CONGRATULATIONS!...and WELCOME TO OUR OBSTETRICS PRACTICE!

Overview
At Lexington OB/GYN, we work as a team to provide you with continuous and complete care throughout your pregnancy. You choose one doctor in the group as your primary obstetrician, who will see you monthly. You will meet each of the other physicians in the practice, usually in the last 3 months of pregnancy, when visits are more frequent.

The obstetricians share on-call coverage so someone from the group is available 24 hours a day, 7 days a week, for deliveries and emergencies. The doctor who is scheduled to be on-call at the time of your baby’s birth will be the one to deliver you.

We will deliver your baby at Mount Sinai Hospital, on Fifth Avenue overlooking Central Park. Mount Sinai is a leader in providing state-of-the-art obstetrical care, with an integrated team approach to ensure the utmost in safety and high quality. For more information about the hospital, see the “Obstetrics Services” and “Resources” pages on our website (www.lexobgynnyc.com).

Prenatal visits
At your first visit, we will review your medical and family history, do a full exam and, if you are more than 4 weeks past conception, perform a sonogram (ultrasound). We will discuss general pregnancy guidelines, including nutrition, exercise, and prenatal testing, and address concerns specific to you. Lab samples are collected in our office and sent out for processing. At subsequent appointments, we check the fetal heart beat and your blood pressure, weight, and urine; we review results and periodically perform additional tests; and we address any questions or concerns you may have. Routine visits are initially once a month, then every 2 weeks starting at 28 weeks, and once a week from 36 weeks on.

Phone calls
If you have a problem in between visits, and need to speak with a doctor, please tell the receptionist the specific nature of your problem so that we can give it the appropriate priority. Non-urgent calls may be returned after office hours, or, in some cases, the following day. For routine questions, our patients find it helpful to keep a list, bringing it to their regular appointments.

If you have an urgent medical problem, or when you are in labor, call our regular office number (212-686-8686). During business hours, select the phone menu option “for emergencies.” After office hours, you will be directed to call the answering service (212-774-1637), and one of the physicians will be paged. Do not call this number during business hours; it is offsite, which will delay our response.

If you have a life threatening emergency, call 911.

Ultrasounds (Sonograms)
We perform 1st trimester ultrasounds in our office. For detailed genetic or anatomy sonograms, we refer you to dedicated ultrasound facilities run by Maternal Fetal Medicine specialists. Although some obstetricians do their own scans, we feel it is to your benefit to see an expert who is specially trained and highly experienced in performing and reading pregnancy ultrasounds.
You will most likely have at least 3 to 4 sonograms during your pregnancy:
- Viability/dating scan (for fetal heart beat and gestational age) at 6-7 weeks
- Down Syndrome screening/nuchal translucency scan at 12 weeks
- Detailed fetal anatomy scan(s) at 16 and/or 21 weeks

Referrals and Precertification
We will give you a requisition form whenever we refer you for an ultrasound or other testing. The facilities will not perform services without this written indication of the test requested and the reason it is needed; you must bring it to your referral appointment.

Most insurance carriers will cover the sonograms listed above, as well as additional scans, as long as there is a medical reason. They will not pay for a routine 3rd trimester or 3-D/4-D scan. Some plans require precertification for more than 3 ultrasounds. This is a formal process, in which we need to submit information to the insurance company, proving that the test is medically necessary; if it is not preauthorized, it will not be covered, and you will be financially responsible. There are a few plans which do not allow a second anatomy scan, even if we recommend it, but most do.

While it is your responsibility to learn the rules and regulations of your plan, our staff is available to advise and assist you in obtaining pre-approvals and precertification.

Lab Testing
We draw blood and collect other lab samples in our office and send them out for processing. We will use a lab which participates with your insurance company, but cannot make guarantees regarding coverage. There will often be a co-pay, for which you will receive a bill from the lab. Any questions related to lab charges, must be directed to the lab and/or your insurance carrier.

Classes
If this is your first pregnancy, we recommend that you take childbirth, breastfeeding, and infant CPR classes. We will give you referrals for classes and also for pediatricians later in your pregnancy.

Again – Congratulations! We look forward to working with you during this special time in your life.

Lexington OB/GYN
Staff and Physicians

(rev 5/14)
OBSTETRICS FINANCIAL INFORMATION AND POLICY

Insurance companies pay a “global” obstetrics fee for our services. This includes:

- Routine prenatal visits
- Delivery
- Postpartum hospital visits
- One routine postpartum office visit (at 6 weeks)

Note that this is the physician’s obstetrics fee only. There will be separate hospital charges. Contact your insurance carrier to learn about your hospital obstetrics benefits.

Additional services – which are not included in the global fee, but are usually, though not universally, covered by insurance – include:

- Ultrasounds (sonograms)
- Blood drawing and lab testing
- Non-Stress Tests (prolonged fetal heart rate monitoring)
- External version (for breech presentation)
- Tubal ligation
- Circumcision
- Visits not related to pregnancy

Costs not covered by insurance include:

- Cord blood collection (for stem cell banking) $400
- Disability (and other) form completion $25+ (dependent upon complexity of filing)

For patients who have plans with which we participate, we will contact your insurance carrier to verify your obstetrics benefits and to obtain an estimate of your financial responsibility for our services, including deductibles, co-pays, and co-insurance. 50% of this amount is due to be paid by the end of the second trimester and the remainder by your due date. Insurance carriers also require that you notify them of your pregnancy directly; failure to do so may result in a denial or reduction of payable benefits, and a greater financial responsibility for you.

If you change insurance plans mid-pregnancy, please notify us as far in advance as possible, so that we can ensure a smooth transition in your coverage benefits.

For patients who have insurance plans with which we do not participate, please meet with our financial team to discuss payment options.

I have read this policy and understand my financial responsibilities. I agree to the terms and conditions stated.

Signature: ___________________________ Date: ________________________

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**HIV Testing**

It is universally recommended that all pregnant women be tested for HIV, preferably at the 1<sup>st</sup> prenatal visit. HIV testing can only be done with a patient’s consent. If a mother declines HIV testing during pregnancy, New York State mandates that the infant be tested at birth using a “rapid test,” without requiring maternal consent. By signing below, you agree to be tested for HIV.

**Authorization for Release of Health Information and Confidential HIV-Related Information***

This form authorizes release of health information including HIV-related information. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff, emergency or health care staff who are accidently exposed to your blood; or by special court order. For more information about HIV confidentiality, call the NYS Dept of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office of Civil Rights at 1-800-368-1019.

By signing below, health and HIV-related information can be given to the hospital(s) listed. Upon your request, you can obtain a copy of this form.

<table>
<thead>
<tr>
<th>Facility disclosing information:</th>
<th>Lexington OB/GYN  145 East 32&lt;sup&gt;nd&lt;/sup&gt; St. NY, NY 10016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information to be released:</td>
<td>All pregnancy records, including HIV-related information.</td>
</tr>
<tr>
<td>Reason for release of information:</td>
<td>Coordination of obstetrical care with hospital.</td>
</tr>
<tr>
<td>Time period during which release is authorized:</td>
<td>Duration of obstetrical care.</td>
</tr>
<tr>
<td>Exceptions to the right to revoke consent:</td>
<td>Information required for care of the fetus or newborn.</td>
</tr>
<tr>
<td>Consequences of failing to consent to disclosure:</td>
<td>Coordination of care and services will be limited, tests will need to be repeated, HIV testing will be required in the hospital for you and/or your newborn.</td>
</tr>
<tr>
<td>Facility to be given health and/or HIV-related information:</td>
<td>Mount Sinai Hospital  1176 Fifth Ave. NY, NY 10029 or other hospital in an emergency situation.</td>
</tr>
</tbody>
</table>

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212)306-7500 or NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility obtaining this release. I authorize the facility noted above to test me for HIV, and to release my health and HIV-related information to the organization listed.

Signature ______________________________________________________ Date ____________________

Lexington OB/GYN (rev 5/14)

*Adapted from NYS Department of Health form DOH 2557 (2/11)*
Lexington OB/GYN

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by law to provide you with a notice that tells you how we may use and share your health information and how you can exercise your health privacy rights. You can view and receive a copy of this notice from our website (www.lexobgynyc.com; see “Resources” section), from the patient portal of the electronic medical record, or in the office.

The law also requires that we ask you to state in writing that you received the notice.

- Signing does not mean you have agreed to any special uses or disclosures of your health information.
- You are not required to sign the acknowledgement.
- Refusing to sign does not prevent us from using or disclosing your health information as the law allows.
- If you refuse to sign, we must keep a record that we failed to obtain your acknowledgement.

I acknowledge that I was provided with the Lexington OB/GYN Notice of Privacy Practices.

Signature:__________________________________________________Date:____________________

For office use only

I made a good faith effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not do so because:

☐ patient refused to sign.
☐ it was not possible due to an emergency situation.
☐ we could not communicate with patient.
☐ other

Employee signature:__________________________________________Date:____________________

(rev 5/14)
PRENATAL QUESTIONNAIRE

Name: ___________________________ DOB: __________ Date: __________

1st day of last period: ______________ Date of ovulation or conception (if known): ______________

<table>
<thead>
<tr>
<th>Did you have fertility treatment to conceive?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any bleeding since pregnant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a blood pregnancy test?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had an ultrasound (sonogram)?</td>
<td></td>
<td></td>
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</tbody>
</table>

**Do you have a personal history of:**

- chlamydia
- herpes
- LEEP/cone biopsy
- miscarriage
- ectopic pregnancy
- preterm labor
- other pregnancy complications
- high blood pressure
- thyroid disorder
- diabetes/glucose intolerance
- chicken pox

**Do you have a family history of:**

- diabetes
- blood clots in legs or lungs

**Genetic testing factors:**

- Will you be 35 or older when due?
- Your ethnicity: circle if: ASHKENAZI JEWISH FRENCH CANADIAN MENNONITE CAJUN
- Ethnicity of baby’s father: circle if: ASHKENAZI JEWISH FRENCH CANADIAN MENNONITE CAJUN

**Do either of you have a personal or family history of:**

- hereditary problems
- neural tube defects
- congenital heart defects
- other birth defects
- mental retardation
- bleeding disorder
- other genetic problems

**Have you ever had genetic testing?**

(rev 4/16)