Garden City	Massapequa	Lake Success	Plainview
200 Garden City Plaza**,** #100	4150 Sunrise Highway	1 Hollow Lane	930 Old Country Road
Garden City, NY 11530	Massapequa, NY 11758	Lake Success, NY 11042	Plainview, NY 11803
Manhattan	**Forest Hills**	**Fresh Meadows**	**Long Beach**
220 E 6rd St, Lobby J	64-63 Austin Street, #1A	163-03 Horace Harding Expy	266 W Park Ave
New York, NY 10065	Forest Hills, NY 11374	Fresh Meadows, NY 11365	Long Beach, NY 11561

- (212) 308-3088 - - (718) 464-3000 - - (516) 663-6400 - - (516) 393-1000 - - (631) 385-6000 -

Congratulations and welcome to our obstetrical practice!

We and our staff share your joy. During the next several months, our goal is to provide you with the best care leading to delivery of a healthy infant.

Our physicians provide you with excellent care, from the very beginning of the pregnancy. Each of our offices are equip with state of the art equipment, highly trained clinicians and staff to best suit your needs at this exciting time. Although you may pick one of us as your primary physician, we highly recommend that you make appointments with all the physicians and midwife so that you meet and feel comfortable with all of us.

We are affiliated with the North Shore Health System at Long Island Jewish Hospital and South Nassau Communities Hospital. One of us is always on call and available for emergencies 24 hours a day.

Our practice is staffed by highly trained sonographers and use state -of-the-art 2 and 3 dimensional ultrasound equipment to provide comprehensive obstetrical ultrasound services.

We are also affiliated with Ocean Perinatology, a highly specialized practice in Maternal Fetal Medicine.

Dr. Gonzalez & Dr. Chun are both Maternal Fetal Medicine Specialists committed to help identify potential obstetrical, medical or fetal problems early enough in the pregnancy to set the proper treatment plan for the pregnancy.

We look forward to providing you with care during this special time in your life.

Sincerely,

Garden OBGYN

Greetings Obstetrical Patients

Thank you for choosing Garden OB/GYN for your obstetrical care and needs. We are driven to provide you with excellent care, support and direction at this special time. We are please to inform you that our Doctors are now delivering at the following hospitals. During the next few weeks you will be discussing with the clinicians the hospital of choice for your delivery. Please be aware you may take tours at each of the hospitals before you make your decision.

Long Island Jewish Hospital – 270 05 76 Ave, New Hyde Park, NY 11004

General Information 718 470-7000

South Nassau Hospital- 1 Healthy Way, Oceanside, NY 11572

General Information 516 632-3000

All of us at Garden OB/GYN wish to extend our congratulations & best wishes to you and your family, at this most precious time.

Sincerely,

Garden OB/GYN

PRENATAL GENETIC QUESTIONNAIRE

Name____ Date of Birth:____/____/_____ Today's Date:____/____/_____

1. Will you be 35 years or older when your baby is born? □YES □NO
   •Would you like further information on prenatal diagnosis and genetic counseling? □YES □NO

2. Are you familiar with Alpha-fetoprotein screening in pregnancy to help rule out open neural tube defects and some cases of Down Syndrome? □YES □NO
   •Would you like further information on the new Triple Marker AFP screening test? □YES □NO

3. Do you or the baby's father have a birth defect? □YES □NO
   •*If yes, please indicate:*____

4. Do you have a child with a major birth defect or problem? □YES □NO
   •*If yes, please indicate:*____

5. Have any of the following occurred in *your family* or in the *baby's father's family*:
   - Bleeding disorder (e.g. hemophilia)………… □YES □NO
   - Cystic fibrosis………… □YES □NO
   - Muscular dystrophy………… □YES □NO
   - Spina bifida or anencephaly………… □YES □NO
   - Hydrocephaly………… □YES □NO
   - Down Syndrome or another syndrome………… □YES □NO
   - Other chromosomal abnormality………… □YES □NO
   - History of two or more miscarriages (indicate #   )………… □YES □NO
   - History of stillbirth or children who died young………… □YES □NO
   - Heart defect………… □YES □NO
   - Severe anemia………… □YES □NO
   - Congenital kidney or liver disease………… □YES □NO
   - Enzyme deficiency (e.g. PKU)………… □YES □NO
   - Huntington's Disease………… □YES □NO
   - Neurofibromatosis………… □YES □NO
   - Tumors of the eye (retinoblastoma)………… □YES □NO
   - Myotonic Dystrophy………… □YES □NO

   •*If yes, please indicate relationship of the affected person to you or the baby's father :*__________________________________
   ____

6. Do any close relatives, in either your family or the baby's father's family, have a familial disorder not listed above? □YES □NO
   •*If yes, please explain:*____

7. Do you or the baby's father have any close relatives with mental retardation? □YES □NO
   •*If yes, please indicate relationship of the affected person to you or the baby's father, and the cause (if known):*
   ____

8. Are you and the baby's father related to each other in anyway (e.g. cousins)? □YES □NO
   •*If yes, please explain:*____

9. Have you taken any medication during this pregnancy? □YES □NO
   •*If yes, please specify name of medication, dosage, and duration of treatment used during pregnancy:* ___________________
   ____
   ____

10. During this pregnancy have you:
    a. Had exposure to x-rays?.. □YES □NO
    b. Had exposure to contagious illnesses?.. □YES □NO
    c. Had any alcohol to drink?.. □YES □NO
    d. Smoked any cigarettes?.. □YES □NO
    e. Used any "recreational" drugs?.. □YES □NO

11. Auto Immune Deficiency Syndrome (AIDS) is a problem for both mother and baby.
    Would you like further information on testing for AIDS? □YES □NO

12. Do you have a chronic medical condition, such as diabetes, PKU, thyroid problem,
    or seizure disorder? □YES □NO
    •*If yes, list diagnosis:* ____
    ____

A NUMBER OF GENETIC DISEASES OCCUR MORE COMMONLY IN CERTAIN RACES AND ETHNIC GROUPS. FOR THIS REASON, IT IS IMPORTANT THAT WE KNOW YOUR RACE AND ETHNIC BACKGROUD.

13. Are you or the baby's father of Ashkenazi Jewish ancestry?...................................... □YES □NO
    •*If yes, indicate who and the ancestry:* ____
    ____

    →Have either of you been screened for Tay-Sachs disease?.. □YES □NO
    •*If yes, indicate who and results:* ____
    ____

14. Are you or the baby's father of Black or Hispanic ancestry?.. □YES □NO
    •*If yes, indicate who and the ancestry:* ____
    ____

    →Have either of you been screened for sickle cell trait?.. □YES □NO
    •*If yes, indicate who and the results:* ____
    ____

15. Are you or the baby's father of Italian, Greek, or Mediterranean ancestry?...................... □YES □NO
    •*If yes, indicate who and the ancestry:* ____
    ____

    →Have either of you been tested to determine if you are carriers of
    Beta-thalassemia, a blood disorder?... □YES □NO
    •*If yes, indicate who and the results:* ____
    ____

16. Are you or the bay's father of Philippine or Southeast Asian ancestry?........................... □YES □NO
    •*If yes, indicate who and the ancestry:* ____
    ____

    →Have either you, or the father of the baby been tested to determine if you are carriers of Alpha-thalassemia, a blood disorder? .... □YES □NO
    •*If yes, indicate who and the result:* ____
    ____

Name______________________________ Date of Birth:____/____/_____ Today's Date:____/____/_____

NEW YORK STATE DEPARTMENT OF HEALTH-DIVISION OF DISEASE CONTROL

LEAD RISK ASSESMENT FOR PREGNANT WOMEN

LEAD RISK EXPOSURE QUESTIONAIRE	YES	NO	UNKOWN
1. Do you or others in your household have an occupation that involves lead exposure? (See list below)			
2. Do you ever eat paint chips, clay, soil, or plaster?			
3. Do you live in a household with ongoing renovations that generate a lot of dust? (Ex. Sanding and scraping)			
4. To your knowledge has you home been tested for lead in the water, and if so, were you told the level was high?			
5. Do you use any traditional remedies or cosmetics that are not sold in a regular drug store or are homemade, which may contain lead? (Ex. Litargirio, serma, kohl, or red dye bindi spots)			
6. Do you or others in your household have any hobbies or activities likely to cause lead exposure?			
7. Do you use non-commercially prepared pottery or lead crystal?			
8. Do you live in a home that has plumbing with lead pipes or copper with lead solder joints?			
9. Do you live near a heavily traveled major highway, where the soil and dust have been contaminated?			

Testing of blood lead levels is not recommended for pregnant women who are not considered currently at risk. If you answered "yes" to any of these questions, you may be at risk for current high-dose exposure and should have a blood lead test. A blood lead test during pregnancy is not indicated for a previous history of childhood lead exposure.

Lead Related Occupations and Industries:

Lead abatement	Production and use of chemical preparations	Bridge, tunnel and elevated highway Operations construction
Firing Range Work	-Metal scrap yards and other recycling	-Brass/copper foundry
Pottery Making	-Occupations using firearms	Manufacturing of industrial machinery and equipment
Use of Lead based paints	-Battery manufacturing and repair	Motor vehicle parts and accessories/Automotive repair shops
Home renovations/restorations	-Glass recycling, stained glass/glass	Manufacturing and installation of plumbing components

If a pregnant woman is exposed to lead at work, she has a tight to a safe working environment under federal and state laws. To obtain information on employee workplace rights under Occupational Safety and Health Administration (OSHA) and Public Employee Safety and Health(PESH), call the New York State Department of Health, Center for Environmental Health Information line at 1-(800)-458-1158.

NEW YORK STATE DEPARTMENT OF HEALTH

DIVISION OF DISEASE CONTROL

INFORMED CONSENT TO PERFORM AN HIV TEST

The decision to have an HIV test is voluntary. In order to have an HIV test in New York State, you must give your consent in writing on the bottom of this form:

Testing for HIV Infection

Human Immunodeficiency Virus:

Human Immunodeficiency Virus (HIV) is a virus that can be passed from person to person through body fluids, primarily blood and semen. When HIV enters the bloodstream, it invades and destroys cells within the immune system (the body's defense against infection). In a person infected with AIDS since the immune system can no longer defend itself various infections and tumors develop called "opportunistic infections." It is not HIV that kills a person with AIDS; it is the opportunistic infections that cause death.

How the Virus is Spread:

The AIDS virus is not spread through the air, in food, or by casual social contract like shaking hands or hugging. It is passed on only when the blood or body fluids of an infected person mix with your own.

Sexual transmission is mainly the result of the transfer of and exposure to infected semen. Women, as well as men, can transmit the virus sexually. The virus has also been detected in vaginal secretions, tears and saliva, but exposure to saliva has not been proven to transmit the infection.

Intravenous drug users and persons receiving blood transfusions can be exposed to the virus through infected blood or body products. However, the spread of the virus from contaminated transfusions has become greatly reduced since the testing of blood began.

A baby may become infected during pregnancy, delivery, or when breast feeding if its mother has the disease

A person may carry the virus for several months or even years before symptoms appear. The HIV positive person can still spread the disease, even though he or she may appear healthy.

Behaviors That Can Increase Your Risk of Being Exposed to HIV:

- Having sexual contact with:
  - Someone who has tested positive for HIV infection
  - Someone who is at risk for infection through risky sexual practices, IV drug use, or blood transfusions
  - A man who has had sex with another man, regardless or whether he is primarily heterosexual, bisexual, or homosexual and/or…
  - More than one sex partner, especially one who could be at risk of an HIV infection.
- Using illicit intravenous drugs.
- Receiving blood transfusions, plasma, blood cells or a blood clotting factor.
- Undergoing artificial insemination with a donor sperm.

Testing Methods:

There are a number of tests that can be done to show if you are infected with HIV, the virus that causes AIDS. Garden Ob/Gyn can provide specific information on these tests. The most common test for HIV is the HIV antibody test. The HIV antibody test is a blood test for the presence of antibodies to the Human Immunodeficiency Virus. It is a screening test. A sample of blood is taken from your arm, with a needle. If it comes back positive, another test called a Western blot is performed from the same sample. Garden OB/Gyn will not report the positive results to you until the Western Blot is performed. A positive test result means that you have been exposed to the virus and are infected (have built up antibodies against the virus). It may not mean that you have AIDS now or that you will necessarily become sick with AIDS in the future. A negative test means that you are probably not infected with the virus. However a negative test may also mean that you have exposed to the virus but have not yet produced antibodies. It takes time to build up the HIV antibodies. You should be tested in several months if you think you may have been recently exposed to the virus.

Meaning of HIV Test Results:

- A negative test result on the HIV antibody test most likely means that you are no infected with HIV, but it may not show recent infection. If you think you have been exposed to HIV, you should take the test again three months after the last possible exposure.
- A positive result on the test means that you are infected with the HIV virus and that you can infect others.
- Sometimes the HIV antibody test result is not clearly positive or negative, or may be a preliminary result. Garden Ob/Gyn will explain such a result, and may ask you to give your consent for another sample of blood so that other tests can be done.

There are Benefits to Being Tested:

If you receive an HIV negative test result:

- Garden OB/Gyn will tell you how to protect yourself from getting infected with the virus in the future.
- You can end the fear which may come from not knowing if you are infected.

If you receive an HIV positive test result:

- Garden OB/Gyn can give you medical care and treatments that will help you stay healthy and manage your HIV illness.
- We can tell you how to prevent passing the virus to your sexual or needle sharing partners.
- You can increase your chances of staying healthy by eating a well balanced, nutritious diet, getting enough sleep, exercising, avoiding alcohol, tobacco, recreational drugs, reducing stress and having regular checkups.

If you are a woman who receives an HIV positive test result:

- If you have given birth to or breast fed a child since you were infected, your child will need to be tested for HIV and, if infected, may need additional care and treatment. We can provide information about medical care available for children who may be infected with HIV.
- If you are a pregnant women, we can provide the care you need and information about services and options available to you, We can tell you about the risks of passing the HIV infection to your baby, about medications given during the pregnancy that can significantly reduce the risk of passing HIV to your baby, and the medical care available for babies who may be infected with HIV.
- If you are thinking of having a child, you will be given information to help you make informed choices about your health care and pregnancy, and about the possibility of passing the virus to your baby.

Confidentiality of HIV Information:

If you take the HIV antibody test, your test results are confidential. Under New York State law, confidential HIV information can only be given to people you allow to have it by giving your written approval, or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers; persons involved with foster care or adoption; parents and guardians who consent to care of minors; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/bodily fluids in the course of their employment; and organizations that review the services you receive. The law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for cure and treatment.

Reporting Requirements:

Your name will be reported to the Health Department if you have a confirmed positive HIV antibody test result. The Health Department will use this information to track the epidemic and to better plan prevention, health care and other services.

Notifying Partners:

If you test HIV positive Garden Ob/Gyn will talk with you about the importance and benefits of notifying your partners of their possible exposure to HIV. It is important that your partners know they may have been exposed to HIV so they can find out whether they are infected and benefit from early diagnosis and treatment. We may ask you to provide the names of your partners, and whether it is safe for you if they are notified, For information related to domestic violence, call 1-(800) 942-6906.

- Under state law, we are required to report to the Health Department the names of any of your partners (present and past sexual partners, including spouses, and needle sharing partners) whom we know.
- If you have any additional partners whom we do not know of, you may give their names to us so they can be notified.
- Several options are available to assist you in notifying partners. If you do not have a plan to notify your partners, the Health Department may notify them without revealing your identity. If this notification presents a risk of harm to you, the Health Department may defer the notification for a period of time sufficient to allow you to access domestic violence prevention services.
- If you do not name any partners or if a need exists to confirm information about your partners, the Health Department may contact you to request your cooperation in this process.

Be Careful About Sharing HIV Information:

Your HIV related information is important information to share will all your health care providers so that they can give you the best care available. However, you should be careful who else you tell if you test positive for HIV since not everyone understands what being HIV positive means. Some people who test positive for HIV are discriminated against by employers, landlords and others. If you are discriminated against because of HIV, you can call the New York State Division of Human Rights at 1-(800) 523-2437 or the New York City Commission on Human Rights at (212)-566-5493 for help. These agencies are responsible for protecting your civil rights.

For More Information:

If you have questions about informed consent for HIV related testing, questions about the laws protecting the confidentiality of your HIV test results, or feel that confidential HIV related information about you was disclosed without your consent, call the New York State Department of Health HIV Confidentiality Hotline at 1-(800) 962-5065. Any health or social service provider who illegally tells anyone about your HIV information may be punished by a fine of up to $5,000 and a jail term of one year. The law also protects you from HIV-related discrimination in housing, employment, health care or other services.

My questions about the HIV antibody tests were answered. I agree to be tested for HIV.

____ Date:_______________________

(Signature of Person to be Tested)

____

(Print Name of Person to be Tested)

Pre-test counseling was verbally provided in accordance with Article 27-F of the New York State HIV Confidentiality Law, including how the HIV test is done, the meaning of the test and test results, the possible consequences of disclosing HIV information, and the protections against unauthorized disclosure of HIV related information provided by law, to the above Informed Consent Form at the time the informed consent was obtained.

Name:____

Title:____

Facility: Garden OBGYN

Patient Information for Cystic Fibrosis Screening

Cystic Fibrosis (CF) is a genetic disorder that particularly affects the lungs and digestive system and makes a child more vulnerable to repeated lung infections. Currently affecting more than 30,000 children and young adults in the United States, Cystic Fibrosis makes children sick by disrupting the normal function of the epithelial cells- cells that make up the sweat glands in the skin and that also line passageways inside the lungs, liver, pancreas, and digestive systems.

In CF, the inherited CF gene directs the body's epithelial cell to produce a defective form of a protein called CFTR (or Cystic Fibrosis Transmembrane Conductance Regulator) found in cells that line the lungs, digestive tract, sweat glands, and genitourinary system. When the CFTR protein is defective, epithelial cells can't regulate the way chloride (part of the salt called sodium chloride) passes across cell membranes. This disrupts the essential balance of salt and water that is needed to maintain a normal thin coating of fluid and mucous inside the lungs, pancreas, and passageway in other organs. The mucus becomes thick, sticky, and hard to move.

Normally, mucus in the lungs traps germs, which are then cleared out of the lungs. But in CF, the thick, sticky mucus and the germs it trapped remain in the lungs, and the lungs become infected.

In the pancreas, thick mucus blocks the channels that would normally carry important enzymes to the intestines to digest foods. When this happens, the child's body can't process or absorb nutrients properly, especially fats. The child has problems gaining weight, even with a normal diet and good appetite.

Humans have 23 pairs of chromosomes made of the inherited genetic chemical called DNA. The CF gene is found on chromosome number 7. It takes two copies of a CF gene- one inherited from each parent-for a child to show symptoms of CF. Persons born with only one CF gene (inherited from only one parent) and one normal gene are CF CARRIERS. CF carriers do not show CF symptoms themselves, but can pass the problem CF gene to their children. Scientists estimate that about 12 million Americans are currently CF carriers. If two CF carriers have a child, there is a one in four chance their child will have CF.

There is a carrier-screening test for Cystic Fibrosis. This is a blood test that determines your risk for carrying an altered gene, the risk for passing that gene on to your child, and it helps determine your child's risk of having Cystic Fibrosis if both parents are screened.

Generally, carrier screening is offered to couples when one partner has CF. It is also offered to individuals who have a family history of CF, a child with CF, or a close relative with CF. Additionally, carrier screening is offered to non-Jewish Caucasians and Ashkenazi Jewish people. All of these people have a relatively high risk of being CF carriers. At lesser risk are Hispanic Americans, African American, and Asian Americans.

Men with congenital bilateral absence of the vas deferens (CBAVD) often are carriers for Cystic Fibrosis or have CF themselves. Such men and their partners therefore may also want to be screened.

A positive screen can mean that you are a CF carrier and you might pass that altered CF gene on to your child. Your child might have CF if your partner is also a carrier. CF Carrier Screening cannot tell you for sure if you will, or will not, have a child born with Cystic Fibrosis. Final Diagnosis of two parents who are carriers is through genetic counseling, amniocentesis and chromosomal analysis. Carrier Screening will, however, give you important information that will help you make the best possible decisions for you and your family.

If you have further questions regarding this test, the healthcare providers at Garden Ob/Gyn will be happy to discuss this with you.

CONSENT TO CYSTIC FIBROSIS SCREENING

I,__________________________________ hereby consent to and request Cystic Fibrosis Carrier Screening. I have read the above, and I understand both the purpose of the test and the risks. I do not require any further information at this time.

Signature: ____ Date:_______________

• or •

NO, I AM NOT INTERESTED IN HAVING THE CYSTIC FIBROSIS SCREENING WITH THIS PREGNANCY.

I,_______________________________ am not interested in having this blood test. I have read the above and understand the purpose of this test as well as the risks. I do not require any further information at this time.

_____ I have previously been tested and found NOT to be a Cystic Fibrosis carrier.

Signature: ______________________________________ Date:_________________

Consent for Sequential Screen Testing for Down's Syndrome and Other Genetic Abnormalities

1. I have been offered the Sequential Screen Test for the purpose of detecting Down's syndrome during my present pregnancy.

2. I understand that this is an option and is an improvement over the testing that would be done at 16 weeks gestation by giving a much higher detection rate of 92%. AFP test, done at only 16 weeks, gives only about a 75% detection rate.

3. I am aware that final result pending second trimester sample will arrive from my11-12 week testing which will identify me as at an increased risk or low risk for Down's Syndrome and other genetic abnormalities, and that the data from this test will be integrated into the 16-week test.

4. After the 16-week test I expect to receive a final result which would identify me as at an increased or low risk for Down's Syndrome and other genetic abnormalities.

5. I have been given a pamphlet from Integrated Genetics., entitled "Sequential Screen" and I have read it and all my questions regarding this test were answered.

6. I will check with my insurance carrier and find out if they will cover this particular test for my pregnancy. Although, Garden Ob/Gyn believes this test is medically necessary for pregnancies, some insurance plans may not yet provide benefits for the Sequential Screen. By signing on the line below, you are acknowledging that you have read this form, understand it and choose to have the Sequential Screen. Your signature also acknowledges that you may be financially responsible for fees billed by our office for these services. For more information regarding testing cost, insurance coverage and testing codes, please contact Integrated Genetics Client Services at 1-800-848-4436.

7. I understand that I may receive a bill for a co-payment from Integrated Genetics. All queries concerning that bill must be directed to Integrated Genetics at 1-800-845-6167.

Patient Name: ______________________________________

Witness: ____

Signature: ____*Date:*________________

I _________________________________ *decline to have sequential testing done and am aware of the risks of not having the tests performed.*

CONSENT TO FRAGILE-X SCREENING

I, ___________________________, hereby consent to and request the Fragile-X Screening. I have read the patient education pamphlet and I fully understand both the purpose and risks of the test. I do not require any further information about Fragile-X at this present time.

Signature: ______________________________________ Date: ____________________

NO, I AM NOT INTERESTED IN HAVING THE FRAGILE-X SCREENING DURING THIS PREGNANCY

I, _________________________, am declining the Fragile-X Screening at this time. I have read the patient education pamphlet and I fully understand both the purpose and risks of the test. I do not require any further information about Fragile-X at this present time.

I, _________________________, have previously been tested and found NOT to be a Fragile-X carrier.

Signature: ______________________________________ Date: ____________________

CONSENT TO SMA SCREENING

I,____________________________, hereby consent to and request the SMA Screening. I have read the patient education pamphlet and I fully understand both the purpose and risks of the test. I do not require any further information about SMA at this present time.

Signature: ______________________________________ Date: ____________________

NO, I AM NOT INTERESTED IN HAVING THE SMA SCREENING DURING THIS PREGNANCY.

I,__________________________, am declining the SMA Screening at this time. I have read the patient education pamphlet and I fully understand both the purpose and risks of the test. I do not require any further information about SMA at this present time.

I, __________________________, have previously been tested and found NOT to be an SMA carrier.

Signature: ______________________________________ Date: ____________________

UMBILICAL CORD BLOOD COLLECTION and BANKING

This form is to ensure your understanding about the potential health benefits of Umbilical Cord Blood Banking. The literature provided from the various companies that offer this service should be reviewed by you and your family. You can also visit the many web sites of the companies available on-line to assist you in making an educated and informed decision regarding Umbilical Cord Blood Banking.

PATIENT EDUCATION CONSENT or REFUSAL FORM

I have been provided with information about banking my newborn's umbilical cord blood to help one make an informed choice regarding the preservations of my newborn's stem cells:

- *I understand that this program is an elective option to collect and store my newborn's umbilical cord blood. It is MY choice to enroll and participate.*
- *I understand that the program is designed to provide a source of genetically related cord blood stem cells for potential future use and that the birth of my newborn represents the only opportunity to collect them.*
- *I understand that this program may not be reimbursed by my insurance carrier and may not be covered by Medicare or comparable state programs. I am responsible for the fees.*
- *I understand that the arrangements must be made at lease forty five (45) days prior to my due date or additional costs may be incurred for late enrollment.*
- *I have had all my questions answered to my satisfaction. I understand the implications of Cord Blood Banking for future use by my newborn and my family. If I have further questions regarding Cord Blood Banking, I understand that Garden Ob/Gyn will be happy to discuss it with me.*

* *

I HAVE CHOSEN TO COLLECT AND BANK MY NEWBORNS UMBILICAL CORD BLOOD. I accept the responsibility to complete the necessary arrangements for Cord Blood Banking.

Signature: ____________________________________ Date: ____________________

NO, I HAVE CHOSEN NOT TO COLLECT AND BANK MY NEWBORN'S UMBILICAL CORD BLOOD.

Signature: ____________________________________ Date: ____________________

FIANCIAL DISCLOSURE

This is to inform you, that Ocean Perinatology, a High Risk Pregnancy Facility is part of our Garden Ob/Gyn Health Care System. Michael Terrani, MD PC and Bethpage Medical PLLC does not hold a financial interest in this facility.

Signature: ______________________________ Date: ____________________

GARDEN OB/GYN

OBSTETRICAL FINANCIAL FLOWSHEET

NAME: ____

LMP:__________________________ EDD:__________________________

INSURANCE: **Y or N** DATE:_________________________

SPOKE WITH:____________________________________

TYPE OF COVERAGE:____

SONOGRAMS: HOW MANY INCLUDED:______________________________

DO ADDITIONAL NEED PRE-CERT: **Y or N**

PHONE NUMBER TO CALL FOR PRE-CERT:___________________________

COPAY FOR SONOS: **Y or N** IF YES AMOUNT $_______________________

HOSPITAL FOR DELIVERY: **LIJ** **SNCH**

PRE-AUTHORIZATION FOR DELIVERY: **Y or N**

AUTHORIZATION # IF REQUIRED:___________________________________

SPOKE WITH:___________________________________

CIRCUMCISION COVERED: **Y or N**

C-SECTION BOOKED:____

BTL BOOKED:____