Grand Rapids Women's Health

# *Congratulations on your pregnancy!*

We welcome you as our patient and appreciate the opportunity to provide medical care to you. Thank you for entrusting us. We look forward to serving you and providing you with an exceptional experience. We are committed to providing the highest standard of care.

OB Interview Date: _____ Time: _____

Please plan to spend 30-60 minutes at this appointment. Our OB education nurse will review your medications and medical history. We will order your prenatal labs and for your convenience, Spectrum Health Lab is located on the 1st floor of this building. Due to the amount of information given during this appointment, we encourage you to bring your significant other and prefer that children do not attend.

OB Physical Date: _____ Time: _____ Provider: _____

This appointment will take approximately 30 minutes. Your physician will perform a complete physical including a pelvic exam. They will review your lab work and discuss anticipated tests to monitor you and your baby's well-being. We recommend that children do not attend this appointment. Subsequent visits are shorter in duration and children are welcome to be active participants in these visits.

## THIS PACKET IS VERY IMPORTANT FOR YOUR FIRST APPOINTMENT.

## PLEASE COMPLETE THE FORMS AND BRING THEM WITH YOU.

## PLEASE ARRIVE AT LEAST 15 MINUTES EARLY FOR YOUR APPOINTMENT.
## PLEASE BRING YOUR INSURANCE CARD AND PHOTO IDENTIFICATION.

1. **TRANSFERRING MEDICAL RECORDS:** If you have already had care for this pregnancy and are transferring to our office, please have your obstetrical records sent to the office before the first appointment. If you experienced complications in previous pregnancies, please have these OB records sent to our office, before the first appointment. Our mailing address or fax number is listed below.

2. **Hours, Location and Parking:** Our office is open Monday through Friday from 8:00am to 5:00pm. Our office is located at 555 Mid Towne NE, 4th Floor. Parking is provided in the ramp east of the building. Please bring your ticket to your appointment, for validation.

If you need to cancel or change your appointment(s), kindly provide 24 hours' notice. Without notice, a $25.00 same day cancellation or no-show fee may apply.

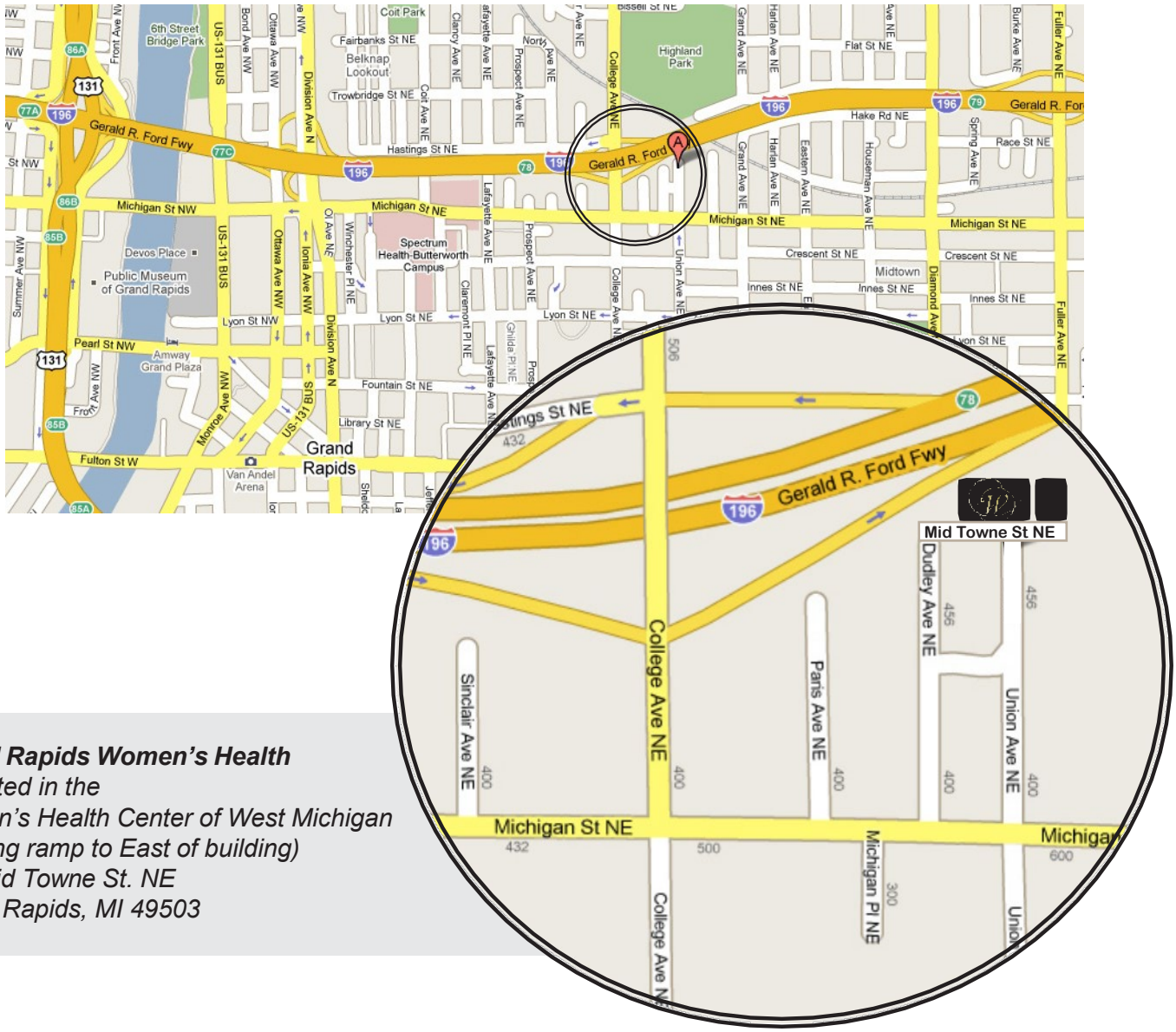
For more information about our practice or providers, please visit our website at www.grandrapidswomenshealth.com.

**GRAND RAPIDS WOMEN'S HEALTH**
**555 Mid Towne NE Suite 400**
**Grand Rapids, MI 49503**
**Phone: 616-588-1200**
**Fax: 616-588-1250**

Grand Rapids Women's Health

**Directions: Near Michigan and College**

Take 196 FWY to College Ave., travel 1 block South and turn left on Michigan St. Turn left at the next light on Union Ave. to the new Women's Health Center of West Michigan on Mid Towne Street.




***Grand Rapids Women's Health***
*is located in the*
*Women's Health Center of West Michigan*
*(Parking ramp to East of building)*
*555 Mid Towne St. NE*
*Grand Rapids, MI 49503*

**Grand Rapids Women's Health**
555 MidTowne St. NE Suite 400
Grand Rapids, MI 49503
616-588-1200

Grand Rapids Women's Health

**PATIENT INFORMATION** Today's Date: _____

Patient Name: _____ Preferred Name: _____

Social Security Number: _____ Date of Birth: _____

Marital Status: ☐Married ☐Single ☐Other _____ Maiden Last Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Number: ☐Home ☐Work ☐Cell E-mail Address: _____

**RACE:**

☐ American Indian or Alaska
☐ Asian
☐ Black/ African American
☐ Native Hawaiian or Other Pacific Islander
☐ White/ Caucasian
☐ Other: _____
☐ Unknown
☐ Decline to Respond

**ETHNICITY:**

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Decline to Respond

**PREFERRED LANGUAGE:**

☐ English ☐ Vietnamese
☐ Spanish ☐ Decline to Respond ☐ Other: _____

**PATIENT GENDER:**

☐ Female
☐ Male

Employer: _____ Employer Phone: _____

Spouse Name: _____ Date of Birth: _____ Phone: _____

Emergency Contact: _____ Phone _____ Relationship _____

**PREFERRED PHARMACY:**

Name: _____ Street: _____ City: _____

**PHYSICIAN INFORMATION:**

Primary Care Physician:_____ Phone: _____

Referring Physician: _____ Phone: _____

**ACCOUNT INFORMATION:**

**Primary Insurance:** _____

Policy Holder's Name (if other than patient): _____

Date of Birth (if other than patient): _____ Relationship to Patient: _____

**Secondary Insurance:** _____

Policy Holder's Name (if other than patient): _____

Date of Birth (if other than patient): _____ Relationship to Patient: _____

_____ _____

Patient Signature Date

Guardian Signature (if applicable): _____ Date: _____

Grand Rapids Women's Health

# INSURANCE AND FINANCIAL POLICY

**INSURANCE** - A copy of your insurance card is required at each visit. If you do not have insurance, you may be asked to pay in full, make payment arrangements or reschedule. We participate with most, but not all insurance companies. It is your responsibility to call your insurance company or our office to determine if we participate with your insurance. If insurance does not pay within 90 days, we reserve the right to request payment in full. This is rare, but it is important that you recognize that insurance is a legal contract between you and your insurance company. It is important to keep us aware of all changes in your insurance coverage. We will submit a courtesy claim to the payer on record at the time of service.

**CO-PAY, DEDUCTIBLES AND NON-COVERED SERVICES -** All co-payments, deductibles and non-covered services are due at the time of service.

**PREAUTHORIZATION, COST ESTIMATES AND BENEFIT CHECKS -** Our office will assist you to the best of our ability with preauthorization, cost estimates and checking benefits. We will relay the information to you as quoted by your insurance company. We do not guarantee any insurance benefit quotes, cost estimates or pre-authorizations. To guarantee benefits or pre-authorizations, we recommend that you contact your insurance company. If your HMO plan requires that you have a referral from your primary care physician, this is your responsibility.

**PAYMENT, NON-PAYMENT AND FEES** - When payment can not be made in a timely manner, we encourage you to contact our billing department as soon as possible to make other arrangements on your account. If your account becomes past due and is forwarded to an outside collection agency, your account will be assessed collection fees based on the remaining balance. We accept cash, personal checks, money orders, Visa, MasterCard, and Discover. A $25.00 fee will be assessed on all returned checks.

**MEDICAL RECORDS, FMLA and DISABILITY FORMS** - We charge an administrative fee for completing disability or FMLA forms and copying/mailing medical records.

**CANCELLATION/NO SHOW POLICY** - We request that you give us 24-hour prior notice to change or cancel your non-emergent appointment. If you miss an appointment without providing notice, a $25.00 charge may be added to your account and must be paid in full before future appointments.

*I have read, understand, and agree that I will be financially responsible for all services provided to me and all costs of collection incurred by the practice. I agree to make payments at the time of service, when applicable.*

*Release of Information: I authorize the release of any medical information necessary to process my insurance claims. I understand and agree that I am responsible for all amounts unpaid or not authorized by my insurance company.*

_____ _____

**Signature of Patient or Patient's Representative** **Date**

_____ _____

**Patient Name Printed** **Date of Birth**

Grand Rapids Women's Health

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**By signing below, I acknowledge that I have been offered or have received a copy of the Notice of Privacy Practices for Grand Rapids Women's Health.**

_____ _____

**Signature of Patient or Patient's Representative** **Date**

☐ Patient refused to sign _____

Employee Signature & Date

## AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I hereby authorize ***Grand Rapids Women's Health*** to obtain/download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe, and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

_____ _____

**Signature of Patient or Patient's Representative** **Date**

## ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize ***Grand Rapids Women's Health*** release medical or other information necessary to process my insurance claim. I authorize payment of medical benefits to Grand Rapids Women's Health. I understand this authorization will remain in effect until revoked by me in writing.

_____ _____

**Signature of Patient or Patient's Representative** **Date**

Grand Rapids Women's Health

# HIPAA AUTHORIZATION FORM

**Patient Name:** _____

**SSN (last four digits):** _____ **Date of Birth:** _____

**Entity Requested to Release Information:** **Grand Rapids Women's Health**

**Purpose of request (who will be authorized to receive information)** - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

## WHO IS AUTHORIZED TO OBTAIN YOUR HEALTH INFORMATION?

Individual Name: _____Relationship_____

Individual Name: _____Relationship_____

Individual Name: _____Relationship_____

## WHAT INFORMATION ARE YOU AUTHORIZING TO BE RELEASED? (Check one)

☐ **Any and all information** to include all clinical information, lab results, billing information and appointments. This may include discussions with my provider or nurse regarding my diagnosis, results and treatment options.

☐ **Limited release, please specify what can be released**

☐ Any and all clinical information related to my diagnosis, results and treatment options. This may include discussions with my provider or nurse regarding my diagnosis, results and treatment options.

☐ Billing Information (previous 3 years only) ☐ Appointment Dates and Times Only

☐ Please specify other _____

- We will ask you to verify this information once per year. If you make any changes to the listed parties, you will be asked to sign a new document.
- This authorization will not expire unless you specify a termination date. Please list the date of expiration if you wish for this authorization to expire. _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.

Grand Rapids Women's Health

# OB Medical History and ROS

**TO EXPEDITE YOUR VISIT, PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT. THIS INFORMATION HELPS THE PHYSICIAN PROVIDE YOU THE BEST CARE**

**Name:**_____ **DOB:** ____-____-_____ **Date:**___-___-_____
**Name of Spouse/Partner:** _____ **Referred By:**_____
**Primary Care Physician:** _____ ❑ **I do not have a primary care physician.**
Reason for today's visit:_____

*Do you wish to have a chaperone for every OB visit?* □*Yes* □*No*

## *Please check the box if you CURRENTLY have a symptom listed below*

**Constitutional**
- ❑ Chronic Fatigue
- ❑ Recent weight loss
- ❑ Recent weight gain

**Eyes**
- ❑ Visual changes

**Head, Ears, Nose, Mouth, Throat**
- ❑ Unusual Headache
- ❑ lightheadedness
- ❑ Sinus symptoms
- ❑ Difficulty swallowing
- ❑ Neck mass/neck swelling

**Breasts**
- ❑ Breast lumps
- ❑ Breast tenderness
- ❑ Breast swelling
- ❑ Nipple discharge

**Cardiovascular**
- ❑ Chest pain
- ❑ Irregular heart beats
- ❑ Swelling of feet or ankles
- ❑ Fainting/lightheadedness

**Respiratory**
- ❑ Difficulty breathing (shortness of breath)
- ❑ Wheezing
- ❑ Chronic cough

**Gastrointestinal**
- ❑ Unexplained Nausea/vomiting
- ❑ Frequent diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Feeling full before you finish a normal meal
- ❑ Cramping or pain in the abdomen
- ❑ Black or tarry stools
- ❑ Bloating
- ❑ Change in stools

**Genitourinary**
- ❑ Urgency with urination
- ❑ Frequent urination
- ❑ Burning/painful urination
- ❑ Nighttime urination
- ❑ Blood in urine
- ❑ Uncontrolled leaking
- ❑ Difficulty urinating
- ❑ difficulty emptying bladder
- ❑ Decreased sexual desire
- ❑ Painful intercourse
- ❑ Spotting with or after intercourse
- ❑ Genital bumps/sores
- ❑ Irregular menstrual periods
- ❑ Painful menstrual periods
- ❑ Heavy & Prolonged menstrual periods
- ❑ Absence of menstrual periods
- ❑ Significant PMS
- ❑ Vaginal discharge
- ❑ Vaginal itching

**Skin**
- ❑ Rashes
- ❑ Itching

New lesions (moles)
- ❑ Changes in moles (color, shape, itching, irritation)
- ❑ Hair growth chin/face/abdomen
- ❑ Acne

**Neurologic**
- ❑ Lack of coordination
- ❑ Numbness or tingling
- ❑ Migraine headaches

**Musculoskeletal**
- ❑ Joint pain
- ❑ Joint swelling
- ❑ muscle pain
- ❑ muscle weakness
- ❑ Frequent back pain

**Endocrine**
- ❑ Excessive urination
- ❑ Excessive thirst
- ❑ Discharge from breasts
- ❑ Intolerant to cold
- ❑ Intolerant to heat

**Psychiatric**
- ❑ Anxiety
- ❑ Depression
- ❑ Difficulty sleeping
- ❑ Physical abuse
- ❑ Emotional abuse
- ❑ sexual abuse

**Hematologic/Lymphatic**
- ❑ Experience easy bleeding
- ❑ Bruise easily

Any unusual swelling or lumps

**Allergic/Immunologic**
- ❑ Seasonal allergic symptoms
- ❑ Environmental allergic symptoms

Other symptoms not listed?

Do you see another physician for any of the symptoms listed?

**PAST MEDICAL HISTORY: (*Check if you have ever had or been diagnosed with any of the following)***

**EYES**
- ❑ Eye problems

**BREAST**
- ❑ Fibrocystic Breast Disease

**CARDIOVASCULAR**
- ❑ Deep Venous Thrombosis
- ❑ Heart murmur
- ❑ *Heart problems*
- ❑ *High blood pressure*
  Usual Blood Pressure_____
- ❑ High Cholesterol
- ❑ Rheumatic fever
- ❑ Stroke

**RESPIRATORY**
- ❑ *Asthma*
- ❑ Chronic Lung Disease
- ❑ Pneumonia
- ❑ Tuberculosis

**GASTROINTESTINAL**
- ❑ Bowel Changes
- ❑ Gallbladder Problems
- ❑ Intestinal Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ *Yellow jaundice or hepatitis*

**GYN / STDs**
- ❑ Cervical pre-cancer/Dysplasia
- ❑ *Chlamydia*
- ❑ Endométriosis
- ❑ *Genital Warts*
- ❑ *Gonorrhea*
- ❑ *Herpes, Genital*
- ❑ Infertility
- ❑ Ovarian Cysts
- ❑ Premenstrual Syndrome
- ❑ *Syphilis*
- ❑ Trichomonas
- ❑ Uterine Fibroids

**URINARY**
- ❑ *Infection*
- ❑ Kidney Stones

**AUTOIMMUNE**
- ❑ *HIV*
- ❑ *LUPUS*

**HEMATOLOGIC/BLOOD**
- ❑ *Anemia*
- ❑ *Transfusions* when____

**PSYCHIATRIC**
- ❑ Anxiety
- ❑ *Depression*
- ❑ *Postpartum Depression*
- ❑ Mental Illness
- ❑ *Eating Disorder*

**MUSCULOSKELETAL**
- ❑ *Arthritis*
- ❑ Fracture/broken bone

**NEUROLOGICAL**
- ❑ *Epilepsy/Seizures*
- ❑ *Headaches*

**ENDOCRINE**
- ❑ *Diabetes* Type_____
  HgbA1C/when_____
  _____
- ❑ *Thyroid Disorder*

Cancer / Type:
Other:

**HEALTH SCREENINGS** – ***please indicate if appropriate***:

| | | | | |
|---|---|---|---|---|
| **Bone Density Test** | Year: _____ | ❑ Normal | ❑ Abnormal | _____ |
| **Colonoscopy** | Year: _____ | ❑ Normal | ❑ Abnormal | _____ |
| **Mammogram** | Year: _____ | ❑ Normal | ❑ Abnormal | _____ |
| **Last Pap Smear** | Year: _____ | ❑ Prior Abnormal Pap Smear | Year: _____ | |

**ALLERGIES**: *Please list all Medication /Food/Environmental Allergies and type of Reaction:*

**PAST SURGICAL HISTORY: (*Please check any that you have had and indicate approximate date*)**

- ❑ Appendectomy_____
- ❑ Breast_____
- ❑ Cesarean section ____
- ❑ D&C_____
- ❑ Gallbladder_____
- ❑ Heart_____
- ❑ Hysterectomy_____
- ❑ Ovary_____
- ❑ Tonsillectomy_____
- ❑ Tubal Ligation_____
- ❑ Vaginal Repair_____
- ❑ Other _____

_____

**CURRENT MEDICATIONS: List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications. You may use additional pages if necessary.**

| Medication | Strength | How Often | Prescribed By | Reason |
|---|---|---|---|---|
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What medications have you taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines? _____

_____

**IMMUNIZATION HISTORY:** *Have you received the following vaccinations?*

❑ Hepatitis B Date_____ ❑ HPV Date_____
❑ Influenza Date_____ ❑ Varicella(Chicken pox) Date_____
❑ Tetanus/Tdap Date_____ ❑ Rubella (Measles) Date_____

**FAMILY HISTORY: (*Please check if any of your close family members have had the following)*** ❑ Adopted

| Condition | Relation to you | Maternal(M) Paternal (P) | Diag Age | Condition | Relation to you | Maternal (M) Paternal (P) | Diag Age |
|---|---|---|---|---|---|---|---|
| ❑ Breast Cancer | | | | ❑ High Blood Pressure | | | |
| ❑ Ovarian Cancer | | | | ❑ Stroke | | | |
| ❑ Colon Cancer | | | | ❑ Osteoporosis | | | |
| ❑Other Cancer not mentioned: | | | | ❑ Bleeding/Blood Clot Disorder | | | |
| ❑Diabetes | | | | ❑ Depression | | | |
| ❑Heart Disease | | | | ❑ Other: | | | |

**OBSTETRICAL HISTORY: (*Fill in blanks or check boxes where appropriate*)**

Age at first menstrual period: ____ Days between the first day of each period: ____ days Duration of flow: _____ days
Flow: ❑Light ❑ Meduim ❑Heavy Frequency that you change protection _____
Have you had a positive pregnancy test: Yes / No If yes, where/when_____
1st Day of Last Menstrual Period: ____/____/_____ Are you certain of this date? Yes / No
Were you using birth control? Yes / No If the pill, when did you stop?_____
Is this pregnancy result of IUI, fertility medication? YES / NO if yes, please list fertility specialist/when seen, method to obtain pregnancy:_____

_____

_____

Have you had symptoms with this pregnancy resulting in emergency department visit, ultrasound, etc.? _____

_____

_____

Being pregnant is:

___Exciting ___Not planned ___Good ___Scary
___Not convenient ___Feeling good ___Feeling bad ___Too long

If there anything in particular that is worrying you about yourself or your baby? _____

_____

*Please list previous pregnancies including miscarriages and abortions:*

Pregnancies____ Full-Term_____ Pre-term_____ Abortions_____ Miscarriages_____ Tubal Pregnancies_____
Multiple____ Living____

| Date | Weeks | Labor Hrs | Baby's Weight | Sex | Delivery Type | Your weight gain | Complications | Location/Physician |
|---|---|---|---|---|---|---|---|---|
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## GENETIC HISTORY

YES NO

□ □ Are you or the baby's father of Mediterranean ancestry? Have either of you been screened for Thalassemia? If YES, please indicate who was screened and the result _____

□ □ Are you or the father of the baby of Jewish, Cajun or French Canadian descent? Has either of you been screened for TaySach's and/or Canavan's Disease? If so, indicate who was screened and the results _____

_____

□ □ Are you or the father of the baby of African American ancestry? Has either of you been screened for Sickle cell disease or trait? If so, indicate who was screened and the results_____

***Have you, the baby's father or anyone in either of your families had any of the following:***

| YES | NO | | Relation | Notes |
|---|---|---|---|---|
| □ | □ | Brain, spinal cord or neural tube defects, Meningomyelocel (open spine), spina bifida, anencephaly? | | |
| □ | □ | Congenital heart disease/defect? | | |
| □ | □ | Down Syndrome? | | |
| □ | □ | Hemophilia (blood that does not clot well) or any other inherited blood clotting disease? | | |
| □ | □ | Muscular Dystrophy, Huntington's Cholea or Cystic Fibrosis? | | |
| □ | □ | Intellectual & developmental disabilities - if YES, was the person tested for fragile X? _____ | | |
| □ | □ | Other inherited genetic or chromosomal disorder? If yes, please identify: | | |
| □ | □ | Do you or the baby's father have a child with any birth defects? | | |
| □ | □ | Are there twins in either immediate family? | | |

## SOCIAL HISTORY:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Steady Relationship ❑ Same-sex relationship

Spouse / Father of the baby occupation _____ Age_____

Your Education: Grade completed _____ ❑ Graduated High School ❑ GED ❑ Some College ❑ Graduated College ❑ Postgraduate Occupation_____

Does your job involve heavy lifting? Yes / No _____

Does your job involve exposure to hazardous chemicals? Yes / No _____

Tobacco Use ❑ Never ❑ Current ❑ Former ❑ Smokes every day ❑ Smokes some days

Alcohol Use ❑ Never ❑ Current ❑ Former Amount_____ Started_____ Stopped _____

Recreation Drug Use ❑ Never ❑ Current ❑ Former Type _____

Started_____ Stopped _____

Do you exercise regularly ❑ None ❑ Minimal ❑ Moderate ❑ Heavy ❑ Active but no formal exercise

Do you use your seat belt? ❑ Yes ❑ No

Do you have a pet cat? If yes, do you change the litter box or does someone else do it? _____

Who comforts you when you have a problem? _____

Do you have a supportive person living in the home? ____ Yes _____No

Are you planning to breast or bottle feed: _____

Do you have any religious objections to any form of medical treatment (e.g. refusal of blood transfusion, male physician) that we should know about? If yes, please describe_____

_____

Do you fear for your safety or is there physical, verbal or emotional abuse where you live? Yes / No

_____

_____

Any other information that we should be aware of?

Grand Rapids Women's Health
OBSTETRICS & GYNECOLOGY SPECIALISTS

# PRENATAL INFORMATION

Congratulations on your pregnancy! Here is some information that may be helpful until you see us at your OB Interview. During your initial visit, the nurse will review, offer additional information and answer your questions.

## MEDICATIONS

Although most medications are safe, it is best to check with our office before taking new medication during your pregnancy. Something you've routinely taken in the past may not be safe while you are pregnant. Tylenol (regular or extra strength) for headache and Robitussin (Plain or DM) or Dimetapp for cough and colds may be used safely. Please let us know if a fever develops or the cough and cold symptoms do not respond to these medications. You will receive a more complete list of safe over-the-counter medications at your OB Interview appointment.

Alcohol, nicotine and illicit drugs should not be used in pregnancy. No safe levels have been proven.

## DIETARY

During pregnancy you need to increase the amount of fluids you drink, particularly in the hot weather or with exercise. Drink 6 – 8 glasses of water/day.

- Caffeine should be limited to one cup per day and herbal products (from health food stores) should be avoided. Safety during pregnancy is unknown with many herbs. Pre-packaged name-brand herbal teas purchased at the grocery store are safe to use during pregnancy.
- Diet pop should be limited to one can/day
- Limit juice to 8oz/day due to it's high sugar content
- Use sweeteners in moderation (splenda)
- Drink skim milk – this contains less fat but the same calcium as whole milk

Soft unpasteurized cheeses and some processed meats may in rare cases contain some harmful bacteria and should be consumed with caution while pregnant.

- Deli and prepackaged lunch meats are safe
- hot dogs/brats/sausages are safe if cooked first
- All soft non-imported cheeses made with pasteurized milk are safe to eat

Avoid fish from Michigan lakes and streams during your pregnancy due to high mercury levels. Women of childbearing age, particularly those who are pregnant or nursing, should not eat shark, swordfish, king mackerel, or tilefish at any time due to elevated mercury levels. If you enjoy eating fish, ask for the pamphlet about safe fish at your OB Interview.

- You can safely eat two cans of tuna/week

Processed, packaged, frozen meals and fast foods are usually high in sodium. Read the labels and limit sodium to 3000mg/day or less.

## NAUSEA

If you should experience nausea ("morning sickness") early in your pregnancy, Seabands, which are worn on you wrists, may help to lessen your symptoms. These are now available, without prescription, at stores such as Walmart or Meijers. Eating small meals/snacks every couple of hours and drinking herbal teas or ginger ale, can also be helpful.

## SPOTTING/DISCHARGE

Different tissues in your body may be more susceptible to bleeding during pregnancy. Bleeding gums with tooth brushing, nasal bleeding, rectal bleeding and spotting after intercourse may occur. This does not mean anything is wrong with the baby. Call if you notice more than light spotting.

Vaginal discharge is increased with pregnancy and may be quite heavy at times. If any itching or bad odor occurs with the discharge, please inform you doctor at your next visit.

ACTIVITY/SAFETY

Always wear a seat belt when you drive or ride in a car.

Activity and exercise as usual are allowed in moderation unless spotting, bleeding or cramping develops. Any new exercise program should be brought to the doctor's attention. Swimming and aqua are ideal as they are easy on joints and overheating is rare. A general guide is that if you become winded and are unable to carry on a normal conversation during exercise, it is too strenuous and should be stopped.

- Abdominal exercises should be avoided after 20 weeks.
- You should limit lifting to about 70 – 75% of what you normally lift. If you are lifting more than 25 – 30 pounds regularly, please let us know. In most cases you will be able to work through your pregnancy, but you may need lifting restrictions toward the end.

Avoid hot tubs in the first trimester. Hot tubs are to be limited to less than 100 degrees and for not more than 10 minutes.

If you have any concerns regarding environmental or work hazards, please talk with your doctor or nurse.

PETS

If you have a pet cat, you should avoid contact with kitty litter boxes and soil contaminated with cat feces. It is possible for cats to be host to a protozoan infection which can cause toxoplasmosis. Although this is a rare infection, it is potentially harmful to the unborn baby.

OFFICE ROUTINES

On your office visit days, avoid the use of lotion on your abdomen as it interferes with hearing the baby's heartbeat.

The physicians, whenever able, cover their own deliveries during the day. Call is shared nights and weekends among all of the physicians.

At times you may come for your visit only to find that your doctor has been called away for an emergency. In this case, we may ask you to see another physician or a nurse for this visit. If you prefer, you may reschedule your appointment.

Your spouse or significant other is always welcome at your visits.

You will generally have one ultrasound halfway through your pregnancy. This is a diagnostic tool for your physician to determine proper growth and development of your baby. Sometimes babies cooperate and we can determine their sex during the ultrasound. If your baby cooperates and you want to know the sex of your child, let the sonographer know. Additional ultrasounds are only ordered for a medical reason.

If all is normal, you will have monthly visits until 28 – 32 weeks. Then they will be every two weeks until 36 weeks after which visits are weekly. Please call if there are any problems or questions between visits.

Visit our website www.grandrapidswomenshealth.com for links to websites that your physician recommends for more accurate information about pregnancy.

*If you have any further questions, please feel free to call us or ask us at your next visit. As always, you and your baby's health and welfare are our primary concern.*

Grand Rapids Women's Health

## Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.**

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

### Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

**You have the right to authorize other use and disclosure** - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication** – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI** - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information** - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability** - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

### How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment** - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices** - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

**Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare -** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as neceesary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

### Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

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We will not retaliate against you for filing a complaint.

**Privacy Manager: Dawn Carpenter 555 Mid Towne NE Grand Rapids, MI 49503 616-588-1110**

**Effective: 9/1/2013**