tay-Sachs ☐ Previous Children with birth defects ☐

Sephardic or Ashkenazi Ethnicity ☐ Recurrent pregnancy loss or stillbirth ☐

French Canadian Ethnicity ☐ Early Ovarian Failure ☐

Sickle Cell Anemia or Trait ☐ Twins/Triplets ☐

Hemophilia or Blood Disorders ☐ Other ☐

PATIENT AUTHORIZATION FORM

Patient Name (Please print)_____

Patient Social Security Number_____ Date of birth _____

I wish to receive treatment from my physician and other employees of Tennessee Maternal Fetal Medicine, PLC ("TMFM"). I authorize my physician and the other employees of TMFM involved in my care to provide the medical and surgical services, tests, procedures, drugs, supplies and other care in ways they deem advisable. I understand that these services may include for example, special tests or procedures such as tests for communicable diseases, ordered by my doctor. I acknowledge that no one has guaranteed, nor can anyone guarantee, the results of the care provided at TMFM. I understand that I may refuse to receive any medical or surgical service provided by TMFM at any time.

I understand that TMFM may test my blood for blood-borne diseases, such as hepatitis B or HIV (the AIDS virus) to protect against transmission of these diseases (for example, my blood may be tested if an employee of TMFM is stuck by a sharp object that has been in contact with my blood). I understand that my blood will not be routinely tested for these diseases and that my test results will be confidential.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for TMFM and acknowledge that TMFM may use and disclose my personal health information as needed for the purposes of treatment, payment, and health care operations.

I authorize direct payment of benefits from my insurance plan to TMFM. I understand that I am responsible for payment of professional fees charged by TMFM, which are not covered, or not properly reimbursed under the terms of my insurance plan.

I understand the privacy risks of communication by mail, telephone, and e-mail. I hereby authorize TMFM to contact me via mail, telephone or e-mail regarding my care, which communications may involve, among other things, appointment reminders, referral arrangements, and laboratory results. I understand that I may revoke this authorization at any time by notifying TMFM in writing.

I have received and reviewed the TMFM Office Policies and agree to abide by them.

I agree that TMFM may, in order to service my account or to collect any amounts I may owe, contact me using any telephone number that I have provided to TMFM, including wireless telephone numbers, or by e-mail using any e-mail address that I have provided to TMFM. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

_____ _____

Signature of Patient (or Parent, Legal Guardian or Representative) Date

_____

Relationship to Patient (if Parent, Legal Guardian or Representative)

PHARMACY INFORMATION

In an effort to provide the highest quality care to all our patients we ask that you provide us with your pharmacy information. This information will be added to your electronic medical record as we move toward implementing this process in order to expedite your pharmaceutical needs. As always, all information is confidential.

1st PHARMACY: _____ PHONE: (_____) _____

ADDRESS: _____

CITY/ST/ZIP: _____

2ND PHARMACY: _____ PHONE: (_____) _____

ADDRESS: _____

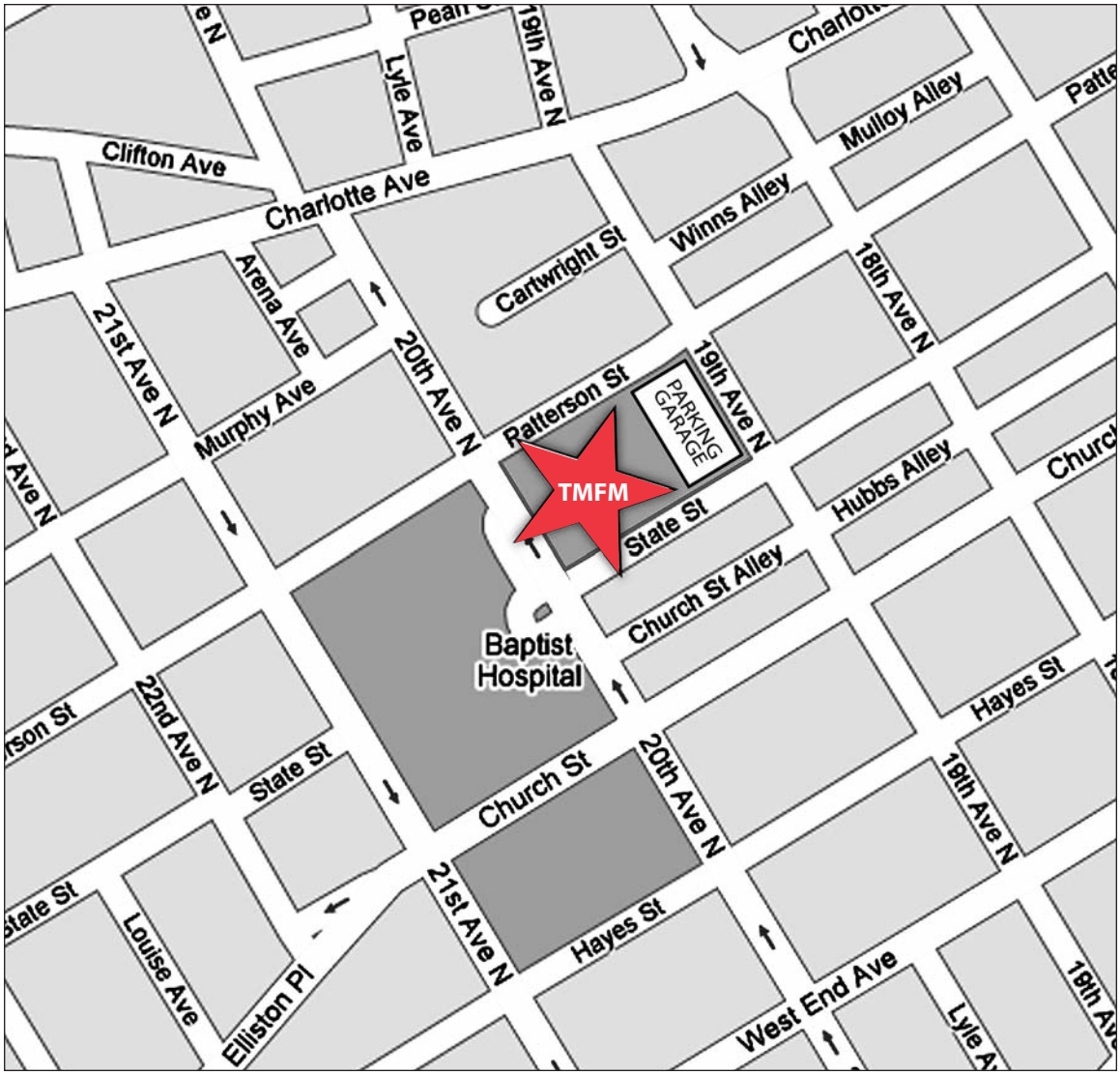
CITY/ST/ZIP: _____

Signature: _____ Date: _____/_____/_____

Tennessee Maternal Fetal Medicine PLC

300 20th Ave N
Suite 702
Nashville, TN 37203
(615) 284-8636
www.tnmfm.com

DIRECTIONS



I-24 E or I-65 S (before merge)

1. Follow signs to I-65 S
2. Exit 209–Charlotte Pike
3. Turn right at bottom of ramp
4. Proceed five blocks away from town
5. Turn left on to 19th Ave N
6. Go to second stop sign and turn right onto State Street
7. Turn right into patient/visitor parking garage (see parking garage instructions)

I-65 N or I-24 W

1. Follow signs to I-40
2. Exit 209A–Church Street/Charlotte Pike
3. Turn left at first light (Church Street)
4. Turn right at 20th Ave N
5. Turn right on State Street
6. Turn left into patient/visitor parking garage (see parking garage instructions)

I-40 E

1. Exit 209–Charlotte Pike
3. Turn right at bottom of ramp
4. Proceed five blocks away from town
5. Turn left on to 19th Ave N
6. Go to second stop sign and turn right onto State Street
7. Turn right into patient/visitor parking garage (see parking garage instructions)

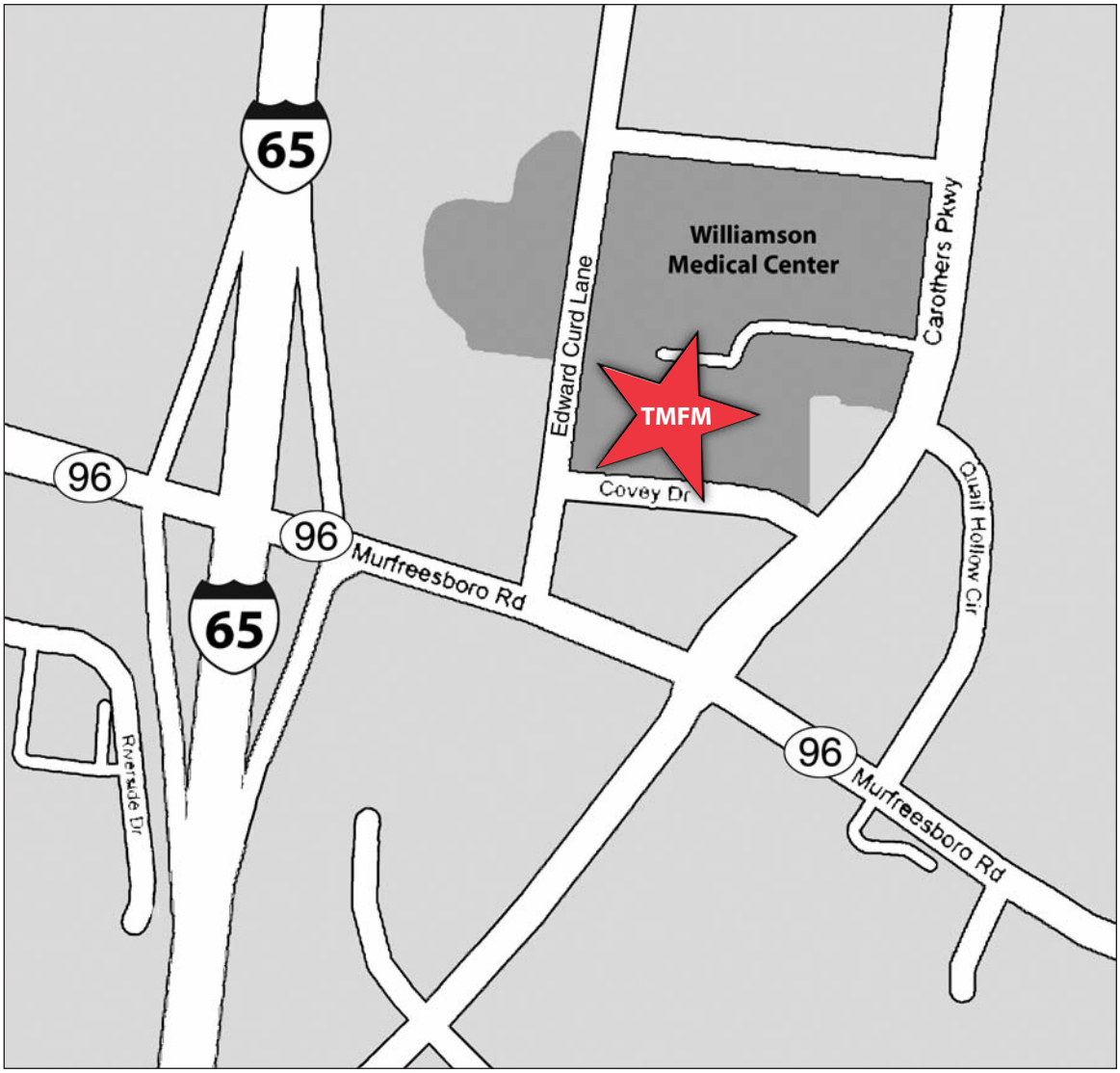
Parking Garage

1. Go to second level in the parking garage
2. Take crosswalk to first floor of Doctor's Building (300 20th Ave N)
3. Take elevator to 7th floor

Tennessee Maternal Fetal Medicine PLC

100 COVEY DR
SUITE 207
FRANKLIN, TN 37130
(615) 284-8636
www.tnmfm.com

DIRECTIONS



From Nashville I-24

1. Head southeast on I-24 E
2. Take exit 50B to merge onto I-40 W toward I-65 S
3. Take exit 210B on the left to merge onto I-65 S
4. Take exit 65 for TN-96 toward Franklin/Murfreesboro
5. Turn left at TN-96 E/Murfreesboro Rd
6. Take the 1st left onto Edward Curd Ln
7. Take the 1st right onto Covey Dr, TMFM on left

From Brentwood/Old Hickory Blvd

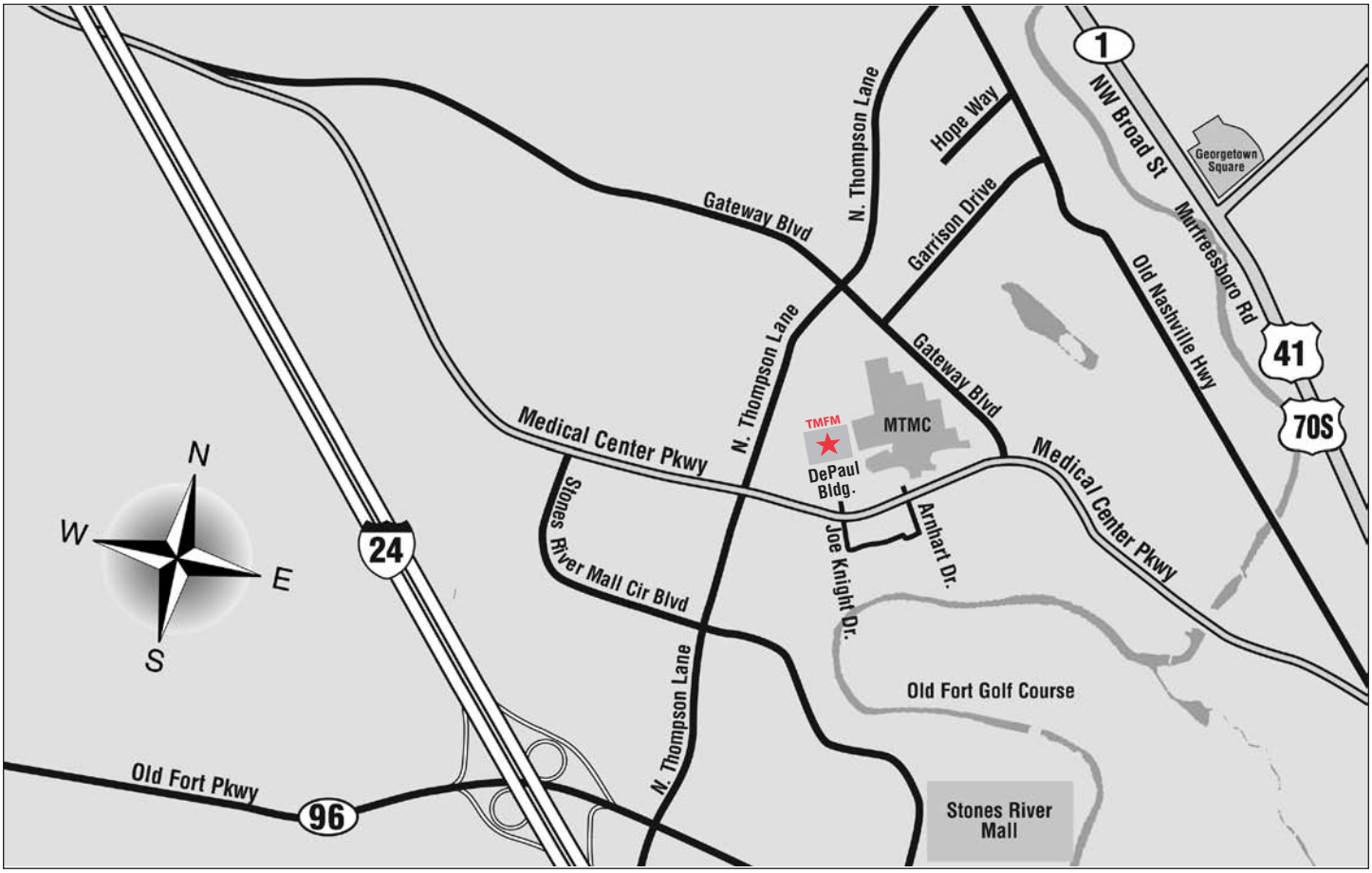
1. From Old Hickory Blvd merge onto I-65 S toward Birmingham
2. Take exit 65 for TN-96 toward Franklin/Murfreesboro
3. Turn left at TN-96 E/Murfreesboro Rd
4. Take the 1st left onto Edward Curd Ln
5. Take the 1st right onto Covey Dr, TMFM on left

From Columbia, TN

1. Head west on W 7th St toward N Garden St
2. Take the 1st right onto US-31 N/N Garden St. Continue to follow US-31 N
3. Take the TN-396 E/Saturn Pkwy ramp to I-65
4. Turn right at TN-396 E/Saturn Pkwy
5. Merge onto I-65 N via the ramp to Nashville
6. Take exit 65 to merge onto TN-96 E toward Murfreesboro
7. Turn left at Edward Curd Ln
8. Take the 1st right onto Covey Dr and see TMFM on left

Tennessee Maternal Fetal Medicine PLC

1800 MEDICAL CENTER PKWY
SUITE 320
MURFREESBORO, TN 37129



From Nashville I-24 E

1. Follow signs for I-24 East
2. Take exit 76 for Medical Center Pkwy / Fortress Blvd.
3. Turn left off of the exit onto Medical Center Pkwy
4. Continue onto Medical Center Pkwy
5. Turn left onto Joe Knight Dr., into DePaul Building Parking, Suite 320

From Franklin/Brentwood TN 96

1. From I-65, take TN-96 east toward Murfreesboro
2. Continue to follow TN-96 for about 26 miles
3. Turn right at TN-11 S/US-31 (S/Horton Hwy)
4. Turn left to merge onto TN-840 E
5. Merge onto I-24 E via Exit 53A toward Chattanooga
6. Take exit 76 for Medical Center Pkwy / Fortress Blvd.
7. Turn left off of the exit onto Medical Center Pkwy
8. Continue onto Medical Center Pkwy
9. Turn left onto Joe Knight Dr., into DePaul Building Parking, Suite 320

I-24 W

1. Head toward Murfreesboro on I-24 W
2. Take exit 76 to merge onto Medical Center Pkwy / Fortress Blvd.
3. Turn right off of the exit onto Medical Center Pkwy
4. Continue onto Medical Center Pkwy
5. Turn left onto Joe Knight Dr., entering DePaul Building Parking, Suite 320

From US-70 E

1. Head west TN-1/US-70S
2. Turn right at SE Broad St
3. Turn left at Medical Center Pkwy
4. Turn right onto Joe Knight Dr., entering DePaul Building Parking, Suite 320