INTERMED
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Welcome and thank you for selecting InterMed Obstetrics and Gynecology as your health care provider during your pregnancy. Choosing a physician is an important decision and we are honored that you have entrusted your care to us. Our staff takes great pride in providing the highest quality health care to patients in all stages of life.

To best serve your needs and enhance your visit, we have enclosed paperwork for you to review and complete prior to your first appointment:

- **Enclosure 1: Authorization to Release Health Care Information**
  This form authorizes your previous primary care or Ob-Gyn provider to transfer your medical records to InterMed.
  Please complete and return this form directly to your previous primary care or Ob-Gyn provider as soon as possible.

- **Enclosures 2-7: Patient Authorization Form and Medical History Forms**
  Thoroughly complete these forms and bring them to your first appointment.

- **Enclosures 8-10: General Patient Information**
  These enclosures are informational only. No action is necessary.

Please bring your health insurance card and driver's license or state issued identification to your appointment. Learn more about InterMed and our services by visiting www.intermed.com. We look forward to meeting you!

Sincerely,
InterMed Obstetrics and Gynecology Team

Address
84 Marginal Way, Portland, 9th floor

Phone Number
(207) 874-2445

Parking
Free and onsite in the parking garage on levels 1 and 2.

Directions
From I-295 take Exit 7 (Franklin Street). Turn right onto Marginal Way. Travel 0.3 miles and look for our building on the right, just before the intersection of Marginal Way and Preble Street.
The entrance to our parking garage is directly across the street from Trader Joe's.

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Obstetrical Care and Insurance Coverage

We appreciate the opportunity to provide you with the healthcare and services you will need during your pregnancy. This letter is to acquaint you with our billing procedures during your obstetrical care at InterMed's Obstetrics and Gynecology Department.

Your insurance carrier determines the maternity coverage portion of your policy, we strongly urge you to contact and discuss the details of your coverage and benefits with a representative. In the event you do not have insurance, InterMed's billing office team will be glad to assist you with setting up a payment plan.

As a courtesy to you, we will submit any costs associated with your prenatal visits, delivery, and post-partum care to your insurance carrier at the time of your delivery. If your insurance carrier changes during your pregnancy, please notify us of the termination date for the old insurance and present your new insurance card to the front office staff with the effective date.

Costs that will be billed to your insurance carrier at the time of services will be ultrasounds and any blood work that may be required during your pregnancy.

We do deliveries at Maine Medical Center, who will be submitting charges for your stay along with the baby's stay after delivery.

Your health is very important to us. We are committed to providing you with exceptional care and want your pregnancy to be a stress-free experience. If you have any questions, please contact our billing office team at 207-828-0361.

Enclosure 1

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

Note: If this form is not completed in its entirety, it will result in a delay in processing.

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Patient Name:_____ Previous Name:_____ DOB:_____
Address:_____ Telephone Number:_____

Section 1: I hereby authorize InterMed, P.A.: (Please select one)

☐ **Verbal communication only to/from:**
☐ **Disclose the information described below to:**
☐ **Obtain the information described below from:**

InterMed, P.A.
100 Gannett Drive, Suite C.
South Portland, ME 04106
Phone: (207) 523-3963 opt 2., Fax: (207) 523-8581

Name/Facility:
Address:
City, State, Zip Code:
Phone Number:
Fax Number or Email:

Section 2: Purpose of Request: (Select at least one)

☐ Transfer of care (leaving or joining InterMed)
- Please indicate the reason for transfer (optional): _____

☐ Coordination of care (NOT transferring)
☐ Disability/FMLA
☐ Insurance Application
☐ Legal Matter(s)
☐ Workers Compensation
☐ At my request

Section 3: Please authorize the following information: (Select all that apply)

☐ Last Two (2) Years of Medical Records
☐ Physical Exams
☐ Office Visit Notes
☐ Immunization Records
☐ Lab and Pathology Results and Reports
☐ Radiology Reports
☐ Radiology Films
☐ Other Specific Records: _____
☐ If more than two (2 years) of records are required, please specify the time frame: _____

Section 4: Sensitive information to be released

I understand that my specific consent is necessary to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. I understand that authorizing the release of such information does not confirm the existence of such history of treatment. **By checking the boxes below, I DO authorize that specific health information to be released:**

☐ Information derived from services by a mental health professional
☐ Alcohol and/or Drug Abuse Treatment
☐ AIDS/HIV
I wish to review mental health, substance abuse or HIV records prior to disclosure ☐

I understand that health care information is confidential and will not be disclosed without my authorization, unless otherwise permitted by law. I understand that InterMed cannot condition treatment or payment on whether I sign this form. If I do not sign this form, however, I understand that my refusal could result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences.

This authorization expires 24 months from the date I sign it. I have the right to revoke this authorization in writing at any time. This will not apply to information disclosed before I provide my revocation but will prevent further disclosures. I understand that once this information is disclosed, it may no longer be subject to Federal privacy rules and might be further disclosed by the recipient. I understand that I have a right to request a copy of the authorization. My signature below indicates that I have read and understand this authorization.

Signature:_____ **Date**:_____

Relationship to patient (if not patient): ☐ Parent ☐ Legal Guardian ☐ Other Legally Authorized Representative

Enclosure 2

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Adult Patient Authorization Form

Patient's Legal Name:_____ **Date of Birth:** _____
First MI Last (preferred) MM/DD/YYYY

Mailing Address:_____
Street City State Zip

E-mail Address: _____

Consent for Treatment: I (print name) _____ consent to routine medical treatment and/or evaluation including but not limited to laboratory and x-ray examinations. I understand that separate consents will be requested for certain special procedures. I also understand I have the right to refuse any proposed procedure or treatment.

Signature: _____ **Date:** _____

Preferred Telephone Number: ☐ Home ☐ Cell ☐ Work	**Okay to leave a <u>detailed</u> voice message?** *May contain medical and/or prescription information*
Home: (_____) _____ - _____	☐ Yes ☐ No
Cell: (_____) _____ - _____	☐ Yes ☐ No
Text message communication: InterMed utilizes text messaging to better serve patients in a convenient manner including appointment reminders, important visit instructions and non-specific clinical information. Message and data rates may apply. I understand I may revoke my election to receive texts by reaching out to InterMed at any time. Please see other side of document for additional information.	☐ I consent to receive text messages ☐ I do **<u>not</u>** consent to receive text messages
Work: (_____) _____ - _____	☐ Yes ☐ No

Primary Coverage	Insurance Carrier:	Subscriber ID:	Group #:
Secondary Coverage	Insurance Carrier:	Subscriber ID:	Group #:

Emergency Contact Information: Please specify your preference for communication should an emergency arise. If the person specified should also receive authorization to communicate on your behalf, please indicate in the section below.

Emergency Contact Name:_____ Relationship:_____
First Last

Emergency Telephone**:** (_____)_____(_____)_____(_____) _____
Home *Work* *Cell*

Communication Authorization: You may specify up to three individuals authorized to receive routine <u>verbal</u> communication about your healthcare, other than mental health treatment. Disclosure of mental health treatment status requires execution of InterMed's release of information. Please provide their <u>first and last names</u>, and the information you authorize to be shared with each individual.

Name:	☐ Prescription Request ☐ Referral Request	☐ Request a new Appointment ☐ Request Changes to Appointment	☐ Medical inquiries/status updates
Name:	☐ Prescription Request ☐ Referral Request	☐ Request a new Appointment ☐ Request Changes to Appointment	☐ Medical inquiries/status updates
Name:	☐ Prescription Request ☐ Referral Request	☐ Request a new Appointment ☐ Request Changes to Appointment	☐ Medical inquiries/status updates

Continue to other side →

INTERMED
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Adult Patient Authorization Form

Patient's Legal Name:_____ **Date of Birth:** _____
First MI Last (preferred) MM/DD/YYYY

MyInterMed Patient Portal Enrollment: MyInterMed is a secure, web-based platform that allows you and your care team bi-directional communication about your non-urgent matters. You can also view your medical record, upcoming appointments, lab results, request prescription refills, & more. Usage of the portal is restricted to communication regarding your care and is not to be used to communicate about the care of others. Enrollment is free.

☐ Enroll me
☐ Do **not** enroll me
☐ Currently Enrolled

Carequality/Commonwell Health: To facilitate primary care and communication with other healthcare practitioners or facilities who have been or may become involved in my care both within and outside the State of Maine I agree to be enrolled in Carequality and Commonwell Health. These are tools that InterMed uses to exchange data with other providers in real-time including pertinent clinical information to assist in the delivery of care, especially in emergency situations; to clinical and non-clinical personnel who may now or in the future become involved in both the management and transition of my care between hospitals, medical practices, other health care facilities and home including care coordination and case management services; and for other lawful functions

☐ Enroll me
☐ Do **not** enroll me
☐ Currently Enrolled

Satisfaction Surveys: InterMed seeks patient feedback after each visit to continuously improve the patient experience. These surveys may be conducted via automated dialing service and/or an artificial or prerecorded voice.

☐ I consent to receive surveys
☐ I do **not** consent to receive surveys

Text Messaging: Text messaging does not use encryption, and there is some risk when information is sent by text message. InterMed has chosen specific non-sensitive clinical information that may be sent to an individual who opts into the service. Example texts could include, but are not limited to, a notification that your labs or imaging were normal, alerts that a result has been posted to your portal, or a confirmation that a refill request has been sent to your pharmacy. If at any time you wish to opt out of receiving non-sensitive clinical information by text, you may do so.

This authorization should be updated every 12 months. This authorization will remain current until an updated version is received, or this version is revoked in writing. I understand I have the right to revoke this authorization in writing at any time. Revocation will not cover information that has already been released. **I understand that I will need to complete InterMed's Authorization to Release Health Care Information form or provide an equivalent HIPAA compliant authorization if I wish to allow my provider to discuss health information not covered by the categories listed above.**

_____ _____
Patient/ Legal Guardian Signature **Date**

Enclosure 3

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Date: _____

First Name:	Middle Name:	Last Name:	Date of Birth:	Physician:
Date of last physical exam, with whom:				
Referring Physician:				

Medications: Please list all prescriptions including over-the-counter medications _____ None

Medication	Dose (# mg)	Instructions (ex: 1 daily)	How long have you been on this medication?

Write in the names of any diseases or conditions you have: _____ I do not have any medical problems

_____

_____

_____

Write in the names of any other provider(s) you obtain care from: _____ I do not have additional providers

_____

_____

_____

Serious illnesses which you have had: (ex: requiring hospitalization) _____ I have never been hospitalized

_____

_____

_____

_____

_____

Write in the names of any operations which you have had: _____ I have had no prior surgeries

Operation	Year	Operation	Year

Continued on other side…

Name any drugs to which you are allergic, list the symptoms caused: _____ No known medication allergy

Medication	Reaction

Have you ever had any of the following problems? If so, please provide approximate date (month/year):

Heart Attack:	Stroke:
Seizure:	Blood transfusion:
Cancer of, please specify:	
Sports injuries (including concussions):	

Do you know of any blood relative who has or had any of the following problems:

_____ I do not know my family history

Please circle and give relationship:

Cancer: Breast	Epilepsy	Heart attack
Colon	Suicide	Stomach ulcers
Melanoma	Migraine	Kidney stones
Ovary	Asthma	Thyroid problems
Other	Eczema	Arthritis
Stroke	Bleeding problems	Leukemia
High blood pressure	Glaucoma	High cholesterol
Tuberculosis	Diabetes	Congenital heart disease
Colon polyps	Mental illness	Mitral valve prolapse
Colitis	Depression	Heart valve problems
Osteoporosis	Alcoholism	Aortic aneurysm
Other:		

Family History		If Living		If Deceased	
	Sex	Age	Medical Problems	Age of Death	Cause
Father					
Mother					
Brothers / Sisters					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband / Wife					
Sons / Daughters					
	M F				
	M F				
	M F				
	M F				
	M F				

Print Name: _____

Date of Birth: _____

Date: _____

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You may complete this form online through your MyInterMed account at **www.intermed.com.**

This visit is scheduled to be for preventive health. In addition to your preventive care needs, please list below other topics or concerning symptoms you may be having and wish to discuss today:

(Please be aware that there may be additional charges to discuss non-preventive topics.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list below any changes to your personal medical history that we may not be aware of:

1. _____
2. _____
3. _____

Please list below any changes to your life history (job, kids, relationships, etc.) or to your family's history since we last met:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list your medications below, including both prescription and over the counter medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please tell us if you have any of the following potentially concerning symptoms.

Heart/Blood Vessels
Chest pain
Shortness of breath
Irregular, fast, or unusually strong heartbeats
Leg swelling
Leg pain/cramping with walking
Fainting or dizziness

Lungs
Wheezing
Bothersome cough
Bloody sputum

Stomach/Bowels
Abdominal pain
Blood in stool
Excessive diarrhea
Change in bowel movements

Systemic Symptoms
Night sweats
Unexplained weight loss/gain
Fever or chills
Excessive thirst or hunger

Bladder/Sexual Organs
Blood in urine
Painful urination
Abnormal discharge
Heavy or irregular periods
Vaginal bleeding after menopause
Vaginal bleeding after sex
Sexual dysfunction
Breast mass

Skin
Black/bleeding/changing moles

Mental Health
Bothersome stress
Bothersome anxiety
Thoughts of self-harm

Brain/Nerves
Loss of coordination
Weakness in limbs
Slurred speech

Vision
Partial or temporary loss of vision

Provider Signature:_____ Patient Signature:_____

Print Name: _____

Date of Birth: _____

Date: _____

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Emotions:

Are you receiving mental health counseling? ☐ Yes ☐ No

Over the last two weeks, how often have you been bothered by or had little interest in doing things?
☐ Not at all ☐ More than half the days
☐ Several days ☐ Nearly every day

Over the last two weeks, how often have you been feeling down, depressed, or hopeless?
☐ Not at all ☐ More than half the days
☐ Several days ☐ Nearly every day

Social Determinants of Health:

Do you put off or neglect going to the doctor because of distance or transportation? ☐ True ☐ False

Within the past 12 months, have you worried that your food would run out before you got money to buy more?
☐ Often true ☐ Sometimes true ☐ Never true
☐ Don't know/decline

Within the past 12 months, has the food you bought not lasted and you didn't have money to get more?
☐ Often true ☐ Sometimes true ☐ Never true
☐ Don't know/decline

How often do you feel lonely?
☐ Often/Always ☐ Some of the time ☐ Occasionally
☐ Hardly Ever ☐ Never

Gender/Sexuality:

Do you think of yourself as: ☐ Straight or heterosexual
☐ Gay or lesbian ☐ Bisexual ☐ I do not know
☐ Choose not to disclose ☐ Other_____

What is your current gender identity: ☐ Female ☐ Male
☐ Gender queer or not exclusively male or female
☐ Choose not to disclose

What is your preferred pronoun: ☐ He/him ☐ She/her
☐ They/them ☐ Other_____

Are you sexually active? ☐ Yes ☐ No
Is/Are your sexual partner(s): ☐ Male ☐ Female ☐ Both
Have you had any new sexual partners since your last visit?
☐ Yes ☐ No
If yes, do you use condoms/protection?
☐ Always ☐ Sometimes ☐ Never
Contraception method(s): _____

Would you like to be screened for STDs? ☐ Yes ☐ No

Tobacco/Alcohol/Drug Use:

Smoking/Tobacco History:
☐ Current smoker ____ packs/day
☐ Former smoker and quit _____ years ago
☐ User of chewing tobacco/snuff/vaporized nicotine
☐ Never smoked or used tobacco

Marijuana use:

How many times in the past year have you used marijuana?
☐ Never ☐ Less than daily ☐ Daily

Drug use:

How many times in the past year have you used an illegal drug (not marijuana) or used a prescription medication for non-medical reasons?
☐ Never ☐ Once or twice ☐ Other _____

Alcohol use:

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ Two to four times a month
☐ Two to three times a week ☐ Four or more times a week

On days that you drink, how many standard drinks containing alcohol do you consume?
☐ None, I do not drink ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6
☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly
☐ Weekly ☐ Daily or almost daily

Lifestyle:

Do you exercise at least 150 minutes per week? ☐ Yes ☐ No
Number of days per week: _____
Do you eat a healthy diet? ☐ Yes ☐ No ☐ I Don't Know
Any concerns regarding weight or eating? ☐ Yes ☐ No
Have you had an eye exam in the past year? ☐ Yes ☐ No
Have you had a dental exam in the past year? ☐ Yes ☐ No
Are the guns in your home secured safely and separately from ammunition? ☐ Yes ☐ No ☐ N/A

Do you have a living will? ☐ Yes ☐ No

History/Risk of Falling:

Have you fallen in the last year? ☐ Yes ☐ No
If yes, did that fall result in injury? ☐ Yes ☐ No
Do you feel unsteady when standing or walking? ☐ Yes ☐ No
Are you worried about falling? ☐ Yes ☐ No

Domestic Abuse:

Is violence at home a concern for you? ☐ Yes ☐ No
Do you have past or current experience of being physically, emotionally, or sexually abused? ☐ Yes ☐ No

Provider Signature:_____ Patient Signature:_____

Enclosure 4

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____

Your Date of Birth:_____ Delivery date or estimated due date:_____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

Yes, all of the time	___(0)
Yes, most of the time	x (1)
No, not very often	___(2)
No, not at all	___(3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

In the past 7 days:

1. **I have been able to laugh and see the funny side of things:**
   - As much as I always could ___(0)
   - Not quite so much now ___(1)
   - Definitely not so much now ___(2)
   - Not at all ___(3)

2. **I have looked forward with enjoyment to things:**
   - As much as I ever did ___(0)
   - Rather less than I used to ___(1)
   - Definitely less than I used to ___(2)
   - Hardly at all ___(3)

3. **I have blamed myself unnecessarily when things went wrong:**
   - Yes, most of the time ___(3)
   - Yes, some of the time ___(2)
   - Not very often ___(1)
   - No, never ___(0)

4. **I have been anxious or worried for no good reason:**
   - No, not at all ___(0)
   - Hardly ever ___(1)
   - Yes, sometimes ___(2)
   - Yes, very often ___(3)

5. **I have felt scared or panicky for no good reason:**
   - Yes, quite a lot ___(3)
   - Yes, sometimes ___(2)
   - No, not much ___(1)
   - No, not at all ___(0)

6. **Things have been getting to me:**
   - Yes, most of the time I haven't been able to cope at all ___(3)
   - Yes, sometimes I haven't been coping as well as usual ___(2)
   - No, most of the time I have coped quite well ___(1)
   - No, I have been coping as well as ever ___ (0)

7. **I have been so unhappy that I have had difficulty sleeping:**
   - Yes, most of the time ___(3)
   - Yes, sometimes ___(2)
   - No, not very often ___(1)
   - No, not at all ___(0)

8. **I have felt sad or miserable:**
   - Yes, most of the time ___(3)
   - Yes, quite often ___(2)
   - Not very often ___(1)
   - No, not at all ___(0)

9. **I have been so unhappy that I have been crying:**
   - Yes, most of the time ___(3)
   - Yes, quite often ___(2)
   - Only occasionally ___(1)
   - No, never ___(0)

10. **The thought of harming myself has occurred to me:**
    - Yes, quite often ___(3)
    - Sometimes ___(2)
    - Hardly ever ___(1)
    - Never ___(0)

Total Score

[1] Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky

Enclosure 5

Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	◯0	◯1	◯2	◯3
2. Not being able to stop or control worrying	◯0	◯1	◯2	◯3
3. Worrying too much about different things	◯0	◯1	◯2	◯3
4. Trouble relaxing	◯0	◯1	◯2	◯3
5. Being so restless that it's hard to sit still	◯0	◯1	◯2	◯3
6. Becoming easily annoyed or irritable	◯0	◯1	◯2	◯3
7. Feeling afraid as if something awful might happen	◯0	◯1	◯2	◯3
Add the score for each column	☐ +	☐ +	☐ +	☐
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ☐
- Somewhat difficult ☐
- Very difficult ☐
- Extremely difficult ☐

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Print Name:_____

Date of Birth:_____

Date:_____

Enclosure 6

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Genetic History Questionnaire for Prenatal Patients

The answers to these questions will help in the care of your pregnancy. Please answer these questions as well as you can, all answers will remain private.

1. Is your family…

   From Southeast Asia, Taiwan, China, or the Philippines? ☐ No ☐ Yes ☐ Not Sure

   From Italy, Greece, or the Middle East? ☐ No ☐ Yes ☐ Not Sure

   African American (Black)? ☐ No ☐ Yes ☐ Not Sure

   Hispanic/Puerto Rican? ☐ No ☐ Yes ☐ Not Sure

2. Is your family, or your baby's paternal father's family European (Ashkenazi) Jewish?

   ☐ No ☐ Yes ☐ Not Sure

The next nine questions will be about you, your baby's paternal father and both of your families. When we reference "blood relative" we mean your child (or unborn baby), mother, father, sister, brother, grandparent, aunt, uncle, niece, nephew, or cousin.

3. Were you, or your baby's paternal father or any blood relative born with an opening in the back or spine, also called Spina Bifida or who had an opening in the head, also called Anencephaly?

   ☐ No ☐ Yes ☐ Not Sure

4. Is any blood relative in your family or your baby's paternal father's family developmentally delayed?

   ☐ No ☐ Yes ☐ Not Sure

5. Have you, or your baby's paternal father, or any blood relative had an unborn baby or a child who had Down Syndrome, also referred to Trisomy 21? ☐ No ☐ Yes ☐ Not Sure

6. Do you, or your baby's paternal father, or any blood relative have any other chromosomal problems?

   ☐ No ☐ Yes ☐ Not Sure

Ask your health care provider about multiple marker screening for Down Syndrome, Spina Bifida, and Trisomy 18, even if there is NO history of these in your or your baby's father's family.

7. Do you, or does your baby's paternal father, or any blood relative have any of the following:
   a. Cystic Fibrosis (CF)? ☐ No ☐ Yes ☐ Not Sure
   b. Fragile X Syndrome? ☐ No ☐ Yes ☐ Not Sure
   c. Muscular Dystrophy? ☐ No ☐ Yes ☐ Not Sure
   d. Hemophilia or other bleeding disorder? ☐ No ☐ Yes ☐ Not Sure
   e. Huntington disease? ☐ No ☐ Yes ☐ Not Sure

Continue to other side →

8. Were you, or your baby's paternal father, or any blood relative born with any of the following:
    a. A heart defect? ☐ No ☐ Yes ☐ Not Sure
    b. A cleft lip and/or cleft palate? ☐ No ☐ Yes ☐ Not Sure
    c. Any other birth defect? ☐ No ☐ Yes ☐ Not Sure
9. Have you ever had any of the following:
    a. Two or more miscarriages? ☐ No ☐ Yes
    b. A stillborn baby **and** one or more miscarriage(s) ☐ No ☐ Yes
10. Do you, or your baby's paternal father, or any blood relative have any other disease or health problem that is inherited (passed on in the family)? ☐ No ☐ Yes ☐ Not Sure

The next two questions will be about medical conditions that you (the patient) may have.

11. Do you have, or have you ever been treated for PKR (Phenylketonuria) or Hyperphenylalaninemia (Hyperphe)? ☐ No ☐ Yes ☐ Not Sure
12. During this pregnancy, have you taken any of the following:
    a. Seizure medications? (Dilantin, Valproic acid, Depakene, Tegretol, Atretol, Mysoline, Tridione) ☐ No ☐ Yes
    b. Lithium for bipolar disorder or depression (Eskalith, Lithobid, Lithonate)? ☐ No ☐ Yes
    c. Medication for Acne (Accutane, Isotretinoin) ☐ No ☐ Yes
    d. Chemotherapy/immunosuppressive medication (Methotrexate, aminopterin, rheumatrex) ☐ No ☐ Yes

Provider Signature:_____ Date: _____

Print Name:_____

Date of Birth:_____

Date:_____

Enclosure 7

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OB/GYN and Sexual Health History Form

Gynecological/Sexual History:

First day of your last menstrual period (LMP): _____
How old were you when your period started? _____
Are your periods: ☐ Light ☐ Moderate ☐ Heavy
How long are your period cycles? _____
Do you have significant pain with your periods? ☐ Yes ☐ No
Are your periods regular in their timing? ☐ Yes ☐ No
How many days of menstrual flow? _____
Do you have bleeding between periods? ☐ Yes ☐ No

If applicable, age of menopause/year of last period? _____
Taken hormone medications since menopause? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No
Do you have pain with sexual activity? ☐ Yes ☐ No
Relationship status (*check all that apply*):
☐ Single ☐ Married ☐ Civil Union ☐ Domestic Partnership
☐ Multiple Partners ☐ Partnered, not cohabitating
☐ Divorced ☐ Widowed ☐ Committed Relationship ☐ Other

Current form of birth control: _____
Are you happy with it? ☐ Yes ☐ No

Past methods of birth control (*check all that apply*):
☐ Rhythm/Natural ☐ Family Planning ☐ Condoms
☐ Withdrawal ☐ Pill ☐ Patch ☐ NuvaRing ☐ Arm Implant ☐ Depo-Provera Injections ☐ Hormone IUD
☐ Copper IUD ☐ Essure Sterilization
☐ Tubal Ligation/removal ☐ Vasectomy ☐ Hysterectomy

Ever had an abnormal Pap or Colposcopy?
☐ Yes ☐ No

Have you had any treatments to your cervix?
☐ No ☐ Cryosurgery ☐ LEEP ☐ Conization

Have you ever had a sexually transmitted disease?
☐ No ☐ Chlamydia ☐ Gonorrhea ☐ Herpes
☐ Other: _____

Have you had the HPV vaccine (Gardasil) series?
☐ Yes ☐ No

Obstetrical History: (if applicable)

Total number of pregnancies: _____
Number of full-term pregnancies: _____
Number of premature pregnancies: _____
Number of multiple births: _____

Number of miscarriages: _____
Number of induced abortions: _____
Number of ectopic pregnancies: _____
Number of children living: _____

Date of Delivery	Preterm Labor? (Y/N)	Gestational Age (# of weeks)	Length of Labor (# of hours)	Birth Weight	Infant Sex	Type of Delivery (Vaginal/C-Section)	Pain medication (Y/N) If yes, what type?	Delivery Doctor and place of delivery	Complications of pregnancy or labor?

Enclosure 8

INTERMED
Care without compromise.

Welcome to InterMed! The following information explains some of our office policies.

After Hours Physician Availability
If a call that requires medical assistance is placed after regular business hours, our answering service will page the on-call physician. The on-call physician will respond to calls in order of priority. If you do not receive a call back within 20 minutes, please call again and let the answering service know you have not received a call back.

To view our regular business hours, please visit our website, ***www.intermed.com***, and select the Obstetrics and Gynecology Department under the *Practices and Services* menu.

Cancellations and Missed Appointments
Should you need to reschedule or cancel an appointment, we require at least 24-hour notice to make the time available for another patient.

- The third time an appointment is missed or cancelled without proper notice within an 18-month period, it may be necessary for us to consider discharge from the practice.
- New patients who miss or cancel their initial appointment twice without providing proper notification shall be discharged from the practice and are not eligible to establish care with another InterMed provider.

To learn more about our policy, please visit our website at ***www.intermed.com***, and select the *Patient Forms and Policies*, under the *Patient Information* menu.

Prescription Refills
Patients may request to fill all ongoing prescription using one of the below methods.

- Contact your pharmacy to confirm refills are not available, and request to fax a request to our office.
- Contact your physician's office.
- Submit a request through InterMed's Patient Portal.
- Speak with your provider at your upcoming appointment

If this is a request for a new medication, we ask that you to contact your physician's office to discuss. When requesting a refill please have the following information at the time of the call:

- The medication name, correct dosage, frequency taken, and quantity requesting.
- The name and location of your pharmacy.

Controlled substances will not be sent to your pharmacy until 3 days prior to when it is due.
For extenuating circumstances, please contact your provider directly to discuss.

Please allow 24-72 hours to fulfill all prescription requests. If we have any questions, we will call you back, otherwise please assume the pharmacy has your refill.

Reporting of Test Results
We make every attempt to report test results as soon as they are received. Different tests take varying amounts of time for results to be received. Feel free to ask your physician or their clinical assistant the timeframe in which they expect to receive your results. Once the results have been received, you will be notified by the physician or their clinical assistant via mail, phone, or online patient portal. Please note that any sensitive test results will not be published to the portal. If for any reason you do not receive communication regarding results on a test after 2 weeks, please contact our office.

Enclosure 9

INTERMED
Care without compromise.

Patient Financial Policy

Insurance Verification and Co-payments
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due and payable at the time of service.

Self-Pay Accounts
Self-pay accounts shall exist if a patient has no insurance coverage, there is no insurance card on file, or if the patient has not met a yearly deductible or coinsurance. Payment is expected at the time of service. Alternatively for large balances, a payment plan may be worked out with authorized personnel in the Billing Office.

Patient Collection Policy
A patient's claim balance will be considered past due 30 days from the date of the first statement. If a patient is unable to pay the balance in full within the 30 days, the patient should call the InterMed Billing Office (207-828-0361) to setup a payment plan. If a patient's claim balance becomes 120 days past due, the balance will be transferred to the Thomas Collection Agency. The patient should then contact the Thomas Collection Agency (207-772-4659) for payment options.

Non-participating Insurance Plans
As a service and courtesy to our established patients, non-participating health insurance plans will be billed as a non-assigned claim. Any outstanding balances are the responsibility of the patient.

Appointments
It is patient's responsibility to call and cancel scheduled appointments within 24 hours of the appointment. If appointments are not cancelled within 24 hours, InterMed shall reserve the right to charge for the no-show.

Accident Cases
Patients shall be financially responsible for medical services related to an accident. InterMed will submit claims to the patient's health insurance carrier. All outstanding balances will be the responsibility of the patient.

Workers Compensation Cases
Patients are responsible for notifying InterMed that certain treatment is injury related. Furthermore, the patient is responsible for providing InterMed the appropriate billing information (insurer, claim #, date of injury, etc.)

Patient Refunds
In order for a patient refund to be issued, there must be no outstanding insurance or patient balances. InterMed will process a refund request within 4 – 6 weeks.

Returned Check Fees
A patient's account will be charged a $25 fee for any checks returned from the bank for insufficient funds.

Child Custody Cases
Unless otherwise notified and accepted by InterMed, the custodial parent shall be responsible for all outstanding charges and balances. If parents share custody (joint custody), unless otherwise agreed by the parties, the parent with the first birthday of the year will have responsibility for outstanding charges and balances. InterMed will bill the insurance carrier for both custodial and non-custodial parents.

Specialty Referrals
If your insurance requires you to choose a primary care physician (PCP), you may need prior authorization completed by your PCP prior to seeing an InterMed Specialist (Audiology, Cardiology, Dermatology, ENT, OB/GYN, Physical Therapy, Sports Medicine and certain ancillary services). It is the patient's responsibility to ensure a prior authorization is obtained. All charges incurred without a required prior authorization will be the responsibility of the patient.

This financial policy is intended to promote a clear understanding with our patients. If you have any questions or need clarification of any of the above issues, please contact the InterMed Business Office at (207) 828-0361.

Enclosure 10

INTERMED
Care without compromise.

Nondiscrimination Notice

InterMed, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. InterMed, P.A. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

InterMed, P.A.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you believe that InterMed has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email.

InterMed, P.A.
Compliance Officer
84 Marginal Way, Suite 900
Portland, Maine 04101
Phone: 207-347-2937 or Fax: 207-523-1428
Email: compliance@intermed.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Services

At InterMed, interpreters are available at no cost to assist with communication between health care providers and patients whose primary language is not English. Patients should indicate if they need an interpreter when requesting an appointment.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-207-774-5816.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-207-774-5816.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-207-774-5816.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-207-774-5816.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-207-774-5816.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-207-774-5816.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-207-774-5816

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-207-774-5816.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-207-774-5816.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-207-774-5816.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-207-774-5816.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-207-774-5816.

PIŋ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-207-774-5816.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-207-774-5816 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-207-774-5816.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-207-774-5816 まで、お電話にてご連絡ください。