Sudha Moola MD
M.D., F.A.C.O.G.
818 Magnolia Ave STE 102
Corona, CA 92879

call : (951) 732 – 7834
fax : (951) 352 - 7758

Please complete the following information. **This information is confidential**

Name:_____
Last Mi First

Address:_____ City:_____State:____

Zip:_____--_____E-mail address:_____

Home phone:_____ Work/cell phone:_____

By providing a phone number, mobile phone number or email address, I authorize Dr. Sudha Moola to contact me or my guardian/legal representative by email, voice or text to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare. ☐ Yes ☐ No

Birth Date: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity: ☐ Asian ☐ African American ☐ Hispanic or Latino ☐ Caucasian ☐ Other _____

In case of emergency, contact:

Name:_____Relationship:_____ Phone:_____
Last Mi First

Please list: Special needs: _____ Allergies:_____

Referred By _____

Responsible Party Information: (Must provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.)

Responsible party: Another patient ☐ Guarantor ☐ Self ☐ Information is same as patient ☐

Insurance company: _____ID #_____Co-Pay _____

Policy holder's name: _____ Policy holder's date of birth: _____

Policy holder's relationship to patient: _____ Phone: _____

Policy holder's address: _____

City:_____State:_____ZiP:_____--_____

Preferred Pharmacy:_____ Phone _____

STUDENTS AND MINORS:

Parent/Legal Guardian _____ Date of Birth _____

Address _____ Phone _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

Thank you for choosing Dr. Sudha Moola as your health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following Financial Policy.

To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any changes of insurance information. **It is the insurance company that makes the final determination of your eligibility and benefits.**

I understand Dr. Sudha Moola:

- Expects Non-Insured or Insured patients to pay co-pays, deductibles on the date of service or make payment arrangements.
- Outside lab tests are billed separately by that company. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay in advance.
- Expects my insurance company to pay within 90 days from the date of service if not paid bill me directly.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel.
- I understand that failure to keep my appointments may result in being discharged from the practice.
- High-Deductible health plan requires me to pay half of service charges at the time of service. The remaining balance will be due upon receipt of a statement from doctor's office.
- I hereby authorize payment of all insurance, Medicaid and/or Medicare benefits directly to Dr. Sudha Moola and I authorize them to file insurance on my behalf. I also authorize them to release medical and/or account information to satisfy claims

I have read and understand the above:

_____ _____

Patient or Parent/Legal Guardian Signature Date

Note: Failure to sign does not relieve you of the above expectations

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services and services offered by lay health workers (i.e. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me. I voluntarily consent to allow **Dr. Sudha Moola** to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings and HIV. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

NOTICE OF PRIVACY AND PATIENT HIPAA CONSENT

I have been given the opportunity to read **Dr. Sudha Moola's** Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment **Dr. Sudha Moola** will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment, payment, and healthcare operations when necessary.

_____ _____

Patient or Parent/Legal Guardian Signature Date

VERBAL COMMUNICATION CONSENT

Dr. Sudha Moola is authorized to discuss medical and financial information with the following individuals:

_____ _____ _____

Name Phone Number Relationship to patient

CONFIDENTIAL PERSONAL HEALTH INVENTORY

Patient Name:_____ **Age:**_____ **Date:**_____

Present Problem is: _____

Previous Pregnancies: Please give all the information in regard to your previous pregnancies

Year of Birth	Birth weight of Infant	Birth Height of Infant	Hours of Labor	Type of Delivery	Complications

1. What age did you start your period?_____
2. Up to this time periods have been: Regular ☐ Yes. ☐. No
3. Last menstrual period occurred on:_____
4. Are you a Jehovah witness?_____
5. Do you smoke?_____. Do you drink Alcohol?_____ Do you take drugs?_____
6. Do you use contraception? ☐ Yes. ☐. No
7. Have you ever had a pap smear? ☐. Yes ☐ No
8. Last pap smear? Date:_____ Place:_____
9. Was it ☐. Normal or ☐ Abnormal

Current Medication List

Pharmacy Name:	
Pharmacy Location:	
Known medication allergies:	
Family Physician name:	
Allergies:	
Medications you take:	

Past Medical History

Diphtheria. ☐	Heart Disease ☐	Kidney Disease ☐	Epilepsy ☐	Asthma ☐
Hay Fever ☐	Scarlet Fever ☐	Hypertension ☐	Diabetes ☐	Syphilis ☐
Rheumatic fever ☐	Thyroid Disease ☐	Blood Transfusion ☐	Gonorrhea ☐	Drug Sensitivity ☐
Varicosities ☐	Thrombophlebitis ☐	Accidents ☐	Tuberculosis ☐	Pneumonia ☐
Cancer ☐	Jaundice ☐	Hepatitis ☐	STD ☐	Anemia ☐

Past Surgical History

Surgery	Date	Notes

Edinburgh Postnatal Depression Scale (EPDS)

Patient Name:_____

Please circle the answer which comes closest to how you have felt in the In the Past 7 Days

I have been able to laugh and see the funny side of things as much as I always could, ☐ 0 - As much as 1 always could ☐ 1 - Not quite so much now. ☐ 2 - Definitely not so much now ☐ 3 - Not at all	**Things have been getting on top of me.** ☐ 3 - Yes, most of the time I haven't been able to cope at all ☐ 2 - Yes, sometimes 1 haven't been coping as well as usual ☐ 1 - No, most of the time 1 have coped quite will ☐ 0 - No, 1 have been coping as well as ever
I have looked forward with enjoyment to things. ☐ 0 - As much as 1 ever did ☐ 1 - Rather less than 1 used to ☐ 2 - Definitely less than 1 used to ☐ 3 - Hardly at all	**I have been so unhappy that I have had difficulty sleeping** ☐ 3 - Yes, most of the time ☐ 2 - Yes, sometimes ☐ 1 - Not very often ☐ 0 - No, not at all
I have blamed myself unnecessarily when things went wrong. ☐ 3 - Yes, most of the time. ☐ 2 - Yes, some of the time ☐ 1 - Not very often ☐ 0 - No, never	**I have felt sad or miserable** ☐ 3 - Yes, most of the time ☐ 2 - Yes, quite often ☐ 1 - Not very often ☐ 0 - No, not at all
I have been anxious or worried for no good reasons. ☐ 0 - No, not at all. ☐ 1 - Hardly, ever ☐ 2 - Yes, sometimes ☐ 3 - Yes, very often	**I have been so unhappy that I have been crying.** ☐ 3 - Yes, most of the time ☐ 2 - Yos, quite often ☐ 1 - Only occasionally ☐ 0 - No, not at all
I have felt scared or panicky for no very good reason. ☐ 3 - Yes, quite a lot ☐ 2 - Yes, sometimes ☐ 1 - No, not much ☐ 0 - No, not at all	**The thought of harming myself has occurred to me.** ☐ 3 -Yes, quite often ☐ 2 - Sometimes ☐ 1 - Hardly ever ☐ 0 - Never
Postpartum depression Is the most common complication of childbearing. 2 The 10 question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of Identifying patients at risk for ’perinatal- depression.	**Total Score:**_____ ☐ **Initial Screening** ☐ **follow-up screening**

Patient Name:_____

RE: OBSTETRIC FEES

Dear OB Patient,

My fee for total obstetric care (global fee) is **$3500.00** for normal vaginal delivery and **$4000** for C-section, if needed. These fees include **Dr. Sudha Moola**'s services during and related to your pregnancy, delivery and post partum. (6 weeks for vaginal delivery and 8 weeks for caesarean section).

Cash arrangements can be made with our billing manager.

The following is **not** included in this fee:

1. Ultrasounds
2. Laboratory Tests
3. Non-stress tests (NST's)
4. Hospital fees
5. Fetal Monitoring
6. Pediatrician fees
7. Anesthesiologist (Epidural, etc.)
8. Office visits unrelated to routine OB care.

(i.e.: colds, urinary tract infections, other illnesses or conditions)

Your insurance company will be contacted to verify eligibility and benefits for prenatal care. You will be responsible to pay, in advance, any deductibles and/or coinsurance amounts that are required by your contract with your insurance company. <u>These contract portions must be paid by your seventh month (28 weeks) of pregnancy.</u>

My office staff will discuss your benefits and arrange for payments.

Sincerely,

Dr. Sudha Moola MD FACOG

I have read and understand that my medical coverage is a contract between my insurance company and myself. I am responsible for any deductibles and coinsurance amounts set for the by my insurance company. I will make arrangements to have my portion paid by my seventh month (28 weeks) of pregnancy. I also agree that if my insurance coverage status changes at any time, I will inform the office immediately.

Signed:_____ **Dated**_____

Insurance Company: _____