Associated Valley Obstetrics & Gynecology
Talbot Professional Center 4011 Talbot Rd. S. Suite 430 Renton, WA 98055 Ph 425.656.2496 Fax 425.572.6150

PLEASE READ

LORI D. CHANNELL, M.D.
Board Certified in
Obstetrics and Gynecology

CARLA P. KOVACS, M.D.
Board Certified in
Obstetrics and Gynecology

KELLY K. MARTIN, M.D.
Board Certified in
Obstetrics and Gynecology

THERESA C. HAMER, M.D.
Board Certified in
Obstetrics and Gynecology

SHELLY M. LEWIS, M.D.
Board Eligible in
Obstetrics and Gynecology

HAILEY W. HUNT, M.D.
Board Eligible in
Obstetrics and Gynecology

Welcome to Associated Valley Obstetrics and Gynecology. In order to provide the best quality care, it is important that you arrive on time for your appointment. Please bring with you the completed paperwork enclosed in this mailing along with your insurance card.

In the event you arrive after your scheduled appointment time, or without your completed paperwork, you will likely be asked to reschedule so as not to disrupt other patients' appointments. Appointments require 48-hour cancellation notice or a $50 missed appointment fee may be assessed.

*Please note: In the event you are scheduled for an ultrasound, our office policy is to limit guests to **TWO** per patient.

Thank you for the opportunity to care for you.

IMPORTANT

Due to our office and ultrasound's full schedule it is very important that you arrive at your appointment on time or earlier with all of your paperwork completed.

IF YOU ARE LATE OR DO NOT HAVE YOUR PAPERWORK DONE IT WILL BE NECESSARY FOR YOU TO RESCHEDULE YOUR APPOINTMENT. NO EXCEPTIONS.

This will assure that your appointment will be on time and patients following you will be seen at their scheduled appointment time as well.

We appreciate your cooperation and consideration with this policy.

ASSOCIATED VALLEY OBSTETRICS AND GYNECOLOGY

Talbot Professional Center • 4011 Talbot Road South – Suite 430 • Renton, Washington • (425) 656-2496

PATIENT REGISTRATION

PATIENT NAME_____ TODAY'S DATE_____

Address_____ Home Phone_____

_____ Cell Phone_____

City/State/Zip_____ Work Phone_____

Birthdate_____ Age_____ May we leave messages on your answering machine? _____

Social Security # _____ Sex: Male Female Marital Status: S M W D

Email Address: _____

How did you hear about our office? _____

Were you referred to us by a doctor? Yes No If so, by whom?_____

What is your preferred method for appointment reminders? Text message Email Phone Call

PREFERRED PHARMACY:

Name_____ Address _____City _____ Phone_____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER _____ SPOUSE'S NAME_____

Address _____ Spouse's Employer_____

_____ Spouse's Cell/Hm Phone _____

Occupation _____Spouse's Soc Sec # _____DOB_____

Patient's relationship to person responsible for bill: Self Spouse

INSURANCE INFORMATION

Primary Insurance Name _____ Secondary Insurance Name _____

Subscriber's Name _____ DOB _____ Subscriber's Name _____ DOB _____

ID # _____ Group # _____ ID # _____ Group # _____

Address _____ Address _____

Phone # _____ Phone # _____

Relationship to subscriber: Self Spouse Dependent Child Relationship to subscriber: Self Spouse Dependent Child

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY (PREFERABLY NOT LIVING AT SAME ADDRESS)

Name _____ Relationship to patient _____ DOB _____

Home Phone _____Work Phone _____ Cell Phone _____ Primary: HM WK CELL

ASSIGNMENT AND RELEASE

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I also understand that I will be charged a service charge of 1% per month (12% annually) on any amount outstanding 60 days past due.

SIGNED: _____

AUTHORIZATION OF TREATMENT OF A MINOR: I authorize Valley OB/GYN to treat the minor patient named above. It is our policy that the parent or guardian who requests treatment of a minor be financially responsible for the services rendered.

SIGNED: _____

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Notice of Privacy Practices Acknowledgment

Associated Valley Obstetrics & Gynecology has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact **Tracy Lewis, Administrator** at **(425)251-3454** to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Associated Valley Obstetrics & Gynecology.

_____

Printed name of patient

_____

Patient or legally authorized individual's signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

May we leave a message on your home recorder? YES_____ NO_____ N/A_____
May we leave a message on your cell voicemail? YES_____ NO_____ N/A_____
May we leave a message with people at your house? YES_____ NO_____ N/A_____
May we discuss your test results with members at your house? YES_____ NO_____ N/A____

Please list family members with whom we may discuss test results, appointments, and your presence at the office:

Name_____

Name_____

For Office Use Only

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons: _____

_____

Associated Valley Obstetrics & Gynecology

Please inform us of all Insurance Plans you are covered under even if you have Apple Health, Provider One, or DSHS.

Billing Insurance Plans out of order can result in claims being denied or payments being recouped by an Insurance Carrier, and can result in additional patient financial responsibility.

I have informed you of all of the Insurance Plans I am covered under.

Signature:_____

Print Name:_____
Acct #_____

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4011 Talbot Rd S, Suite 430
Renton, WA 98055
Phone (425) 656-2496 Fax (425) 572-6150

PATIENT ID: _____ DOCTOR: _____ NEW OB DOCTOR APPT ON: _____ INTAKE DATE: _____

PLEASE FILL OUT ALL PAGES COMPLETELY IN ORDER TO AVOID DELAY IN YOUR SCHEDULED APPOINTMENT

NAME	AGE	HT	ETHNIC	RELIGION	OCCUPATION
PATIENT:					
FATHER OF BABY:					
MARITAL STATUS:					

TOTAL # PREGNANCIES	FULL TERM 37 WEEKS OR MORE	PREMATURE LESS THAN 37 WEEKS	MISCARRIAGE	ELECTIVE ABORTION	LIVING CHILDREN

LMP: _____= EDC DATE: _____ **OFFICE USE ONLY**

U/S DATE: _____GEST AGE AT U/S: _____= EDC DATE: _____ WT: _____BP: _____

MENSTRUAL AND PAP HISTORY			
LAST MENSTRUAL PERIOD:		WAS THIS A PLANNED PREGNANCY?	
PREVIOUS MENSTRUAL PERIOD:		HAVE YOU HAD SPOTTING OR BLEEDING SINCE PREGNANT?	
AGE PERIODS STARTED:		WHEN WAS YOUR LAST PAP TEST?	
HOW OFTEN ARE YOUR PERIODS?		DO YOU HAVE HISTORY OF AN ABNORMAL PAP?	
LENGTH OF MENSTRUAL FLOW:		WHEN? HOW WAS YOUR ABNORMAL PAP TREATED?	
LAST FORM OF CONTRACEPTION:		HAVE YOU EVER HAD AN INFECTION OF YOUR UTERUS, TUBES OR OVARIES?	
WHEN DID YOU STOP CONTRACEPTION?		OTHER MENSTRUAL AND PAP HISTORY NOT LISTED	
DID YOU DO A HOME PREGNANCY TEST? IF SO, WHEN?			

PATIENT'S NAME:_____

PAST PREGNANCIES (Please start with your oldest child)					
NAME					
SEX					
BIRTH DATE					
BIRTH WEIGHT					
WEEKS OF PREGNANCY AT DELIVERY					
C/SECTION OR VAGINAL					
HOW LONG DID YOU PUSH?					
FORCEPTS/VACUUM					
EPISIOTOMY					
ANESTHESIA					
YOUR WEIGHT GAIN					
COMPLICATIONS					
HOW LONG DID YOU BREAST FEED?					
IS YOUR BABY BOY CIRCUMCISED?					
DR AND HOSPITAL YOU DELIVERED AT?					

DAILY LIVING					
	Y/N	HOW MUCH		Y/N	NOTES
DO YOU DRINK COFFEE, TEA OR COLA?			DO YOU HAVE SEASONAL OR FOOD ALLERGIES?		
DO YOU SMOKE CIGARETTES?			DRUG/ LATEX ALLERGIES? REACTION?		
DO YOU DRINK ALCOHOL?			DO YOU TAKE DAILY MEDICATIONS?		
DO YOU USE ANY ILLICIT/RECREATIONAL DRUGS? WHAT KIND?			WHAT MEDICATIONS HAVE YOU TAKEN SINCE BECOMING PREGNANT?		
HAVE YOU USED ANY DRUGS IN THE PAST? WHAT KIND?			HAVE YOU HAD ANY X-RAYS DURING THIS PREGNANCY?		
DO YOU EXERCISE?					

PATIENT'S NAME:_____

PERSONAL MEDICAL HISTORY					
	Y/N	DATE/TREATMENT/NOTES		Y/N	DATE/TREATMENT/NOTES
DIABETES			HISTORY OF BREAST CONDITIONS		
HYPERTENSION			UTERINE ANOMALY/DES		
HEART DISEASE			INFERTILITY		
AUTO IMMUNE DISORDER			RECURRENT PREGNANCY LOSS OR STILLBIRTH?		
KIDNEY DISEASE/ UTI			GYNECOLOGICAL SURGERY		
NEUROLOGIC/SEIZURES/ HEADACHES			OTHER OPERATIONS/ HOSPITALIZATIONS		
PSYCHIATRIC/ DEPRESSION/ANXIETY			ANESTHETIC COMPLICATIONS		
HEPATITIS/LIVER DISEASE			OTHER MEDICAL HISTORY		
VARICOSITIES/PHLEBITIS			IN AN EMERGENCY SITUATION WOULD YOU AGREE TO A BLOOD TRANSFUSION?		
THYROID DISEASE					
DO YOU HAVE ANY HISTORY OF TRAUMA / DOMESTIC VIOLENCE?					
BLOOD TRANSFUSIONS					
D (Rh) SENSITIZED					
PULMONARY/ASTHMA					
TUBERCULOSIS, POSITIVE SKIN TEST OR XRAY?					

INFECTION HISTORY					
	Y/N			Y/N	
LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			DO YOU WORK IN CHILDCARE OR HEALTHCARE?		
DO YOU OR YOUR PARTNER HAVE HISTORY OF GENITAL HERPES			HAVE YOU HAD CHICKEN POX?		
RASH OR VIRAL ILLNESS SINCE YOUR LAST MENSTRUAL PERIOD?			DO YOU HAVE A CAT IN YOUR HOME? INDOOR OR OUTDOOR?		
HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, SYPHILLIS			OTHER INFECTION HISTORY NOT LISTED?		
HISTORY OF HEPATITIS					

PATIENT'S NAME:_____

GENETIC SCREENING (Includes patient, baby's father or anyone in either family)					
	Y/N			Y/N	
YOUR AGE AT YOUR ESTIMATED DELIVERY DATE			DOES PATIENT OR FATHER OF THE BABY HAVE A CHILD WITH BIRTH DEFECTS NOT LISTED		
THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN OR ASIAN) MCV GREATER THAN 80			CYSTIC FIBROSIS		
NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANENCEPHALY)			HUNTINGTON'S CHOREA		
CONGENITAL HEART DEFECT			MENTAL RETARDATION/ AUTISM (IF YES, HAVE YOU BEEN TESTED FOR FRAGILE X?)		
DOWN SYNDROME			OTHER GENETIC OR CHROMOSOMAL DISORDER		
TAY-SACHS (EG, JEWISH, CAJUN, FRENCH CANADIAN)			MATERNAL METABOLIC DISORDER (DIABETES, PKU)		
CANAVAN DISEASE			ARE YOU OF JEWISH ANCESTRY		
SICKLE CELL DISEASE OR TRAIT (AFRICAN)			ANY OTHER GENETIC OR ENVIROMENTAL EXPOSURE?		
HEMOPHILIA OR OTHER BLOOD DISORDERS			ARE YOU AND THE FATHER OF THE BABY RELATED TO EACH OTHER? COUSINS?		
MUSCULAR DYSTROPHY			OTHER GENETIC HISTORY?		

MOTHER'S FAMILY MEDICAL HISTORY		
(CIRCLE) CONDITION	YES	**DESCRIBE THE PROBLEM** AND **INCLUDE PERSON'S RELATIONSHIP TO YOU**
DIABETES, HIGH CHOLESTEROL, THYROID DISEASE		
HIGH BLOOD PRESSURE, HEART ATTACK, BLOOD CLOTS, STROKE		
TUBERCULOSIS, ASTHMA, OTHER LUNG DISEASE		
BREAST DISEASE, BREAST CANCER		
STOMACH, GASTROINTESTINAL, OR COLON DISEASE OR CANCER		
KIDNEY DISEASE, KIDNEY STONES		
GYNECOLOGICAL DISEASES, OVARIAN CANCER , FIBROIDS		
MUSCULOSKELETAL DISEASES, OSTEOPOROSIS		
NEUROLOGIC, OR NERVOUS SYSTEM DISEASE, MIGRAINES		
SEVERE DEPRESSION OR OTHER PSYCHIATRIC CONDITION		
GENETIC DISEASE OR BIRTH DEFECTS		
LEUKEMIA, LYMPHOMA OR ANY BLOOD OR BONE MARROW DISEASE		
HAS ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT		
ANY TYPE OF CANCER OR MALIGNANT TUMORS		

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HIV VIRUS ANTIBODY BLOOD TEST CONSENT FOR TESTING

The American College of Obstetrics & Gynecology recommends routine HIV testing for all pregnant women, regardless of risk factors.

I hereby agree to have a blood test in order to detect whether I have antibodies in my blood to the HIV virus which causes AIDS.

I understand that if my test result is positive, I should consider myself infectious (able to pass the virus) to other persons through sexual contact, needle sharing, contact with my blood or body fluids, or through my blood or organs if I sell or donate blood or organs.

I understand that if my test result is positive and I fail to return for discussion and counseling, you are required to report my identity to the health department.

I understand that I have the choice of not being tested, or of being tested somewhere else including the health department where anonymous testing (where no one knows my name) can be done. I understand that if I am at a high risk for a positive test I should not have anonymous testing done.

I have been informed of the risk and benefits related to this test, as well as the alternatives to this test. By signing this document I specifically acknowledge that I have read this patient information sheet about HIV virus testing and have received personal counseling. I have been given all of the information that I need to make an informed decision to have the HIV testing done. I have had the chance to ask questions and all of my questions have been answered so that I understand all of the answers.

Name (please print)_____

_____ _____
(Signature) (Date)

_____ _____
(Witness) (Date)

If I am pregnant and my test is positive, I give my permission for my infant/child(ren) to be tested.

_____ _____
(Signature) (Date)

_____ _____
(Witness) (Date)

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INFORMED CONSENT FOR ULTRASONOGRAPHY

Your physician has requested that you have an ultrasound examination of your pregnancy. This information sheet will answer several important questions about this diagnostic procedure.

WHAT IS ULTRASOUND AND WHAT CAN IT SHOW ABOUT MY PREGNANCY?
Ultrasound uses the same principles as sonar. Sound waves from the ultrasound probe (far beyond the range of hearing) bounce off your uterus and your developing baby producing echoes which a computer converts into detailed images.

IS ULTRASOUND SAFE?
There has been extensive evaluation of the safety of ultrasound over the course of 40+ years. There is no evidence that diagnostic ultrasound causes harm to either the mother or the fetus.

TYPES OF EXAMS
A basic or standard sonogram provides information concerning placenta location, fetal position, twin pregnancies, gestational age and the possible presence of fetal malformations.

A detailed or level 2 sonogram is a more detailed exam providing not only the information of a basic scan, but in addition, more specific evaluation for fetal growth and/or fetal abnormalities.

A vaginal sonogram, in which a special ultrasound instrument, about the thickness of a tampon is inserted into the vagina is occasionally used to provide extremely detailed views of the uterus, ovaries, or portions of the fetus that are low in the pelvis. This may be used to see the heartbeat or location of a very early pregnancy, or to evaluate the placenta or birth canal. As with other ultrasound exams, the procedure is safe. It is generally less uncomfortable than a pap smear.

DOES A NORMAL ULTRASOUND PROVE THAT MY BABY WILL HAVE NO ABNORMALITIES?
While a basic sonogram will detect some abnormalities, it is not definitive for fetal malformations. Despite a normal interpretation of the test, some babies may be born with anomalies not visible by the ultrasound or examiner during the study.

You should realize that even with a normal sonogram, abnormalities may later be discovered after birth. Thus, although ultrasonography is a very helpful diagnostic tool, it does not guarantee a baby without any birth defects.

CONSENT
Should you have any questions concerning ultrasonography, do not hesitate to discuss them with your doctor or the person performing your ultrasound before undergoing the procedure. You are requested to sign this document prior to the performance of your ultrasound examination and thereby acknowledge that you have read and understood the information contained herein, and have given an informed consent to this procedure.

IMPORTANT

DURING ULTRASOUNDS THERE ARE **NO CAMERAS OR VIDEOS** ALLOWED. DUE TO THE SMALL ULTRASOUND ROOM, **ONLY 2 PEOPLE ARE ALLOWED IN THE ROOM** DURING AN ULTRASOUND

_____ _____
Patient Signature Date

_____ _____
Witness Date

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Dear Mother-To-Be:

Welcome to Associated Valley Obstetrics and Gynecology! We look forward to our association during this important time. We are a six Obstetrician practice. Our group of physicians shares "after hours" call, which means that you may speak with or be delivered by someone other than your chosen physician.

During your OB visits we will draw blood for lab studies to find out your blood type, blood count, and whether you are immune to German measles or have any irregular blood antibodies. In addition, we recommend testing for other conditions that could be dangerous for the pregnancy if unrecognized. These include: gonorrhea, chlamydia, hepatitis, syphilis, and human immunodeficiency virus (AIDS virus). You may also have a pap smear. Results of all these tests will be shared with you at your subsequent visit. These lab results cannot be made available to anyone outside this office without your written consent. This policy is to ensure protection of your privacy.

At 16 weeks of gestational age, we offer a blood test called alpha fetoprotein which is a screening test for spinal cord defects such as spina bifida. You may also choose to have a test called a prenatal risk profile that calculates an individual's risk for downs syndrome. Although these are good screening tests, a normal result does not guarantee that your baby will not have any of these problems.

We also offer you ultrasound exams of your infant, routinely performed at 8 weeks and approximately 16 to 20 weeks gestation. These tests are done to confirm your due date and to look for any abnormalities in your infant. While this is an excellent test, not all anomalies are detectable with ultrasound. Ultrasound is also used for medical evaluations when there is bleeding, poor fetal growth, or decreased fetal movement. Ultrasound is used extensively across the country and has not been associated with any later abnormalities in children.

If the above presented plan of care is acceptable to you, please note your approval by signing the line below. If for any reason, you question or decline any part of this plan, please place your initials in the margin near the item in question. We encourage you to let us know of any questions or concerns you may have throughout your pregnancy. Our nurses can answer many of your questions by phone, or if necessary they will defer to one of the physicians for more extensive medical problems.

The entire staff including: physicians, clinical nursing staff, and business office personnel have as our goal the expedient, courteous, and professional care of you and your infant during this important time.

Again, welcome to Associated Valley Obstetrics and Gynecology.

Signature of Acceptance_____Date_____

Printed Name_____

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OB Guidelines

Please visit our website for Pregnancy & Childbirth educational information:
www.avogmd.com

COURSE OF PRENATAL CARE

You will have approximately 14 doctor visits during your pregnancy. Typically your appointments are every 4 weeks until 30 weeks, every 2 weeks until 36 weeks, then weekly until your delivery.

LAB WORK DURING PREGNANCY

INITIAL LABS WILL BE DRAWN AT YOUR NURSE VISIT AND INCLUDE

- Complete blood count
- Hepatitis B
- HIV
- RPR (a required test for Syphilis)
- Rubella
- Urine Analysis
- Thyroid and blood sugar levels are optional depending on your physicians preference

At your initial doctor appointment you will be given written information on cystic fibrosis screening and a specialized prenatal risk screening (called a first trimester screen) that includes a 1st trimester ultrasound combined with bloodwork. In the 2nd trimester there is a screening test for open neural tube defects (AFP), done via a blood test. These tests are optional.

16-22 weeks
Prenatal Risk Screen (Quad Screen)—Assesses your risk for having a baby born with birth defects and combines blood values with your medical history to produce the result.
Early diabetes screening—May be done if you have history of gestational diabetes with a previous pregnancy or other risk factors.

18 – 20 weeks
Ultrasound— A detailed anatomical scan is done at this time. Hopefully you can find out the sex at this time if you choose and the baby cooperates.

28 weeks
Gestational Diabetes Screen
Rhogam injection if you have an Rh negative blood type
Pre register for the hospital

36 weeks
Group B Strep Culture

Weight Gain
Recommended weight gain is 25 – 30 lbs.

Lifting limit
30 – 40 lbs

Nutritional Recommendations –

- **8 – 10 glasses of water every day. This is about 1 glass per hour while awake. This is important because of increased risk for urinary tract infection and kidney stones. Also, being dehydrated may increase your risk to have preterm contractions.**
- **1200mg Calcium = 4 glasses of milk or dairy servings or 2 Tums EX**
- **Add 300 calories to your daily diet**
- **We encourage you to stay active during your pregnancy. Walking and swimming are excellent forms of exercise. There are no work restrictions during your pregnancy unless otherwise advised by your physician.**
- **Limit caffeine intake to 2 servings per day (coffee, tea, soda, chocolate)**
- **Prenatal vitamins: We would recommend that you begin taking a Prenatal Vitamin. Over the counter Prenatal Vitamins are fine to take (Costco, Fred Meyer brand, etc) We do not recommend Vitamins that contain any herbs. If you wish to have a prescription sent to your pharmacy please let us know at your initial visit. If you are having trouble with nausea and vomiting it is just fine to hold off on your vitamins until you are feeling better.**

Nausea and Vomiting—

- **Try to eat small amounts of food frequently throughout the day. Have a little snack every 2-4 hours.**
- **Sip liquids constantly – the most important thing is to stay HYDRATED. If vomiting is continuous and you are unable to hold liquids down, CALL the office (425) 656 2496.**
- **Vitamin B6 50mg 2 or 3 times per day up to total of 200mg per day may be helpful. This can be taken in combination with Unisom (will cause drowsiness). Both of these medications are Over The Counter at any pharmacy and do not require a prescription.**

Approved Over the Counter Medications

- **Tylenol and Extra Strength Tylenol – can be used as directed on packaging**
- **NO ASPIRIN OR IBUPROFEN (unless directed to do so by physician)**
- **Stool softener for relief of constipation (Colace, Docusate Sodium, DOS, Miralax) – NO Laxatives**
- **Cold Medications – Sudafed*, Tylenol Sinus*, Tylenol Cold*, Benadryl, Tylenol PM, Chlortrimeton, Claritin, Zyrtec. Robitussin Cough Formula*, Delsym and Throat lozenges are ok as well as directed.**
- ***Medications can be taken in 2nd and 3rd Trimester only, all others ok in 1st Trimester**
- **Heartburn/Stomach upset – Tums, Mylanta, Maalox, Prevacid, Zantac, Pepcid**

Dental Work

OK to have dental work done with a local anesthesia without Epinephrine, NO nitrous gas

X-Rays are ok with a lead shield over your abdomen
We do not recommend dental fillings in the first trimester, ok after 12 weeks. This is due to a possible increase in the risk associated with cleft palate.

Call the office for the following

Bright red vaginal bleeding and/or spotting
Fluid leaking from vagina. An increase in discharge is normal.
Temperature over 100.4. IF you do not have a thermometer, please purchase one.

- ********NO ALCOHOL, NO SMOKING, NO HOT TUBS, NO SAUNAS*******

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Prenatal care and delivery is charged as a flat fee rate that is billed at the time of delivery.
Prenatal care INCLUDES:

- Office calls pertaining to maternity after the initial visit
- Delivery of your baby
- Postpartum checkup through six weeks

This fee EXCLUDES:

- Ultrasounds (routinely two ultrasounds are done)
- Non-Stress tests
- Lab work (this is usually sent to the laboratory of pathology)
- Office visits for infections and other illnesses
- Injections and Blood draws
- Hospital charges, anesthesia charges and pediatric fees

You will need to pre-register about six weeks before your due date with the hospital.
They can also answer questions regarding hospital and anesthesia fees. The hospital costs are *not* included in our fee.

CREDIT AND INSURANCE POLICY

Our global fee is $3,800.00 for a vaginal delivery; $4,200.00 for a cesarean section or vaginal birth after previous C-section. An assistant surgeon is required for C-sections; that fee is $810.00. High-risk pregnancy may have an additional charge, these conditions may include: hypertension, twins, diabetes, excessive weight, etc.

Our office policy is that you pay the portion not covered by your insurance prior to your eighth month of pregnancy. We will set you up on a monthly payment plan and send you statements as a reminder to make your payment. If you do not have maternity coverage, you will need to pay 1/3 of the flat fee at your first visit and monthly payments on the balance so that our fee is paid in full prior to your eighth month.

An estimate of your expected flat fee rate will be applied to your account after the first visit. This fee is not charged to your insurance company until after you deliver. Interest will not be charged until 60 days after delivery.

In the event that you are scheduled off-site for an ultrasound such as Valley Diagnostic Imaging you will receive three separate bills from their office. These charges are *not* included in your global fee. You can contact their office for a personalized estimate at 253-661-4750.

We like to make you aware that **Apple Health** does not cover the cost of a circumcision. Should you elect to have your male child circumcised, the cost for the procedure is $400.00 due at the time of service, paid by cash, credit or debit card.

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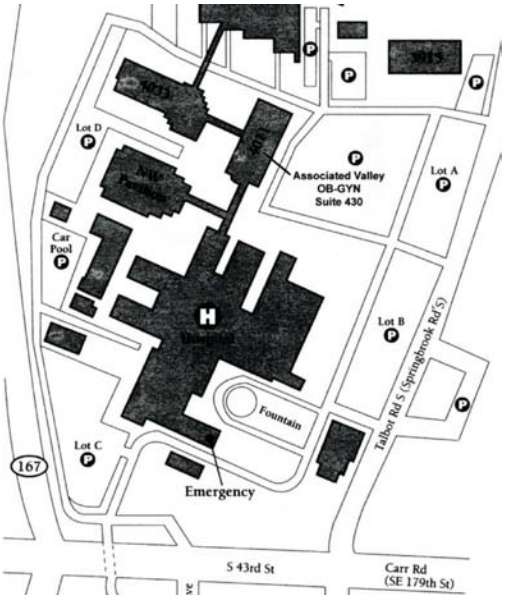
Office Information

Office Hours are Monday through Thursday 9:00AM to 5:00PM,
Friday 9:00AM to 3:00PM.
Office Phone Numbers:

(425) 656-2496
(425) 251-3454 (Business Office)

Location

Associated Valley Obstetrics & Gynecology is conveniently located next to Valley Medical Center.



4011 Talbot Rd. S. – Suite 430
Renton, WA 98055

Directions

Driving north or south on I-5, take the northbound I-405 exit. At Renton, take the southbound Hwy. 167 (Kent/Auburn) exit. From 167, take the first exit (S. 180th), turn left, and on 43rd St. turn left. If you are Northbound on Hwy.167, take the 43rd St. exit, and turn right on 43rd St. Turn left on Talbot Rd. S. We are the second entrance on the left.