SAMUEL D. VAN KIRK, M.D. 2139 AIRPARK DRIVE; REDDING, CA 96001
OBSTETRICS & GYNECOLOGY TEL: (530) 247-0270; FAX: (530) 247-0271

Congratulations On Your Pregnancy!

We understand that you have a choice in selecting your healthcare provider and we are pleased that you picked our practice. Our goal is to provide respectful, compassionate, excellent medical care for women throughout our lives. We are committed to the highest medical and ethical standards of our profession. Our goal is to educate you and involve you in decisions about your medical treatment, answering your questions about treatment options and medical risks.

Our practice can help you deal with medical issues unique to women, including: pregnancy, pre-pregnancy counseling, birth control, well-woman visits, teen gynecology, colposcopy for abnormal pap smears, premenstrual syndrome, infertility, menopause, pelvic prolapse, and both medical and surgical treatments for abnormally heavy periods. We are excited to offer laparoscopic hysterectomies as well.

Dr. Van Kirk is board certified in Obstetrics and Gynecology. He graduated with a B.A. from the University of California, Santa Barbara and a M.A. from Stanford University. He received his medical degree from the University of Southern California and completed his residency at the Oregon Health Sciences University. Dr. Van Kirk speaks both English and basic Spanish.

Appointments

Patients are seen during scheduled appointments. If you are 15 minutes late or more, it will be necessary to reschedule your appointment. If you are unable to keep your scheduled appointment, please let us know in advance. *We believe that you are our partner in achieving you and your baby's best possible health and we expect you to reschedule your missed appointments to ensure that you and your baby's health needs are met.*

Results

For most abnormal results, for lab problems (such as an inadequate specimen) and for results that necessitate further testing, our office will notify you by phone. *If you do not hear from our office by two weeks after tests are performed, please contact us.* Please read our office's Privacy Policy and fill out the Authorization to Disclose Health Information form to let us know how and with whom we may leave messages regarding your health care.

Payment Options

We are contracted with most of the major insurance carriers of Northern California. We will bill all insurance carriers for services rendered, however, all co-payments must be paid at the time of service. All private pay patients must pay at the time service is rendered. Due to the long-term care needed for obstetrics, global obstetric patients will receive a payment plan after their first visit. It is our office policy to collect an "OB deposit". This money is applied to your bills as they are processed. After you have the baby, we will send a final bill for any amount due or send you a check if a refund is due. If you are in the process of applying for Blue Cross Aim, we require you to pay for each visit until your benefits begin. We accept MasterCard, VISA, personal checks, and cash as forms of payment.

Once again, congratulations! We look forward to caring for you throughout your pregnancy. If you have any questions, please do not hesitate to call our office.

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Basic Expectations for Obstetrical Care and Delivery at Mercy Hospital

1. Dr. Van Kirk delivers his own patients during regular office hours and when he is on call. When Dr. Van Kirk is out of the office or it is after hours, his patients are cared for by our group of on-call doctors, consisting of Doctors Oliva, Pena, Serr, Skipitis, Kang, Keurentjes and Williams. Seeing Dr. Van Kirk for prenatal care means being cared for by our on-call physicians if the need arises.

2. Office hours are Monday through Thursday 8am-5pm and Friday 8am-12noon.
3. Our office collects an OB deposit during the first trimester if your insurance does not cover 100% of your pregnancy.

4. All of our deliveries occur at Mercy Hospital in the Labor and Delivery unit.

5. The placement of an IV and fetal monitoring on Labor and Delivery during the labor and delivery process is the standard of care and is an expectation.

6. Children under 16 years old are not permitted in the delivery room for the delivery. The hospital's policy is for no more than two other people besides yourself in the room for delivery.

7. It is important to have your normal labs done in a timely fashion. The standard set of prenatal labs should be done after your first prenatal appointment in the office. Your diabetes screening glucose test should be done between 24-28 weeks in the pregnancy. Rhogam injections should be done for patients with rH negative blood types, such as A-, B- , and O-, at approximately 28 weeks.

8. Normally ultrasounds are done at your first visit with Dr. Van Kirk to determine your due date, around 20-23 weeks to look at the anatomy of the baby (and usually the sex of the baby can be determined), and around 30-33 weeks to check the growth of the baby.

9. If you will be age 35 or older (AMA) on the baby's due date, you will be referred for a genetic consult and level II ultrasound during your second trimester with a perinatal specialist.

Patient Signature Date

Physician Signature

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature Date Physician Signature

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Patient Demographics - ANNUALLY UPDATED FOR ALL PATIENTS

In order to serve you properly, we will need the following information. All information will be strictly confidential. After completing this form, please provide your current insurance card and your driver's license to the receptionist to photocopy.

Social Security Number:_____		Are you currently employed?_____
First Name:_____	Date of Birth:_____	Employer:_____
Middle or Nickname:_____	Marital Status:_____	Job Title:_____
Last Name:_____		Employer's Address:_____
Address:_____	Primary Care Physician:	_____
_____	_____	Home Phone:_____
	What is your ethnicity?	Cell Phone:_____
Whom shall we thank for referring you?	_____	Work Phone:_____
_____	SS#	Preferred Phone: _____
		Fax: _____
		E-mail:_____

First Insurance:_____ Group #:_____ ID#_____ Co-pay:___

Are you the subscriber?____ If no, please provide the subscriber's following information:

Name:_____ Date of Birth:_____ Employer:_____
Address:_____ City:_____ Home Phone:_____
_____ State:_____ Work Phone:_____

Second Insurance:_____ Group #:_____ ID#_____ Co-pay:___

Are you the subscriber?____ If no, please provide the subscriber's following information:

Name:_____ Date of Birth:_____ Employer:_____
Address:_____ City:_____ Home Phone:_____
_____ State:_____ Work Phone:_____

Spouse/Emergency Contact Information:
First Name:_____ Relationship:_____ Home Phone:_____
Last Name:_____ Work Phone:_____

Assignment of Benefits: Financial Agreement

I hereby give lifetime authorization for payment of insurance or Medicare benefits to be directly to Dr. Van Kirk, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. A service charge of 1% per month (18% per year), but in no event more than the maximum rate permissible under state law, will be charged on the unpaid balance on all accounts not paid within 30 days of the treatment date. All other payment options will need authorization prior to treatment from the business office. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all protected health information for the purposes of treatment, payment and health care operations. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient, Parent, or Guardian Signature: _____ Date: _____

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Obstetrical Information (Page 1 of 3)

In order to serve you properly, we will need the following information. All information will be strictly confidential.

New Pregnancy:

Date of positive pregnancy test: _____ Type of Test: _____ urine _____ serum

Date of conception: _____

Your weight prior to pregnancy: _____

Menstrual History:

Date of last menstrual period:_____ _____ normal _____ abnormal _____ on birth control pills?

Menarche (age onset): _____ years

Menstrual Frequency: _____ regular: every _____ days _____ irregular: Duration: _____ days

Family OB History:

Patient birth weight: _____lbs._____oz. Highest birth weight in prior pregnancies: _____lbs._____oz.

___Y or ___ N: History of Traumatic Births in Close Family Members

Pregnancy Summary:

Total: ____ Full Term: ____ Premature:_____ Abortions: ____ Miscarriage: ____ Ectopic Pregnancy: ____ Multiple Births: _____

Current Number of Living Children: _____

Past Pregnancies:

Date of Delivery	Gestational Age	Length of Labor	Birth Weight	Sex	Type of Delivery	Anesthesia	Place of Birth	Complications	Comments

Medications:

Current Medications and Dosages:_____

_____

Preferred Pharmacy (Name & Location):_____

List any allergies to medications:_____

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Obstetrical Information (Page 2 of 3)

History	Y/N	Date	Comments	History	Y/N	Date	Comments
Allergies/Runny Nose				Liver Disease			
Anemia/Hematologic				Neurologic Disorder			
Asthma/Pulmonary				Renal Disease			
Autoimmune Disorders				(Rh) Sensitized			
Abnormal Pap Smears				Thyroid Disorder			
Blood Transfusion				Trauma History			
Breast Disorder				Uterine Abnormalities			
Depression				Varicosities/ Leg blood clots			
Psychiatric Disorder				Anesthetic Complications			
Diabetes				Other Family History			
Heart Disease				Other			
Hypertension				Other			
Infertility				Other			

Substance	Y/N	Amount/Day Pre-Pregnancy	Amount/Day Pregnancy	# Years Use	Comments
Tobacco (packs/day)					
Alcohol (drinks/day)					
Illicit Recreational Drugs					

Surgery/Hospitalizations	Year	Comments

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Obstetrical Information (Page 3 of 3)

Genetic Screening	Yes/No	Comments	Genetic Screening	Yes/No	Comments
Patient Age > = 35 Years as of Est. Date of Delivery			Autism		
Neural Tube Defect (Spina Bifida, Anencephaly)			If yes, was person tested for Fragile X?		
Trisomy 21 (Down Syndrome)			Mental Retardation		
Congenital Heart Defect			If yes, was person tested for Fragile X?		
Cystic Fibrosis			Muscular Dystrophy		
Tay-Sachs (Jewish, Cajun, French Canadian)			Sickle Cell Disease or Trait (African)		
Thalassemia (Italian, Greek, Mediterranean, Asian)			Other Inherited Genetic or Chromosomal Disorder		
Canavan Syndrome			Maternal Metabolic Disorder (Type 1 Diabetes, Pku)		
Hemophilia or Hematologic Disease			Recurrent Pregnancy Loss, or A Stillbirth		
Huntington's Chorea			Other Birth Defects		
Other			Other Genetic Screening		

Exposure/Infection History	Yes/No	Comments
Partner has History of HIV		
Patient or Partner has History of Genital Herpes		
Exposure to TB		
Rash or Viral Illness since Last Menstrual Period		
History of Sexually Transmitted Disease		
Other Exposure or History of Infection		

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Authorization to Disclose Health Information

(1) Under the Patient Privacy Act, the use and disclosure of a patient's health information is limited to strictly defined situations. These are explained in our NOTICE OF PRIVACY PRACTICES. This means that our office cannot release any information to ANYONE other than the patient (even spouses), except under certain defined situations, or unless we have the patient's written permission. Please complete this form, to indicate if you would like us to be able to speak to your family members regarding your health care.

(2) It is our general office policy to notify patients by e-mail (for patients using secure messaging) or postal mail of all normal lab and test results and of some abnormal results (such as increased cholesterol, abnormal thyroid tests and vascular calcifications on mammograms). For most abnormal results, for lab problems (such as an inadequate specimen) and for results that necessitate further testing, our office will attempt to notify you by phone**.** ***If you do not hear from our office by two weeks after tests are performed, please contact us.*** Many patients would like to be notified by answering machine or voicemail. Unfortunately, we cannot guarantee that such information will not be inadvertently set to, or overheard by, other individuals. Taking this into consideration, please complete this form, to indicate if you would like us to be able to leave machine messages regarding your test results.

[] I authorize the office of Dr. Sam Van Kirk to release any information regarding my healthcare to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

-OR-

[] I **DO NOT WISH** the office of Dr. Sam Van Kirk to release any information regarding my healthcare, except as explained in the NOTICE OF PRIVACY PRACTICES.

Patient signature: _____ Date: _____

[] I authorize the office of Dr. Sam Van Kirk to leave electronic messages regarding test results on my answering machine or voicemail.

-OR-

[] I **DO NOT WISH** the office of Dr. Sam Van Kirk to leave any messages regarding test results on my answering machine or voicemail.

Patient signature: _____ Date: _____

[] I do not use secure messaging and will use postal mail for lab results (I understand this will take longer for me to get my results).

-OR-

[] I **WILL NOTIFY** the office of Dr. Sam Van Kirk of any changes in my e-mail address to ensure that electronic communications are sent to me.

Patient signature: _____ Date: _____

Patient signature:_____ Date:_____

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Drug Use Consent Form

Dear Patient:

Drug abuse is a serious addiction which affects both a mother and her unborn child. If you are addicted to drugs, you need to start a rehab treatment program immediately. If you use drugs "recreationally" or use "medical marijuana" you need to stop immediately.

The direct medical consequences of drug abuse include heart attack, stroke, life-threatening infections and death. The indirect effects of drug abuse include engaging in dangerous behaviors due to your judgment being impaired. These include engaging in high risk sexual behavior, driving under the influence and not wearing a seat-belt (leading to death or killing others in a car crash), engaging in criminal activity, being the victim of physical abuse (including being murdered) by other drug addicts, and/ or engaging in child abuse (or allowing others to abuse your children).

Using drugs places your baby at risk. Drugs can cause birth defects, miscarriage, preterm labor, decreased oxygen delivered to the baby (causing brain damage or stunted growth), stillbirth and abruption where the afterbirth tears away before labor which can kill the baby). Some drugs, when used in pregnancy, have been linked to later behavior problems in children such as attention deficit disorder.

I expect my patients to stop using drugs for the sake of their unborn child. If you are not willing to do this, then you should find another physician. By signing below, as a condition of accepting you into my practice, you are agreeing to random drug testing. If, at any time, a drug screen returns positive, you will be immediately dismissed from my medical practice.

Samuel Van Kirk, MD

I HAVE READ AND UNDERSTAND THE ABOVE, I AGREE TO RANDOM DRUG TESTING. I UNDERSTAND THAT IF I TEST POSITIVE FOR DRUGS, I WILL IMMEDIATELY BE DISMISSED FROM THIS MEDICAL PRACTICE.

Patient Signature:_____ Date:_____

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Blood Transfusion Consent/Refusal Form

- Your blood contains fluid (plasma), red blood cells (which carry oxygen), white blood cells (which fight infection), and platelets (which help your blood to clot). If your blood fluid volume or red blood cell count drops very low (severe anemia), you will die.
- Any surgery causes some blood loss. The goal is to do surgery with as little blood loss as possible. If there is moderate blood loss, most patients will tolerate moderate levels of anemia (depending upon a patient's age and health). An anemic patient will slowly build their blood back up, but may suffer from headaches, fatigue, and a decreased ability to fight off infection.
- On rare occasions, a patient may suffer severe blood loss (hemorrhage), either before, during or after surgery. With severe hemorrhage, there comes a point where a patient will die if they do not receive blood.
- Receiving a blood transfusion has some risks. On rare occasions, patients may develop a life-threatening allergic reaction, or become infected with diseases, such as hepatitis or HIV.
- Some patients, due to their religious beliefs, would rather die than receive a blood transfusion. If you would refuse a blood transfusion, you must notify your doctor immediately and you must bring your immediate family with you to your pre-operative visit to discuss this. Our office reserves the right not to schedule elective surgeries, or insist that all alternatives to surgery be attempted first. If you do not agree with this policy, we will help refer you to another office.
- You may contact the local blood bank if you are interested in having family members donate blood, to save and transfuse if needed. Family members must be of the same blood type, be willing to submit to testing for infectious diseases, and donate blood several days in advance.
- You may contact the local blood bank if you are interested in donating your own blood (autologous donation), to save and transfer if needed. You cannot donate if you are already anemic. You must donate 6 – 8 weeks before your surgery.

I have read and understood all of the above. I have been given the opportunity to discuss all of the above with my surgeon, and to have all my questions answered.

Initials:_____ I consent to the use of blood or blood products, if deemed medically needed.

-OR-

Initials:_____ I would rather bleed to death, than receive a blood transfusion or blood products.

-OR-

Initials: _____ I will accept the following:

_____ Red Blood Cells _____ Platelets _____ Fresh Frozen Plasma

_____Albumin _____ Isolated Factor Preparations

Patient Signature:_____ Date:_____

Physician Signature:_____

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Office Consent: Special Tests During Pregnancy

Please read the attached handouts before your appointment

Cystic Fibrosis

Please see attached handout that describing Cystic Fibrosis. For further information, please go to:

http://www.acog.org/publications/patient_education/bp171.cfm

Some insurance plans cover this test. If you have questions regarding your insurance benefit, contact your insurance carrier. You only need to be tested for this gene mutation once in your life. So if you've been tested before, you don't need to be tested again.

Patient's Initials: ____ I would like to have this test done.

____ I would NOT like to have this test done.

Tests for Birth Defects

Please see the attached handout on testing for birth defects. For further information, please go to:

http://www.acog.org/publications/patient_education/bp165.cfm

You have a choice if you would like to have testing for birth defects done. Testing is done by an ultrasound (not done here) and blood test on you between 11 and 13 weeks in the pregnancy and another blood test between 15 and 20 weeks. See the attached handout specifically under the screening test section. This testing does not refer to an amniocentesis. Some insurance plans cover this test. If you have questions regarding your insurance benefit, contact your insurance carrier. We will also routinely perform another ultrasound here in the office at approximately 20 to 24 weeks.

Patient's Initials: ____ I would like to have this test done.

____ I would NOT like to have this test done.

I have read and understand all of the above. I have been given the opportunity to discuss all of the above with my surgeon, and to have all my questions answered.

Patient Signature:_____ Date:_____

Physician Signature:_____

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Office Consent: Special Tests During Pregnancy

HIV Testing

This is a blood test done to detect human immunodeficiency virus. Treating an infected mother for HIV greatly reduces the chances that HIV will be passed on to the baby.

Patient's Initials:

____ I would like to have this test done.

____ I would NOT like to have this test done.

I have read and understand all of the above. I have been given the opportunity to discuss all of the above with my surgeon, and to have all my questions answered.

Patient Signature:_____ Date:_____

Physician Signature:_____