insight
MEDICAL GENETICS

Affix label here

Genetic Intake and History Form

Preferred Name: _____ Female ☐ Male ☐ Email address:_____	Preferred contact number: _____ May we leave a message? ☐ Yes ☐ No
Partner's name: _____ Partner's date of birth:_____	Referring Physician: _____ Referring Practice/Location: _____

Personal and Family History

Do you or your partner have a personal or family history (including aunts, uncles, cousins, grandparents, etc) of the following? ***If yes, please describe; if no, leave blank.***

	You	Your partner
Genetic conditions (Down syndrome, cystic fibrosis, muscular dystrophy, etc)		
Birth defects (heart defects, cleft lip, spina bifida, etc)		
Infant/child death		
Muscle weakness		
Developmental delay, intellectual disability or learning disabilities		
Autism or behavior disorder (ADHD, ADD, etc)		
Premature ovarian insufficiency (early menopause) **or** adult tremors		
Other medical conditions		

Affix label here

Carrier Screening

What countries were your ancestors originally from?

_____

What countries were your partner's ancestors originally from?

_____

Any Ashkenazi (European) Jewish descent? Me ☐ My partner ☐ Neither ☐

Any French Canadian or Cajun descent? Me ☐ My partner ☐ Neither ☐

Are you and your partner related by blood (for example, cousins)? ☐ Yes ☐ No

Please check below if you or your partner have ever had previous carrier screening for genetic conditions (such as cystic fibrosis, Tay Sachs disease, sickle cell anemia, etc). *If not, please skip to the next section.*

☐ You ☐ Your partner Where? _____

Were you or your partner found to be a carrier of a genetic condition?

☐ You ☐ Your partner Which condition(s)?_____

Pregnancy History

How many pregnancies, if any, have you or your partner had? _____

Name of living child(ren)	Date of birth	Any health problems, birth defects, or genetic disorders?

	How many?	Weeks gestation/age of child	Causes (if known)
Miscarriages			
Terminations			
Infant or child deaths			

Questions?

Do you have any specific concerns you would like to discuss today? _____

_____

insight
MEDICAL GENETICS

Affix pt label here

Patient Financial Policy

Thank you for choosing Insight Medical Genetics as your genetic counseling and testing provider. We are committed to providing you with high quality and affordable health care. Please note that insurance plans do vary in their coverage. We will assist you in securing insurance payment for the clinical and laboratory services you receive at Insight Medical Genetics; however you may be responsible for any part of the charges not covered by your insurance plan. As with any medical test, you may be responsible for any applicable co-pays, deductible or co-insurance according to your plan. By signing this form, you acknowledge receipt of our "Insurance, Costs and Payments" brochure. In addition, our Financial Counselor is available to assist you with any questions or concerns.

1. **Insurance.** We will pre-certify your services to your carrier if your carrier requires this. If you are not insured by an insurance plan or do not have an up-to-date insurance card, the patient self-pay payment in full is expected at time of your appointment. Understanding your insurance benefits is your responsibility, although we will be happy to answer any questions that we can. Please contact your insurance company with any questions you may have regarding your policy coverage, co-insurance and deductible.

2. **Co-payments**. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Non-covered services**. Please be aware that some – or perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurer. We will do all we can to appeal any decision that reflects financially on you. However, there may be a time when you are assessed a financial responsibility. This patient liability is assessed on *a per test basis*.

4. **Proof of insurance**. All patients must complete our patient information form before seeing the counselor or doctor. We obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be assessed financial responsibility.

5. **Insurance claims submission & appeals**. We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain additional information directly. It is your responsibility to comply with their request for any additional information. If they request your medical records, we will promptly send these to the carrier. If your insurance carrier denies the claim, we will appeal and actively follow-up on your behalf.

6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Non-payment**. If the balance assigned to you is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full or make payment arrangements. Partial payments will not be accepted unless otherwise negotiated.

8. **IMG Patient Access Care Program.** We believe in providing high quality genetic testing in such a way that the costs to you will be affordable. The IMG Patient Access Care Program assist patients with the billing process and is designed to aid individuals with financial challenges. If you have any questions about this program please ask to speak with our Financial Counselor.

Insight Medical Genetics is the business name representing two separate companies functioning seamlessly together. Insight Medical Genetics LLC is our laboratory services company, whereas IMG MD, LLC is our clinical and physician services company. Though the services you experience are completely integrated, billing your insurance for our services may occur through both of our companies.

FINANCIAL AGREEMENT:

**I have read and understand the Insight Medical Genetics Patient Financial Policy.*

**I understand that I am financially responsible for any clinical or laboratory services not covered by my health insurance carrier.*

**Photocopies of this are valid as the original.*

AUTHORIZATION TO RELEASE INFORMATION:

**I authorize the release of medical information necessary to process insurance claims for treatment.*

_____ _____

Signature Date

insight
MEDICAL GENETICS

Authorization Form to Release Protected Health Information (PHI)

I hereby authorize Insight Medical Genetics to use and disclose my individually identifiable health information to the individual(s) named below. Such information includes all radiology, laboratory or other test results, as well as billing and financial information. Additionally, I authorize the individual(s) named below to make or confirm appointments, receive telephone communication, voicemail, and email messages regarding my care and be made aware of my diagnosis and prognosis.

Name of Authorized Individual(s):_____

Relationship to Patient: _____

Authorized Individual's Phone: _____ **May we leave a message?** ☐ Yes ☐ No

If the individual's address is different from the patient's, please provide this information:

_____

By signing below, I agree to the following statements:

1. I understand that this authorization will be effective for the lifetime of the patient unless revoked (see # 2 below).
2. I understand that I may revoke this authorization at any time by notifying Insight Medical Genetics in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Insight Medical Genetics prior to their receipt of the revocation.
3. I understand that my treatment cannot be conditioned on whether I sign this authorization.
4. I understand that this authorization is voluntary and I can leave this form blank if desired.
5. I understand that once information is disclosed to the authorized individual(s), the released information may no longer be protected by federal privacy regulation.

Patient's Signature: _____ **Date:**_____

insight
MEDICAL GENETICS

Patient Name _____

Date of Birth _____

Date of Service _____

Informed Consent to Participate in Telehealth Services

I, _____, wish to receive health services remotely from IMG/MD, LLC and physicians provided by Northwestern Medicine using an Interactive Telecommunications System.

My health care provider as explained to me how the Interactive Telecommunications System ("Telehealth Encounter") will be used to render health services. I understand that these services will not be provided in the same manner as a traditional, face to face in-person patient/health care provider visit, because I will not be in the same room as my health care provider.

I understand there are potential risks in participating in a Telehealth Encounter, including the possibility of interruptions, transmission errors and other technical difficulties, any of which may result in errors or delays in my medical evaluation and treatment.

I understand that I or my health care provider can discontinue the Telehealth Encounter if at any time either of us determines that the technical connections are not adequate for the situation, or that the use of a Telehealth Encounter is not appropriate for the condition being diagnosed or treated.

I understand that others may be present with my health care provider during the Telehealth Encounter, including personnel who will assist in the operation of the telehealth equipment/software. Such individuals are required to maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (i) omit specific details of my medical history/physical examination that are personally sensitive to me; (ii) ask non-medical personnel to not be present during the videoconferencing consultation; and/or (iii) terminate the consultation at any time.

I understand that my health care provider has no control over the location where I participate in the Telehealth Encounter, and it is my responsibility to determine whether others are present at the location where I am during the Telehealth Encounter and can hear or see the information transmitted. I understand that I may not record all or any part of the Telehealth Encounter without my health care provider's prior consent.

I understand that health information discussed during the Telehealth Encounter will be documented in my electronic medical record at Insight Medical Genetics, LLC who may not record or retain the Telehealth Encounter itself.

I have read this document carefully, and understand the risks and benefits of the Telehealth Encounter. I hereby consent to participate in a Telehealth Encounter under the terms described herein.

Signature: _____ Dated: _____

Witness: _____ Relationship: _____

insight
MEDICAL GENETICS

INFORMED CONSENT FOR GENETIC SCREENING/TESTING

Prenatal or preconception genetic screening/testing is offered to all parents before or during pregnancy. It is performed on a sample of blood or saliva.

I understand that:

- The purpose of this screening/testing is to determine whether I and/or my fetus have an increased risk for a genetic disorder or a genetic change(s) associated with a genetic disorder(s).
- The decision to consent to or refuse any of the offered procedures, screening, or testing is entirely mine.
- All screening tests carry a small chance of false positive and false negative results. I have the option to pursue diagnostic testing rather than screening.
- In the event of screen positive results, further consultation with a physician or genetic counselor to discuss the full meaning of the results is available and recommended.
- Screen negative results significantly reduce, but do not eliminate, the chance that I am a carrier of and/or my fetus is affected with the condition(s) screened.
- In rare cases, genetic screens/tests may detect a variant of uncertain significance (VUS). If a VUS is detected, further testing may be recommended to help determine possible clinical significance, however, the clinical significance of the VUS may never be known.
- Some of the genetic disorders for which I am being offered screening/testing have variable expressivity, meaning that the same disorder expresses itself differently in different people. Severity of the disorder cannot be predicted with this screening/testing, nor with further diagnostic testing.
- In some cases, genetic screening/testing may reveal non-paternity or consanguinity (parents are related by blood).

Screens/tests offered to me:		**I elect the following:**	
□ First trimester screening	□ CVS	□ First trimester screening	□ CVS
□ cfDNA screening	□ Amniocentesis	□ cfDNA screening	□ Amniocentesis
□ Carrier screening	□ Microarray analysis	□ Carrier screening	□ Microarray analysis
□ Other _____		□ Other _____	

After my specimen is used for my intended screening/testing, I agree to allow excess specimen(s) to be used by Insight Medical Genetics, LLC for the purpose of research, education and development/quality control. I understand that any information identifying me will be kept confidential so that it will not be possible to determine from whom the specimen was taken. There will be no compensation to me resulting from research and development using this sample. If I do not agree, my specimen(s) will be used for my screening/testing purposes only and will be destroyed after screening/testing is complete and regulatory requirements for sample retention are met.

□ Yes, IMG may use my specimen for research. □ No, IMG may NOT use my specimen for research.

My signature below asserts that I have read and understood the above information. I have had the opportunity to discuss this consent and the information provided to me today. I have all of the information that I want and all of my questions have been answered. I request that Insight Medical Genetics, LLC perform genetic screening/testing. I understand and accept the consequences of this decision. I ask that the results be released to Dr. _____.

_____ _____

Patient Signature Date Healthcare Provider Signature Date

insight
MEDICAL GENETICS

Affix lab here

Acknowledgement of Receipt of Notices of Health Information Practice

I hereby acknowledge that Insight Medical Genetics, LLC, has provided me with the opportunity to read its Notice of Health Information Practices and/or given me a copy.

_____

Signature