GENETIC COUNSELING BILLING FORM

Integrated GENETICS
LabCorp Specialty Testing Group

PATIENT INFORMATION (Please print legibly/Escribir legible)

Name/Nombre: last/apellido first/nombre			☐ Male Masculino ☐ Female Femenino	Patient #: Date of Birth/Fecha de Nacimiento
Address/Domicilio: Número y calle			Home Phone/Teléfono de la casa	Work Phone/No. de Teléfono del trabajo
			Social Security Number/Número de Seguro Social	
City/ Ciudad	State/Estado	Zip/Zona Postal	Genetic Counselor	Date of Appointment

CLIENT INFORMATION

Antepartum Testing Center 889934/200443
Englewood Hospital and Medical Center
350 Engle Street, Room 4125
Englewood, NJ 07631

BILLING/INSURANCE INFORMATION / INFORMACIÓN DE SEGURO PARA COBRO

(Complete Section 1 if you are paying by cash OR Section 2 to have your insurance company billed.)
(Llenar sección 1 si pago es en dinero efectivo. Llenar sección 2 si quiere que su cuenta sea enviada a su seguro médico.)

SECTION 1:

☐ Physician or Institution/Doctór ó Institución
☐ Medicare: (Copy of card required/Copia de la tarjeta)
  ☐ Inpatient/Paciente hospitalizado
  ☐ Outpatient/Paciente no hospitalizado
Card # / # de la tarjeta: _____
☐ Medicaid: (Copy of card required/Copia de la tarjeta)
Card # / # de la tarjeta: _____
State/Estado: _____
☐ California PNS Program
☐ Patient/Self-Pay/Cobro al paciente
☐ Payment Enclosed/Pago incluído

* Do not attach credit card information to this form

SECTION 2: Copy of insurance card (front & back) required, attach copy of authorization if available.
Copia de la tarjeta del seguro (parte delantera y posterior), adjuntar copia de la autorizacion si está disponible.

☐ Insurance/PPO/Seguro/PPO
☐ Blue Cross/Blue Shield
☐ *Medical Group/IPA**
  Attach co-pay/Adjuntar co-pago
☐ *HMO**
  Attach co-pay/Adjuntar co-pago

*Authorization #
*# de autorización

Non-authorized services will be billed to the patient.
Servicios no autorizados serán cobrados a Usted.

Insurance Co Name/Nombre de la compañia de seguro:
Billing Address/dirección de la compañia:
City, State, Zip/Ciudad, Estado, Zona postal:
Telephone # / # de teléfono:
Name of Insured/Nombre del asegurado:
Policy # / # de la póliza: | Group# / # del grupo:
Name of Employer/Nombre del empleador:
Relation to Insured/Parentesco con asegurado:
Self/Asegurado Spouse/Cónyuge Child/Hijo/a Other/Otro

The charge for these services is separate from any other tests or procedures. I authorize Integrated Genetics to furnish my designated insurance carrier any information concerning my services that is necessary for reimbursement. I also authorize benefits to be payable to Integrated Genetics. I understand that I am responsible for any amount not paid by insurance.

Many insurance carriers will pay only for services they deem to be reasonable and necessary or a covered service. If my insurance carrier determines that a particular service is not reasonable and necessary, my insurance carrier may deny payment. If my plan does not cover the genetic counseling or medical consult provided by Integrated Genetics, I agree to be responsible for full payment.

Signed _____ Dated _____

El cobro de estos servicios son aparte de cualquier otro examen o procedimiento. Yo autorizo que Integrated Genetics supla a mi seguro médico de cualquier información que sea necesaria para reembolso. Yo también autorizo que los beneficios sean pagados a Integrated Genetics. Yo entiendo que soy responsable por cualquier cantidad que no sea pagada por mi seguro médico.

Muchos seguros médicos solamente pagan por servicios que consideran razonables o necesarios. Si mi seguro determina que algún servicio en particular no es considerado razonable o necesario, mi seguro medico puede negar pago. Si mi plan no cubre la charla con la consejera genetica o consulta médica provista por Integrated Genetics, yo accedo hacerme responsable por la cuenta en completo.

Firma _____ Fecha _____

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Patient Information & Pregnancy Questionnaire

Last Name: _____ First Name: _____ Date of Birth (M/D/Y):_____

Address:_____ City: _____

State:_____ Zip: _____ County (CA only):_____ Occupation:_____

PARTNER INFORMATION (if the patient is pregnant, then "partner" is the father of the pregnancy)

Last Name: _____ First Name: _____

Date of Birth (M/D/Y):_____ Occupation: _____

PATIENT CONTACT INFORMATION:

Cell: _____Home: _____ Work: _____

May we leave detailed voice messages that may include **confidential medical information and test results**? ☐NO ☐YES

If yes, please provide a confidential phone number: _____

Can we leave test results with anyone else? ☐NO ☐YES If yes, please provide information below:

Name: _____ Confidential #:_____

REFERRING DOCTOR OR CLINIC INFORMATION:

Name: _____ Phone: _____

Address: _____ City: _____

PREGNANCY AND EXPOSURE INFORMATION

Are you currently pregnant? ☐NO ☐YES **Due date**: _____

Have you taken any medications during this pregnancy (besides prenatal vitamins or Tylenol)? ☐NO ☐YES
If yes, please list:

_____

_____

Since becoming pregnant, have you had any:
(or if not pregnant please check current exposures)

Recreational Drugs ☐NO ☐YES _____

Cigarettes ☐NO ☐YES _____

Alcohol ☐NO ☐YES _____

Fevers (greater than 101˚ F) ☐NO ☐YES _____

X-rays (other than dental) ☐NO ☐YES _____

Do you have any of the following conditions?

Diabetes? ☐NO ☐YES _____

A seizure disorder? ☐NO ☐YES _____

Lupus? ☐NO ☐YES _____

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE
PATIENT SIGNATURE:_____ DATE: _____

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Carrier Screening in Pregnancy for Common Genetic Diseases

Although most people have healthy babies, with every pregnancy there is a 3-4% chance to have a baby born with problems. The following are a few common, serious disorders that can occur even without a family history. You can have carrier screening (a simple blood test) before the baby is born to determine if you *carry* the genes that cause the disorders shown below.

What is a carrier?
A carrier is a person who has a gene that increases the risk to have children with a specific genetic disease. People do not know if they are carriers until they have a blood test or an affected child. Some disorders occur only if both parents are carriers and other disorders occur only when the mother is a carrier.

What is carrier screening?
Carrier screening involves a blood test from one or both parents to determine if they carry a specific gene that increases the risk for that disorder. If you turn out to be a carrier, prenatal testing such as amniocentesis or chorionic villus sampling (CVS) is available to determine if your unborn baby is affected. All testing is optional and you can choose which disorder(s) for which you want to be tested.

Disease	Cystic Fibrosis (CF)	Fragile X Syndrome	Spinal Muscular Atrophy (SMA)
Symptoms of Disease	*Most common inherited disease in North America.* A chronic disorder that primarily involves the respiratory, digestive and reproductive systems. Symptoms include pneumonia, diarrhea, poor growth and infertility. Some people are only mildly affected, but individuals with severe disease may die in childhood. With treatments today, people with CF can live into their 20's and 30's. CF does not affect intelligence.	*The most common inherited cause of mental retardation.* Fragile X syndrome is a disorder that causes mental retardation, autism, and hyperactivity. It affects both boys and girls, although boys are usually more severely affected than girls. Women who are carriers are at risk to have a child with mental retardation.	*Most common inherited cause of infant death.* SMA destroys nerve cells that affect voluntary movement. Infants with SMA have problems breathing, swallowing, controlling their head or neck, and crawling or walking. The most common form of SMA affects infants in the first months of life and can cause death between 2 and 4 years of age. Less commonly the disease starts later and people can survive into adulthood. SMA does not affect intelligence. There is no cure or treatment.
Inheritance	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with cystic fibrosis.	If a mother is a carrier, there is up to a 50% chance to have a child fragile X syndrome.	If both parents are carriers, there is a 1 in 4 (25%) chance to have a child with SMA.
General Population Carrier Frequency	1 in 25 Caucasians 1 in 26 Ashkenazi Jewish 1 in 46 Hispanics 1 in 65 African Americans ~1 in 90 Asian	1 in 260 females in North America Occurs in all ethnic backgrounds	1 in 35 Caucasians 1 in 41 Ashkenazi Jewish 1 in 117 Hispanics 1 in 66 African Americans 1 in 53 Asian
Have you ever had testing for this condition? **(please circle one)**	YES NO Not Sure	YES NO Not Sure	YES NO Not Sure
Do you want this testing or more information?	YES NO	YES NO	YES NO

Revised October 2010