Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

WELCOME TO GEORGIA PRENATAL

We are thrilled that you have chosen to put your prenatal care in our hands!
The journey ahead of you is life-changing— but we're here to help ease that process.
So, we happily welcome you to our Georgia Prenatal family & care.

In order to best serve you, we need your help!
If you would please take the time to provide us with the required information & consents outlined in this packet.

Please read below as we have provided our practice guidelines & rules:

_____

GEORGIA PRENATAL | OB CARE GUIDELINES & RULES

No Call, Now Shows ..... $25 Fee
If you fail to call within 24 hours of your appointment this fee will be applied to your account. This excludes Medicaid patients.

15 Minute Rule $00.00
Please note that if you arrive more than 15 minutes late to your scheduled appointment, you risk being rescheduled or waiting at minimum the same amount of time you were late.

COVID-19 and the Use of Masks $00.00
Due to COVID-19 and unknown omicron variants, the use of masks is optional for patients. This also applies to spouses, couples, and any other

Late to PNC $400.00
All patients who start their prenatal care with us on or after the 20 week mark are required to pay $400 of their selected prenatal care package upfront.

Georgia Prenatal

Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.

Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

Patient PRN #: _____

WELCOME TO GEORGIA PRENATAL

PATIENT INFORMATION

Last Name _____

First Name _____

Date of Birth | Month _____ Day _____ Year _____ Age _____

Social Security Number (SS#) _____Phone Number _____

Email _____

Address | Street Number _____ Street Name _____ Apt. # _____

City _____ State _____ Zip Code _____

Marital Status (Please circle one of the options below):

Single Married Divorced Life Partner Widowed

Occupation _____ Declines to Answer _____

Preferred Language: English Spanish Portuguese Other: _____

Ethnicity _____ Declines to Answer _____

Preferred Method of Communication (Please circle one of the options below):

Email SMS Voice Either, No Preference

EMERGENCY CONTACT

First & Last Name _____

Mobile Phone Number _____ Preferred Language:_____

Address | Street Number _____ Street Name _____ Apt. # _____

City _____ State _____ Zipcode _____

Do you have Health Insurance (Please circle one of the options): Yes No

If you have Health Insurance, fill in the information below:

Name of Primary Medical Insurance: _____ Policy Number: _____

Name of Secondary Health Insurance: _____ Policy Number: _____

FINANCIAL POLICY

Our goal in Georgia Prenatal is to keep your insurance and other financial arrangements as simple and clear as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

- I authorize the release of medical information to my Primary or Secondary Insurance Company as necessary to process insurance claims, insurance applications, prior authorizations, and prescriptions.
- I also authorize payment of medical benefits to the physicians.
- I am ultimately responsible for payment of charges for services I receive in your office not covered by my insurance.
- It is my responsibility to provide the office with my current address, telephone number and insurance information.
- It is my responsibility to contact my insurance carrier to confirm that the providers participate with my plan.
- If my insurance is not Active at the time of service, I will be responsible for payment in full.
- If I do not provide correct insurance information I will be responsible for payment in full.
- Co-payment, co-insurance and / or deductible not satisfied is due at the time of service.
- Lab charges not covered by your medical insurance will be billed to you.
- Any unpaid charges after delivery will be transferred to an outside collection agency.

Please be advised all patients, with insurance and self-pay (no insurance), must disclose when the patient under our care currently has private insurance, adds private/commercial insurance or medicaid. Georgia Prenatal is not responsible for any charges accrued, nonpayment, or retro pay due to not disclosing information.

I _____ understand and comply with Georgia Prenatal Financial Policy.

Signature _____ Date _____ / _____ / _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

OBSTETRIC CARE REGISTRATION

PREFERRED PHARMACY & CONSENT

This consent form authorizes Georgia Prenatal to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Georgia Prenatal can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Georgia Prenatal to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Preferred Pharmacy Name _____

Pharmacy Phone Number _____

Address _____

Patient Name _____ Date _____ / _____ / _____

Signature _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

OBSTETRIC CARE REGISTRATION

PATIENT CARE & COMMUNICATION CONSENT

MEDICAL TREATMENT Initial _____

By initialing and signing below, I authorize the providers, midwives, and nurse practitioners to treat me at the Georgia Prenatal clinic. I understand that the providers will treat me in accordance with the standards of care established by the American College of Obstetrics and Gynecology. I understand that this treatment may include laboratory tests, ultrasound, and other diagnostic procedures in order to provide me with the best care possible. All information obtained from myself by all Georgia Prenatal providers will be confidential and will remain confidential unless I sign a release of this information to another party. No one will be able to access the information in my Georgia Prenatal records without my prior written permission/consent.

PRIVACY POLICY NOTIFICATION Initial _____

It is my understanding that Georgia Prenatal has a patient privacy notice and policy, which is available for me at any time. They have made me aware of my rights as a patient and made me a copy of their policies.

(Please circle one of the options):

I choose to receive a copy I choose not to receive a copy

Patient Name _____ Date _____ / _____ / _____

Signature _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

OBSTETRIC CARE REGISTRATION

APPOINTMENT REMINDERS & GENERAL COMMUNICATION CONSENT

EMAIL Initial _____

By initialing & signing below, I am authorizing Georgia Prenatal to send me appointment reminders and practice updates via the email provided in the patient information portion of my registration.

TEXT MESSAGE Initial _____

By initialing & signing below, I am authorizing Georgia Prenatal to send me appointment reminders and practice updates via the text provided in the patient information portion of my registration. I understand that this service is offered for free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for my patient mobile phone number.

VOICE MESSAGE Initial _____

By initialing and signing below, I authorize Georgia Prenatal to call me and leave voice messages, at the phone number I provided in the patient information record, regarding my upcoming appointments and any other general updates related to my care.

Patient Name _____ Date _____ / _____ / _____

Signature _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

OBSTETRIC CARE REGISTRATION

PATIENT CARE & COMMUNICATION CONSENT HIV TESTING

I, _____ acknowledge that I have received information and advice prior to taking the Human Immunodeficiency Virus (HIV) test, the virus that causes Acquired Immunodeficiency Syndrome (AIDS). I have been informed about everything concerning this blood test, benefits and risks. I understand that HIV blood tests are not 100% accurate, they can be False Positives or False Negatives. I am also aware that a positive HIV test means that a person has probably been infected with the virus, but it does not mean that the person will develop AIDS. I have understood that even if a person does not develop AIDS, or get sick with the virus, they can transmit the virus to other people; therefore it is important to know if the Virus is present or not, to avoid contagion and thus protect other people.

I understand that the results will become part of my record and will be made available to the Medical and Administrative Staff of the Hospital, Georgia Prenatal, and Health Insurance Companies. However, the contents of my file will not be disclosed to third parties without written consent, unless authorized or required by law.

I also understand that I will be notified of the results and receive instructions after the exam. Based on this I authorize the HIV test to be performed.

Patient Name _____ Date _____ / _____ / _____

Signature _____ Date _____ / _____ / _____

Witness _____ Date _____ / _____ / _____

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

OBSTETRIC CARE REGISTRATION

PRENATAL CARE PACKAGE | SELF-PAY PATIENTS

REGULAR PRENATAL PACKAGE Initial _____

Our regular obstetric care package costs *$1,500.00 USD*, of which you have the option to pay upfront in one payment, or in 8 payments with our *Preferred Patient Payment Plan.* Should you choose to do a payment plan, please see the general agreement on the next page.

Please note that this package is for regular obstetric-care. If for any reason the doctor deems you are, for any reason, as a high-risk patient— there will be additional costs, or you can be upgraded to a high risk package. You can scan the QR code below to see if you could possibly be considered a "high-risk" patient.

WHAT COMES IN MY PRENATAL CARE PACKAGE?

Welcome Bag
All Northside Hospital Required Paperwork/ Registration, OB Info Sheets & brochures, Prenatal Vitamins, & other little gifts from us!
Routine Prenatal Appointments
Emergency Walk-In or Scheduled Appointments
Scheduled appointments are preferred, and are more likely to secure your spot.
Dating Ultrasound | *To estimate the probable date of delivery and confirm the weeks of gestation.*
Anatomy Ultrasound
Biophysical Ultrasound or Growth Ultrasound | *Depending on which ultrasound is required for the patient.*
Obstetric On-Site Labs
PAP Smear, Physical Exam | *Depending on the age*
Postpartum Appointment | *As long as you make your postpartum appointment no later than 6 weeks after giving birth.*

Patient Name _____ Date _____ / _____ / _____

Signature _____ Date _____ / _____ / _____

Could I be high risk?
Scan here & see.

Georgia Prenatal
Obstetrics-Gynecology

950 Indian Trail Lilburn Rd.
Lilburn, GA 30338
P (470) 545 - 2131
F (470) 545 -2143

info@gaprenatal.com
www.georgiaprenatal.com

OBSTETRIC CARE PAYMENT PLAN

AGREEMENT & POLICIES

PREFERRED PATIENT PAYMENT PLAN Initial_____

1st Payment	.....	$200.00 USD
2nd Payment	.....	$200.00 USD
3rd Payment	.....	$200.00 USD
4th Payment	.....	$200.00 USD
5th Payment	.....	$200.00 USD
6th Payment	.....	$200.00 USD
7th Payment	.....	$200.00 USD
Final Payment	.....	$100.00 USD

DISCOUNTS & THINGS TO KNOW:

OBSTETRIC CARE PAYMENT PLAN AGREEMENT & POLICIES

- If you would like a printed copy of your payment tracker, we can provide it upon your request.
- *Your prenatal care package must be paid in full by the time you reach 35 weeks of gestation.*
- If you are a transfer patient and are able to provide us with your medical records from your previous clinic, you will receive a discount of $150.00 USD from your total amount of $1,500.00 USD. (The discount will be applied once we have received said records).
- Your prenatal care package cost of $1,500.00 USD does not include your physician delivery fee of $1,000.00 USD or hospital delivery and additional prenatal care fees.
- If you feel this amount is out of your financial capabilities, you are encouraged to apply for Emergency Medicaid, as it will help cover all of your hospital fees. Our practice *insurance specialist* can help you with this process and information and can be reached at: billing.collections@gaprenatal.com
- If you *DO NOT QUALIFY* for *Emergency Medicaid* and do not have medical insurance, you will be required to pay your physician delivery fee of $1,000.00 USD at our practice *BEFORE* your 35th week of gestation, *IN ADDITION* to your $1,500.00 USD prenatal care package.
- If you have applied for insurance and it's pending official activation, you will still be required to pay your agreed upon self-pay package— until it has been fully processed and shows up as active on our system.
- Medicaid patients, please ensure that to call your case worker and switch your insurance policy over to PREGNANCY MEDICAID... until you do so, pending your policy type, you may acquire a copay amount due at every visit that can range between $2.00 USD to $12.50 USD.

Patient Name _____ Account Number _____

Signature _____ Date _____ / _____ / _____