

*Gary E. Farhat, M.D.*  
*Obstetrics and Gynecology*

*1100 E. Michigan - Suite 204*  
*Jackson, Michigan 49201*



*Telephone* (517) 787-6247  
*Fax* (517) 787-1988

To My Patients:

I share regular duty-call rotation for night and weekend coverage of the obstetrical requirements of my patients with Dr. Garland Scott, Michael McDonnell, Rajan Pastoriza, Arthur Vendola, who are Board Certified Obstetrician-Gynecologists.

Please note by signing below that you understand the above information and agree to continue care on said basis.

Sincerely,

Gary E. Farhat, M.D.

I have read the foregoing message, understand same, and consent that my continued care shall be on said basis.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

WITNESS:

\_\_\_\_\_

**YOUR SIGNATURE IS NECESSARY FOR US TO  
PROCESS ANY INSURANCE CLAIMS AND TO ENSURE  
PAYMENT OF SERVICES RENDERED**

For Non-Medicare Patients

I hereby assign to the Provider any and all benefits from any insurance plans or any other protection maintained by the Patient and/or for the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to the Provider for services provided to the Patient by the Provider. I certify that the information given by me to the Provider in applying for payment under Medicare and/or Medicaid programs, Insurance plans, or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

For Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Gary Farhat, M.D. for any services furnished me by that provider. I authorize any holder of my medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to the Provider in applying for payment under the Medicare program is correct and complete. I authorize release of all records required to act on this release and assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE  
READ THIS INFORMATION AND UNDERSTAND IT.

Patient Name \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

**STANDARD CONSENT FORM-THE HUMAN IMMUNODEFICIENCY VIRUS TEST**

The HIV test looks for infection with the AIDS virus. I understand that if this test shows I have the AIDS virus, I am most probably infected and could give the AIDS virus to someone else. I could pass the virus to someone I am having sex with, someone I am sharing needles with, or to my unborn baby if I am pregnant. If the test shows I do not have the AIDS virus, I understand I still might have the AIDS virus but it is too early to tell by blood test.

I understand that the information from my test will help me and my health care worker make important choices. If I do not have the AIDS virus, it will help me know how to keep from catching it or if I need another test. If I have the AIDS virus, it will help me know how to take care of myself and how to keep from passing the AIDS virus to someone else.

I understand that Michigan has laws to keep my HIV test information and other health information from being given to anyone else without my written approval. By agreeing to take this test, I understand my test information will not be shared with anyone else unless I say it is okay, in writing, except when the law says it is necessary to share my information with someone who needs to know it.

I understand I can change my mind about taking this test at any time before the test is done. I also understand I have a right to request this test be done without anyone knowing my name.

I understand I should return here to get my test information and talk about my test and if I do not come back, someone may try to get in touch with me to talk about my test.

I understand that after I sign this form, I cannot sue my testers for not making sure I know what this test is all about.

I have been given an information booklet on HIV testing. I understand what the HIV test is, what I might gain or lose from it, and the meaning of the test information. I also understand that I should ask all my questions before the test is done. I also have a copy of this signed form.

**I AGREE TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS.**

\_\_\_\_\_  
Patient/Parent/Guardian (Please Print)

\_\_\_\_\_  
Relationship, if not patient

\_\_\_\_\_  
Patient/Parent/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS.**

\_\_\_\_\_  
Patient/Parent/Guardian (Please Print)

\_\_\_\_\_  
Relationship, if not patient

\_\_\_\_\_  
Patient/Parent/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**FAMILY HISTORY:**

List any and all family members who have had any of the conditions or problems listed below. Please specify who had the problem, i.e. mother, maternal grandmother, paternal aunt, first cousin, etc.

	Your Family	This Baby's Father's Family
Twin/Multiple births	_____	_____
2 or more miscarriages(<5 months pregnant)	_____	_____
Stillborn(born dead at >5 months pregnant)	_____	_____
Child died before age 6	_____	_____
Child seriously ill	_____	_____
Mental retardation	_____	_____
Learning disabilities	_____	_____
Epilepsy/Seizure/Convulsions	_____	_____
Spina bifida(open spine)	_____	_____
Hydrocephaly(water head baby)	_____	_____
Cleft lip(hare lip/palate)	_____	_____
Down Syndrome(Mongolism)	_____	_____
Chromosomal abnormality	_____	_____
Skeletal/bone problem	_____	_____
Club foot	_____	_____
Dislocated hip	_____	_____
Birth marks	_____	_____
Other birth defects	_____	_____
Blindness	_____	_____
Deafness	_____	_____
Cancer	_____	_____
Kidney Problems	_____	_____
High Blood pressure	_____	_____
Heart problems	_____	_____
Blood or bleeding problems(anemia)	_____	_____
Hemophilia(bleeders)	_____	_____
Sickle cell disease or trait	_____	_____
Asthma	_____	_____
Diabetes(blood sugar)	_____	_____
Thyroid Problems	_____	_____
Cystic Fibrosis	_____	_____
Muscular dystrophy	_____	_____
Any trait or disease that runs in family	_____	_____

Are you or the father of this pregnancy:

- a. Related(1st cousin or closer)?    Yes    No
- b. Adopted:                            Yes    No    Who: \_\_\_\_\_
- c. Jewish:                                Yes    No    Who: \_\_\_\_\_
- d. Mediterranean origin:    Yes    No    Who: \_\_\_\_\_

**OBSTETRICAL INFORMATION QUESTIONNAIRE**

The following information will help us assist you with your pregnancy. Thank you for filling out this form before you see our physician. Enclosed is a self-addressed envelope to return the forms to us prior to your appointment.

1. Please list the starting date of your last period: \_\_\_\_\_
2. Did your last period come at the expected time?    Yes    No  
Did it last the normal number of days?            Yes    No
3. How many days between menstrual periods? 21 days 28 days 31 days irregular  
Usual length of menstrual flow \_\_\_\_\_ days.
4. Were you using any type of birth control when you became pregnant? Yes No  
If yes, what? Pills Condom Diaphragm Sponge Foam DepoProvera IUD Norplant
5. Were you using birth control pills at any time in the 6 months before you became pregnant? Yes No If yes, when did you take your last pill? \_\_\_\_\_
6. Have you had a pregnancy test? Yes No  
Type: Home pregnancy test    Date: \_\_\_\_\_  
Urine test(laboratory)        Date: \_\_\_\_\_    Where: \_\_\_\_\_  
Blood test(laboratory)        Date: \_\_\_\_\_    Where: \_\_\_\_\_

7. During this pregnancy are you frequently bothered by any of the following:

- |                         |                       |                                    |
|-------------------------|-----------------------|------------------------------------|
| _____ Headache          | _____ Nausea          | _____ Vomiting(# of times per day) |
| _____ Heartburn         | _____ Abdominal pain  | _____ Pain with urination          |
| _____ Vaginal bleeding  | _____ Constipation    | _____ Swelling of hands or feet    |
| _____ Vaginal Discharge | _____ Vaginal itching |                                    |

8. Are you on a special diet now? \_\_\_\_\_
9. Do you avoid any foods for health or religious reasons? \_\_\_\_\_
10. Have you had a fever over 101° or taken saunas or hot whirlpool baths during this pregnancy? \_\_\_\_\_
11. Have you had any illness during this pregnancy? \_\_\_\_\_

**CURRENT MEDICATIONS/DRUGS**

Please list any medicines, drugs, or vitamins you have taken since becoming pregnant (prescription or over the counter).

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Do you smoke? Yes No Cigarettes per day? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, how frequent and what amount? \_\_\_\_\_

Do you or the father of the baby use any street, illegal, or recreational drugs? If yes, please list. \_\_\_\_\_

Have you been exposed to any X-rays, chemicals, or environmental hazards since your last period? Yes No

**OBSTETRICAL HISTORY**

<u>Total Pregnancies</u>	<u>Births near your due date</u>	<u>Premature (more than 2 wks early)</u>	<u>Abortions Elective</u>	<u>Abortions Spontaneous miscarriages</u>	<u>Ectopic or Tubal Pregnancies</u>	<u>Twins</u>	<u>Living Children</u>

List all pregnancies in order and provide information for each pregnancy

Year Delivered	Length of Pregnancy (How many months or weeks)	Birth Weight	Sex	Length of Labor (hours)	Delivery Vaginal or C-section	What Anesthesia	Where Delivered?	Problems with Pregnancy delivery or baby
1.								
2.								
3.								
4.								
5.								

Check if you have ever had any of the following pregnancy complications:

- |  |   |
|--|---|
| <input type="checkbox"/> Blood sugar problems(diabetes in pregnancy) | <input type="checkbox"/> Baby died before birth                             |
| <input type="checkbox"/> Breech Deliver(bottom first)                | <input type="checkbox"/> Baby died after birth                              |
| <input type="checkbox"/> Bleeding during or after pregnancy          | <input type="checkbox"/> Fever or infection during pregnancy/after delivery |
| <input type="checkbox"/> High blood pressure                         |   |

**HEALTH HISTORY:** Check if you have had or been told that you had any of the following problems or conditions:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Endometriosis                                     | <input type="checkbox"/> Heart problems              | <input type="checkbox"/> Diabetes(blood sugar problems)    |
| <input type="checkbox"/> Breast problems                                   | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Kidney/Bladder/Urine problems     |
| <input type="checkbox"/> Thyroid problems                                  | <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Epilepsy/Seizures/Convulsions     |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Pneumonia/Bronchitis        | <input type="checkbox"/> Sickle Cell disease or trait      |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Migraine headaches          | <input type="checkbox"/> Blood clots in legs or lungs      |
| <input type="checkbox"/> Skin problems                                     | <input type="checkbox"/> Bleeding problems           | <input type="checkbox"/> Stomach/Intestine problems        |
| <input type="checkbox"/> Muscle problems                                   | <input type="checkbox"/> Psychiatric problems        | <input type="checkbox"/> Hepatitis(yellow jaundice)        |
| <input type="checkbox"/> Back problems                                     | <input type="checkbox"/> Abnormal pap smear          | <input type="checkbox"/> Rubeilla(3-day or German measles) |
| <input type="checkbox"/> Infertility problems(difficulty getting pregnant) |  |  |
| <input type="checkbox"/> Cancer: type _____                                |  |  |
| <input type="checkbox"/> Sexually Transmitted Disease: type _____          | <input type="checkbox"/> Syphilis                    | <input type="checkbox"/> HIV/Aids                          |
| <input type="checkbox"/> Herpes  | <input type="checkbox"/> Gonorrhea                   | <input type="checkbox"/> Hepatitis B                       |
| <input type="checkbox"/> Chlamydia   | <input type="checkbox"/> Condyloma or venereal warts |  |

Have you ever had a blood transfusion? Yes \_\_\_ No \_\_\_ If yes, what year? \_\_\_\_\_

Do you know your blood type? If so, what is it? \_\_\_\_\_

If Rh negative, have you ever received Rhogam? \_\_\_\_\_

**MEDICAL HISTORY**

Hospitalizations/Surgery: List any time you have been in the hospital or any time you have had surgery. Pregnancies are already covered above and need not be reported.

Year	Why?	What was done?	Where?

Are you allergic to any medications?

Name of Drug	What happens?

**PREGNANCY AND DELIVERY PLANS**

Check if you are interested in any of the following:

- Prepared Childbirth Classes
- Birthing Room
- Postpartum Tubal Ligation
- Breast-feeding

- Anesthesia preferred:
- No preference
  - Natural Childbirth
  - Epidural
  - Local anesthetic

If male baby-do you want child circumcised? Yes No

Physician of Choice for care of baby: \_\_\_\_\_

Please list any other interests, concerns, or questions you would like to discuss during your appointment.

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To our patients:

Please notify the Medical Assistant of any special instructions that you may have for your **lab work**. As a general rule, most lab work is sent to Foote Hospital. If you or your insurance company require your lab work be sent to any other location, it is necessary to inform the Medical Assistant **PRIOR** to labs being sent out.

We are not responsible for labs being sent to the wrong location, if not specified at the time of service.

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Patient Signature

Date

# PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

\_\_\_\_\_

\_\_\_\_\_

2. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information.

( ) \_\_\_\_\_, this number is my: HOME WORK OTHER

3. Can confidential messages (i.e.: appointment & out pt service reminders) be left on your home phone answering machine or voicemail? YES NO

4. Can confidential messages (i.e.: appointment & out pt service reminders) be left with a family member that answers your home telephone? YES NO

If so who? \_\_\_\_\_

5. If you do not have voicemail, can a confidential message be left at your place of employment? YES NO  
If yes, list number \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_ WITNESS \_\_\_\_\_

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WOMENS ALLIANCE of JACKSON  
PRIVACY ACT

GARY FARHAT MD  
GARLAND SCOTT MD

I have been given the HIPAA Privacy Statement to read and take with me to keep for reference.

I understand that Womens Alliance of Jackson, P.C. has notified me of their privacy policy.

I understand this document will be in my patient file.

I understand I will be notified of any changes to the Privacy Statement.

PATIENTS NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

\* valid, unless revoked in writing.

# PATIENT INFORMATION FOR MEDICAL RECORDS

## PATIENT INFORMATION

PLEASE PRINT

TODAYS DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Last First M

Address \_\_\_\_\_  
Street City State Zip

Phone (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ FAMILY Doctor \_\_\_\_\_  
Home Work

SSN \_\_\_\_\_ Marital Status M \_\_\_ S \_\_\_ W \_\_\_ D \_\_\_ Sep \_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## SPOUSE, PARENT, OR GUARDIAN INFORMATION:

Name \_\_\_\_\_ SSN \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Last First M

Address \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_ Address \_\_\_\_\_

## 1ST INSURANCE COVERAGE

Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance address \_\_\_\_\_ Effective date \_\_\_\_\_

Subscriber \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient \_\_\_\_\_

## 2ND INSURANCE COVERAGE

Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance address \_\_\_\_\_ Effective date \_\_\_\_\_

Subscriber \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient \_\_\_\_\_

## 3RD INSURANCE COVERAGE

Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance address \_\_\_\_\_ Effective date \_\_\_\_\_

Subscriber \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient \_\_\_\_\_

## PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, have insurance coverage with \_\_\_\_\_ Name of Insurance Carrier  
and assign directly to \_\_\_\_\_ all surgical and/or medical benefits, if  
Name of Doctor

any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby, authorize the doctor to release all information necessary to secure the payment of benefits.

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SIGNED \_\_\_\_\_

The Health of you and your baby are important to us... Taking a few minutes now to answer these questions will help us provide you with the care and services you need.

Please answer each question by putting an X in the box next to the answer.

1. Was this a planned pregnancy?

Yes  No

2. How do you feel about this pregnancy now?

happy  unhappy  not sure

3. Are there any barriers that keep you from meeting your health care needs? If so, check all that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Transportation                            | <input type="checkbox"/> Child care                            |
| <input type="checkbox"/> Lack of health insurance                  | <input type="checkbox"/> Language barrier                      |
| <input type="checkbox"/> Finances - lack money to meet basic needs | <input type="checkbox"/> Understanding health care information |
| <input type="checkbox"/> Cultural barriers                         | <input type="checkbox"/> Work hours                            |
| <input type="checkbox"/> Clinic or office hours                    | <input type="checkbox"/> None                                  |
| <input type="checkbox"/> Other _____                               |  |

4. How long has it been since you had a dental cleaning and checkup?

less than a year  more than a year

5. Did you breastfeed any of your other children?

yes  no  does not apply

6. Do you plan to breastfeed this baby?

yes  no  not sure

7. How do you rate your current stress level?

low  medium  high

8. During the last two weeks have you felt unhappy, sad, or hopeless?

yes  no

9. During the last two weeks have you had little interest or pleasure in going things you used to enjoy?

yes  no

10. Do you or anyone in your family have a history of nerves, depression or other mental health issues?

yes  no  don't know

11. Is there someone you can count on to help you during your pregnancy and with your new baby?

yes  no  not sure

12. How many times have you moved in the past 12 months?

0-2    3 or more

13. Do you currently have any housing concerns?

yes    no

14. Do you have enough food for your family?

always    sometimes    never

15. Are you in a relationship with anyone who threatens you, yells at you, or tries to control you?

yes    no

16. Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by someone?

yes    no

17. Within the last year has anyone forced you to engage in sexual activities that made you feel uncomfortable?

yes    no

18. Have you ever been emotionally, physically or sexually abused?

yes    no

19. In the month before you knew you were pregnant how many cigarettes did you smoke each day?

I didn't smoke then    less than half a pack    half to one pack    more than one pack

20. Do you smoke now?

yes    no

21. Does anyone smoke in your home or workplace?

yes    no

22. In the month before you knew you were pregnant how much beer/liquor/wine did you drink?

did not drink then    less than 7 drinks per week    more than 7 drinks per week

23. Do you drink now?

yes    no

24. Does your partner use alcohol?

yes    no

25. In the month before you knew you were pregnant, did you use any street drugs or drugs not prescribed by your doctor?

yes    no

26. Does your partner use street drugs?

yes    no

27. Is there anything else you would like to tell us? \_\_\_\_\_



## MATERNAL SERUM SCREENING

**Patient's name:** \_\_\_\_\_

**Maternal serum screening brochure provided on (date):** \_\_\_\_\_

### INFORMED CONSENT

The recommended test for maternal serum screening is the **Quadruple Test**. It requires a blood sample from a pregnant woman who is between the 15<sup>th</sup> and 22<sup>nd</sup> weeks (4-5 months) of pregnancy.

The Quadruple Test measures the levels of alpha fetoprotein (AFP), unconjugated estriol (uE3), chorionic gonadotropin (BhCG), and inhibin-A (DIA) in a pregnant woman's blood. The woman's age and the levels of these four biochemical markers are used to assess the risk for certain pregnancy complications.

- The purpose of screening is to identify if you are at an increased risk to have a baby with the following:
  - Open neural tube defect, open abdominal wall defect, or Down syndrome.
- The screening may also be helpful in identifying:
  - Women at risk for having a baby with trisomy 18, Smith-Lemli-Optiz syndrome, a low birth weight baby, premature delivery, placental abnormalities, or fetal loss.
  - Women who may be carrying twins.
  - Women whose pregnancies are further along or not as far along as expected.
- Maternal serum screening does not diagnose birth defects. About 1 in 20 (5%) of women who have this screening will have an abnormal result. Abnormal results are an indication for further evaluation of the pregnancy to determine whether or not there is a problem, such as the ones listed above. If your maternal serum screening results are abnormal, your prenatal care provider may recommend other kinds of tests, such as an ultrasound or amniocentesis.

Continued...

- Maternal serum screening does not identify all fetal abnormalities. The screening will pick up approximately 85% of open spina bifida cases and 75% of open abdominal wall defects. The **Quadruple Test** will pick up about 76% of Down syndrome pregnancies. The **Triple Test** is also available. It uses three biochemical markers instead of four at a lower cost. The Triple Test will pick up about 69% of Down syndrome pregnancies.
- You may stop the screening at any time without changing the prenatal care you may need now or in the future.
- The decision to pursue screening is voluntary.

You have been provided a brochure with written information about maternal serum screening. You have been given the opportunity to have your questions answered by informed medical professionals.

The MSU Prenatal Screening program has permission to obtain information from any medical records relevant to maternal serum screening. The screening results will be available through your requesting physician.

<p><input type="checkbox"/> Yes, I want maternal serum screening.</p> <p><input type="checkbox"/> No, I do not want maternal serum screening.</p>
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Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_