Integrated GENETICS
LabCorp Specialty Testing Group

PATIENT INFORMATION & PREGNANCY QUESTIONNAIRE

PATIENT INFORMATION

Last Name: _____ First: _____ Birth date (M/D/Y):_____ Age: _____

Address: _____ City: _____

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

PARTNER INFORMATION

Last Name: _____ First: _____ Birth date (M/D/Y):_____ Age: _____

Occupation: _____ Is your partner the biological father of the pregnancy? ☐NO ☐YES

If no, did you use a sperm donor? ☐NO ☐YES

PATIENT CONTACT INFORMATION AND AUTHORIZATION

Cell: _____ Home: _____ Work: _____

May we leave a detailed voice message that includes **confidential medical information and test results**? ☐YES ☐NO

If YES, check all that apply: ☐Cell ☐Home ☐Work

If we are unable to reach you, is there another person with whom we can leave a detailed voice message that includes **confidential medical information and test results**: ☐NO ☐YES If YES, complete below:

Name: _____Relationship:_____Number: _____

●Patient has the right to revoke permission for the confidential voice mail ●Patient assumes responsibility for information left on the confidential voice mail

REFERRING DOCTOR (PRIMARY OB/GYN) OR CLINIC INFORMATION

Name: _____ Phone: _____

Address: _____ City: _____ State: _____

PREGNANCY AND EXPOSURE INFORMATION

Do you have or have you ever had any of the following?

Diabetes? ☐NO ☐YES
Seizure disorder? ☐NO ☐YES
Lupus? ☐NO ☐YES
Graves' disease or Hashimoto Thyroiditis or thyroid cancer? ☐NO ☐YES

Are you currently pregnant? ☐NO ☐YES

Due date: _____

Are you or the biological father of the pregnancy adopted?
☐NO ☐YES If yes, please specify: _____

Do you take any medications on a regular basis? ☐NO ☐YES
If yes, please specify. If you are pregnant, please list any medications you have taken since conception (other than prenatal vitamins and Tylenol): _____

_____

_____

Since becoming pregnant, have you had any:

Cigarettes ☐NO ☐YES _____
Alcohol ☐NO ☐YES _____
Recreational Drugs ☐NO ☐YES _____
Fevers (greater than 101˚ F) ☐NO ☐YES _____
X-rays (other than dental) ☐NO ☐YES _____

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE: _____ **DATE:** _____

Genetic Counseling Patient Rights and Obligations

Reproductive Genetic Counseling

Your health care provider has referred you to Integrated Genetics/Esoterix Genetic Laboratories for genetic counseling. In addition to providing genetic counseling services, Integrated Genetics/Esoterix Genetic Laboratories performs genetic testing. Genetic counselors support patients and their physicians by identifying genetic risks, explaining appropriate genetic testing options, discussing the implications of test results, and helping patients make informed healthcare decisions.

During the genetic counseling session, the genetic counselor will ask you detailed questions about your personal reproductive history, as well as your personal and family medical history. Based on the information provided during the session, the genetic counselor will identify and discuss identified genetic risk factors that may affect you or your offspring. The genetic counselor will explain any available test and procedure options, such as amniocentesis, including their benefits and limitations. Based on your inclination and your judgment, you decide whether or not to have any genetic tests or procedures. The decision is entirely yours.

It is important to understand that the genetic counselor will use only the information provided by you and your health care provider's office in order to assess specific genetic risks. It is your responsibility to ensure that the information provided to the genetic counselor is as accurate and complete as possible. If any relevant genetic test results are unavailable at the time of genetic counseling, the genetic counselor cannot provide you with the most relevant risk assessment regarding these test results and the underlying genetic condition(s). It is your responsibility to contact your current and former health care provider's offices to forward any relevant test results to the genetic counselor and to contact the genetic counselor to schedule a follow-up consultation if you desire further risk assessment regarding these test results. If you learn any new or different information about your family or reproductive history, it is likewise your responsibility to recontact the genetic counselor following your genetic counseling appointment. If you choose to email necessary test results or other medical information or records to your genetic counselor, you will assume all responsibility for the security of the e-mail transmission and any potential risk of your e-mail being misdirected to any unintended recipient.

Our policy prohibits audio/video recording of the genetic counseling session or taking photographs/video of the materials or genetic counselor.

You may decide to proceed with the genetic testing that you discussed with the Integrated Genetics' genetic counselor. It is your responsibility to ensure the testing you have requested is performed. Your physician is responsible for ordering the testing and selecting the laboratory which will perform the testing.

Your genetic counselor will discuss with you how you will receive your test results. Results for most genetic tests are available in approximately 2 to 3 weeks. If you are expecting that either the genetic counselor or your health care provider's office will contact you with test results, and you have not heard from them in 2 to 3 weeks after testing, you should contact either your health care provider's office or the genetic counselor.

The genetic counselor provides genetic counseling at the request of your health care provider. Charges for genetic counseling and any genetic testing are separate from any ultrasound or physician charges during your pregnancy. Integrated Genetics/Esoterix Genetic Laboratories will bill your insurance company if you have provided insurance information to us. You will be responsible for payment of any remaining balance, including any deductible, co-payment or co-insurance.

Thank you for reviewing this and we hope you find this information helpful in understanding the role of genetic counseling. Please sign below to acknowledge that you have received and reviewed the above information.

Patient Name: _____ Reviewed with patient during TGC (GC initials: _____)

Patient DOB: _____

Genetic Counselor: _____ Phone: _____ Date: _____

GENETIC COUNSELING BILLING FORM

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
			Referring Physician Name (First and Last)/Médico Remitente (nombre y apellido)	
City/ Ciudad	State/Estado	Zip/Zona Postal	Genetic Counselor	Date of Appointment

CLIENT INFORMATION

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 compañía 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 _____

Integrated Genetics is a business unit of Esoterix Genetic Laboratories, LLC, a wholly-owned subsidiary of Laboratory Corporation of America Holdings..

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
☑ TO INTEGRATED GENETICS

I hereby authorize the use or disclosure of my medical records as described below:

- I understand that this authorization is voluntary.
- I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

Patient name _____
Last First
DOB _____
Also Known As _____
Home Address , , , _____
Other identifying data _____
(chart #, ID #, date services provided)

I hereby authorize _____The CA Prenatal Screening Program____ to release

the medical records (including those which may contain confidential information) to _____Integrated Genetics_____

We are especially interested in:
CA Prenatal Screening Program results from the first and/or second trimester

_____ _____
(Signature of Patient) (Date)

Or

_____ _____
(Signature of Parent/Legal Guardian) (Date)

_____ _____
(Witness) (Expiration Date of Medical Release)