



Patient Registration Form

PATIENT INFORMATION				
First:	M.I.:	Last:	How would you like to be addressed:	
Address:		City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	SS#:	Religion:
Date of Birth:	Age:	Race:	Marital Status:	Spouse's Name:
Patient Employer:		Patient's Occupation:		
Address:		City:	State:	Zip:

PLEASE COMPLETE SPOUSE'S INFORMATION OR IF YOU ARE UNDER 18 COMPLETE PARENT'S INFORMATION				
Name/ First:	M.I.:	Last:	Relationship to patient:	
Address:		City:	State:	Zip:
Home Phone:	Work Phone:	SS#:	Date of Birth:	
Employer:	Address:	City:	State:	Zip:

INSURANCE INFORMATION			
Primary Insurance Company:	Copoly Amount:	Deductible:	
Policy Holder Name:	Policy Holder DOB:	ID #:	Group #:
Secondary Insurance Company (if Applicable):		Copoly Amount:	Deductible:
Policy Holder Name:	Policy Holder DOB:	ID #:	Group #:

According to my insurance I must utilize the following facilities for services: Lab _____ Radiology _____ Hospital _____. I understand that it is my responsibility to notify the office of any changes that may affect the above listed requirements. I am aware that failure to do so may result in additional financial responsibility. _____ (initial)

Does your insurance require a referral?	Y	N	Primary Care Doctor?
Who can we thank for referring you to our office?			

Emergency Contact (not living with you):	Relationship to Emergency Contact:
Emergency Contact Phone:	Home: Work or Other:
Is it okay to leave a detailed message for you at and/or with: Home? Y or N Work? Y or N Cell? Y or N Family/Spouse? Y or N	
What is the best time and place to contact you?	

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply. I acknowledge that I have received a copy of this providers Notice of Privacy Policies and understand its contents.

Signed: _____ **Date:** _____

PATIENT'S GUARANTOR BILLING AGREEMENT

1. I verify that I have reviewed the information on this form, and that it is correct.
2. I understand that if my insurance claim is denied due to incorrect personal information or incorrect insurance information, that I have provided, I will be billed and payment in full will be due immediately.
3. If The Fertility Center of Colorado is contracted with the patient's insurance, I authorize assignment of payment directly to the physician for services provided to the patient. I understand that The Fertility Center of Colorado will file a claim with the patient's insurance company, and that I am responsible for following up with the insurance company to insure the claim is paid within 60 days of the date of service.
4. I understand that if the patient has a billable insurance plan, and the insurance has not paid the claim within 60 days of the date of service, charges for that visit will become my responsibility to pay.
5. I understand that, under the terms of the contract with the insurance company, co-payment, deductible, and co-insurance must be paid at the time of service.
6. If the patient has insurance that The Fertility Center of Colorado is not contracted with, I agree to pay all fees in full at the time services are provided. I understand that The Fertility Center of Colorado cannot act as an intermediary between the patient's insurance company and me.
7. If the patient has **no** insurance coverage, I agree to pay the balance in full at the time services are provided.
8. I hereby request and authorize The Fertility Center of Colorado physicians and personnel to deliver medical care to the patient listed on the reverse side of this form.
9. I understand that medical records are the property of the physicians of The Fertility Center of Colorado; however, I may request photocopies, with sufficient advanced notice, upon my written request. I understand that there may be a charge for photocopies of the patient's record.
10. I hereby authorize the release of medical information to the insurance company(ies) concerning any illness and treatment of the patient.
11. I acknowledge that I can obtain a copy of The Fertility Center of Colorado's Privacy Practices/Patient's Privacy Rights, Patient information Letter and the Patient Financial Policy from the front desk personnel upon request.
12. I understand that a \$50.00 fee will be charged for all appointments missed or not canceled at least 24-hours in advance.
13. A service charge of \$25.00 will be assessed on all returned checks.

RESPONSIBILITY AGREEMENT

I acknowledge and understand that I am financially responsible for all services rendered to me by The Fertility Center of Colorado. Although The Fertility Center of Colorado may bill my insurance carrier for services on my behalf, I understand that it is still my responsibility to make sure that the bill is paid within a reasonable length of time. If for any reason, there is a balance owing after the insurance pays, I agree to pay the balance within 30 days of being billed. I also understand that if litigation becomes necessary to recoup any balance due to The Fertility Center of Colorado, I will be held liable to any attorney's fees and court cost that are applicable.

Patient/Guarantor Signature _____ Date _____

Updates: I have reviewed the information on the reverse side of this form and I verify that all the information is current and unchanged.

Initials/Date



Welcome to The Fertility Center of Colorado. It is the goal of our practice to keep you healthy with the highest quality of medical care. Here is some information about our office and what to do if you need us. Please read the following carefully.

OFFICE POLICIES:

- Our phone is answered 24 hours a day, 7 days a week, either by our office staff or the on call provider. All after hour calls should be emergency related. Our regular phone hours are 8:00 a.m. to 4:00 p.m., except Fridays which are 8:00 a.m. to 12:00 p.m.
- Our office hours are 8:00 a.m. to 4:00 p.m., Monday through Thursday and 8:00 a.m. to 12:00 p.m. on Friday.
- Routine medical care, including scheduling/canceling appointments, prescription refills, and non-emergent care will be handled only during office hours.
- Routine appointments should be scheduled at least 2-4 weeks in advance.
- Prescription refills: Call your pharmacy and have them contact us during our regular office hours. In order to avoid being without medication(s), contact your pharmacy at least 48 hours prior to running out. If requesting a new prescription, please have your pharmacy telephone number available. **Please note that prescription requests will not be handled after hours.**
- In case of an emergency the on call provider will be promptly contacted.
- Due to the sensitive nature of our practice and for safety reasons, we request that all children be accompanied by an adult at all times; they may not be left in the waiting room unattended.

FIRST APPOINTMENT POLICIES:

- Complete and return New Patient paperwork, to our office as soon as possible, preferably **1 week** prior to your initial appointment with the physician.
- Complete the **entire** registration form including **all** insurance information.
- Mail or fax us, at least one week prior to your appointment, a copy of your medical records that pertain to any previous infertility testing, treatment or surgeries you or your spouse may have had. **Please make a copy for yourself prior to your appointment, as we will not be able to copy them for you.**
- Please bring a copy of yours and your spouses' driver's license (or we can copy them for you).
- Please provide complete insurance information to our office **at least one week prior** to your visit so we may verify your coverage. Please bring a current insurance card to your visit so we can make a copy of it.
- Obtain a referral for your initial visit, if required by your insurance company.
- Arrive at least 15 minutes prior to your appointment to review and sign paperwork. Understand that if you arrive late for your appointment it may need to be rescheduled.

Patient Signature

Date

PATIENT ACCOUNTS AND INSURANCE POLICY

To help you understand and anticipate any difficulties in insurance benefits you may encounter, please review this document.

Insurance coverage in this area of medicine is not as straightforward as in most other areas. For example:

- Many times there is coverage for testing to determine **why** you are infertile, but no coverage for its treatment.
- Many times payment depends on **why** the service was performed. For instance, if we do an ultrasound of your ovaries to ensure that an ovarian cyst is shrinking, it will be paid (in most cases), but if we do the ultrasound to track your response to fertility medication, it will often not be paid.
- Many times the information we get from your insurer over the phone is incorrect or incomplete.

To best serve you, we have developed this approach:

Determination of Insurance Benefits

When you become a patient at The Fertility Center of Colorado, we contact your insurance company to obtain information regarding the coverage you have for fertility care. We have developed a list of the questions that we ask so as to get a picture of the nature and extent of your coverage. We will provide you a copy of this summary. Please review this information. If you think you have different coverage or a different level of benefits, please notify us so we may clarify the information. We suggest that you also call your insurance company for clarification.

Unfortunately, this “*verification*” of benefits does not oblige insurers to pay. Insurance companies protect themselves by stating that verification of your insurance coverage by them is:

- Not a guarantee of payment, and is
- Not a guarantee of what is actually covered and not covered.

Because of this disclaimer, even when they have told you or us that a service is covered there is no obligation for them to pay. The true determination as to whether a service is covered is made at the time a claim is received by the insurance company. Whether insurance will pay is dependent on whether:

- The service you received is covered by your plan.
- The reason for the service (the diagnosis) is covered by your plan.
- The appropriate deductibles and co-pays have been met.
- “Pre-existing condition” exclusions apply.

Further complicating payment is that some plans require that:

- You have experienced infertility for a specified amount of time before services will be covered, or
- The infertility is not due to a prior elective sterilization, or
- Certain treatment steps are taken before other treatment steps will be covered. This may not always be consistent with the course of treatment that we think is best for you. For instance, some companies will pay for IVF treatment, but only after 3 cycles of gonadotropins have failed.

There may be occurrences where your insurance company denies payment and deems that a service “*is not consistent with the diagnosis*” assigned to you.



CLAIMS FILING

• **For Insurance Companies/Networks With Which We Are Contracted**

We will be happy to file a claim for coverage of rendered services with your insurance company if you have insurance with a network with which we participate, if your plan provides benefits for the service provided for the reason it was provided and if there are no other restrictions on covered services of which we are aware. We will collect any required co-payment, co-insurance, deductibles and non-covered services at the time of your visit.

If you have insurance with an insurer with which we participate, but your plan does not provide benefits for your diagnosis or for the procedures/services rendered, then full payment is required at each visit. We expect all balances to be settled on the day it occurs.

Currently, we participate with these networks (subject to change):

<ul style="list-style-type: none"> • Aetna • Anthem BC/BS • Affordable • Beechstreet PPO • Blue Advantage HMO • CCN PPO • Choice Care PPO • Cigna (all plans) • First Health PPO • Great West Healthcare • M-Care • Medical Network • Mountain Medical Affiliates 	<ul style="list-style-type: none"> • One Health Plan • PacifiCare HMO/PPO/Indemnity • Private Healthcare Systems (PHCS) • Rocky Mountain Healthcare HMO • Sloans Lake Managed Care • TriCare Prime/Standard/Extra • Total Healthcare • Unicare • United Healthcare (all plans) • Many more-check with your plan!
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• **For Insurance Companies/Networks With Which We Are Not Contracted**

If you have health insurance with an insurer with which we do not participate, then full payment for all services rendered is required at the time of your visit. As noted above, we require that each patient's balance be settled on the day it occurs. We will provide you with a statement that can be submitted to your insurance company for reimbursement directly to you (if any).

Other Items

Infertility treatment can be expensive, and we do not want to let you get "in over your head". Thus, we collect in full for each service as it is rendered, except in the case of IVF services, which is discussed later in this packet. We strive to anticipate how much each services will cost you for each and every visit (by calculating your portion of charges after insurance is applied), and expect that costs be paid at that visit. On occasion, however, this is not possible. In some cases the actual charge can only be estimated (as in surgery). In other cases, we discover monies owed after a visit has occurred. These situations are described below and also the way we handle them.

- **All IVF Cycles**

Fees for all IVF Cycles (IVF, Frozen Embryo Transfers, Egg Recipient/Donor Cycles, etc.) are collected in advance of the start of the Cycle.

- **All Ovulation Induction (OI) Cycles**

Fees for all OI Cycles (Office visits, ultrasounds, labs, inseminations, etc.) are collected at the time of each individual appointment.

- **Surgery**

If you are having surgery, we will calculate an estimate of the charges you will be responsible to pay based on your "in" or "out" of network status and based on the information the insurance company provides to us. This payment is required prior to surgery. We will also file the claim with your insurance company. If you are "in" network, you are responsible for any patient balance after insurance adjustments have been taken. If you are "out" of network, you are responsible for the difference between what we charge and what insurance pays.

- **Additional Services Rendered**

Occasionally, when the doctors review lab results, they determine that another test is needed to make a complete evaluation. When this occurs, the charges for the additional test will be posted to your account at the time the test is ordered.

Occasionally, our audits detect that services were incorrectly posted to your account, resulting in overcharges or undercharges. When we identify such errors, we will correct your account, resulting in a credit or a balance.

- **Settling of Balances**

As discussed above, there are times when insurance companies process a claim in a manner different than expected. In these cases,

- A claim may be completely denied as not covered, with no payment being made, thereby making you responsible for the entire charge. _____ **(Initial)**
- A claim may pay differently than was anticipated, also thereby making you responsible for a larger portion of the charge than expected. _____ **(Initial)**
- Even though your insurance company communicated to us and we in turn communicated to you that a given service or set of services is/are covered, this ***IS NOT A GUARANTEE BY US*** of your insurance company's coverage for that service or set of services. If your insurance company denies coverage for any reason, you are responsible for full payment of the services billed. Because the insurance company states that the verbal information they provide is not a guarantee of payment nor can it be relied on as a guarantee of coverage, we are not responsible for any statement made by your insurance company, nor any statement made by us to you based on information given to us by your insurance company. It is very important for you to understand that the only ***TRUE*** representation of whether a given service is covered is when your insurance company actually processes the claim. _____ **(Initial)**

When this occurs, we will first try to understand why: Was the claim processed correctly? Were the appropriate diagnoses used? Were benefits incorrectly stated to us at verification? Typically an insurance company will send an EOB ("Explanation of Benefits") that outlines what they paid and didn't pay and why. If we believe there are errors in the claim, we will resubmit it. If you receive an EOB that processed your claim differently than you expected, please call your insurance company to clarify. If the insurance company states that they processed the claim incorrectly, please obtain the name of the person you spoke with and call us with that information so we can note this in your account. If your insurance company reprocesses the claim, when you receive the corrected EOB showing payment was made to us, please call us to issue a refund to you.

If however there are no errors, we will make the corresponding adjustments to your account, determine the portion of the charge you are responsible for and post this portion to your account. As stated previously, there are times when an insurance company states that the test or procedure performed is not consistent with the diagnosis assigned to you. The providers at The Fertility Center of Colorado perform or order services to be performed when they determine that they are important in the diagnosis and treatment of the patient for the particular circumstances of the patient. When your insurance company denies payment and renders the decision that the services are "not consistent with the diagnosis", it has decided otherwise.

When services have been performed/ordered by our providers and your insurance deems the services to be "inconsistent with the diagnosis" your physician has deemed them to be important in your diagnosis and treatment and for your particular circumstances. Your signature below acknowledges your agreement that you will be responsible for the payment for these services should your insurance company deny payment and state that these services are "inconsistent with the diagnosis" assigned to you. _____ **(Initial)**

- **Credit Card Authorizations**

As you may now understand, there are instances of charges being generated or recognized on days when there is no office visit scheduled. With the very busy lives of our patients, it is difficult to reach patients to come in and settle balances as they arise. Therefore, we offer a policy to keep a credit card authorization maintained on file so that your balance can be settled as they occur. Our patients like this strategy for convenience. _____ **(Initial)**

When these cases arise:

- We will call you before making any charge in excess of \$500.
- We will call you before making any charges to a Debit Card, regardless of the amount.
- We will call you before making any charge for a service provided more than 6 months ago.
- We will mail you a copy of your credit card receipt and your statement on the day the charge is made.

An authorization form will be supplied to you and your spouse for your signature(s).

- **Insurance Company Look Back Periods**

Insurance companies often perform audits of paid claims. These audits can be performed for up to two years from the latter of the following (a) the date of services, (b) the receipt of the claim, (c) the payment of the claim, or (d) the receipt of an appeal. When an insurance company performs an audit and determines that claims were paid in error and should not have been, the insurance company contacts us for a refund of the monies they paid. They then direct us to collect for these services from the patient. Unfortunately, this may mean that for a period of up to two years after any one of the above listed events your insurance company may reverse their decision. If this should occur we will then contact you for payment of these services.



- **Interest on Unpaid Balances**

Should you have an outstanding balance on your account that is your responsibility and that is greater than 30 days old, we will assess simple interest of the unpaid balance at a rate of 1.5% per month. This represents an annual interest of 18%.

- **Administrative Billing Fee When Your Co-Pay, Co-Insurance or Patient Responsibility Balance Is Not Paid at the Time of Service.**

When your co-pay, co-insurance or patient responsibility balance for that day's visit is not paid at the time of service, we will assess a \$25.00 administrative billing fee and subsequently bill you for the unpaid amount.

- **Account Representatives**

We understand that infertility is a challenging problem. Unfortunately, managing insurance benefits is often troublesome in this area. We have staff that are well trained to help you navigate these often troubled waters. Feel free to work with them.

Patient's Attestation:

I fully understand The Fertility Center of Colorado's Patient Accounts and Insurance Policy described above. I understand that I am responsible for any balance not covered or not paid by insurance for any reason.

Patient Signature

Date



General Information

Name _____ Date _____
 Address _____
 Home _____ Work _____ Cell _____
 Birth date _____ Age _____ Height _____ Weight _____
 Ethnic Background _____
 Highest Education _____ Husband's Name _____
 Marriage date _____

Referred by: _____

OB/GYN Doctor: _____ **Primary Care Doctor:** _____

Do you wish us to send a note to your PCP _____ **OB/GYN** _____ **Other** _____

Gynecologic History

Age of first period _____ Date of first day of last period _____
 Usual cycle length _____ days _____ range
 (interval from start of one period to start of next)
 Usual duration of bleeding _____
 Do you have any symptoms at time of ovulation (i.e., pain, mucous)?
 _____yes _____no
 Amount of flow _____ Light _____ Moderate _____ Heavy
 Is cramping _____ None _____ Minimal _____ Moderate _____ Severe
 _____ back pain _____ diarrhea
 Medication required to start period Yes No
 What age did periods stop? N/A _____
 Circle symptoms preceding period:

None Breast soreness Irritability Spotting
 Weight (circle): losing gaining stable

History of: Pelvic Pain _____

Endometriosis _____

Gynecologic surgery _____

Last PAP _____ Breast exam _____ Mammogram _____

Treatments for abnormal PAP:

Cryotherapy _____ LEEP _____ Conezation _____ Laser _____

Have you ever been treated for: _____ Dates _____

Syphilis _____

Gonorrhea _____

Chlamydia _____

Genital warts _____

Do you have a history of genital herpes _____yes _____no

Did your mother take any medications while pregnant with you?
 _____yes _____no _____don't know _____ What?

Was DES taken _____yes _____no

Sexual History

Frequency of sexual intercourse per week _____
 Use of lubricants ___ yes ___ no _____
 Name of lubricants _____
 Does husband ejaculate in the vagina during intercourse ___ yes ___ no
 Is intercourse painful to you? _____ yes _____ no
 Is intercourse painful to your partner? _____ yes _____ no

Contraceptive History

Birth control pills _____ yes _____ no # of years taken _____

Date stopped birth control pills _____

Were menses regular before birth control pills ___ yes ___ no

Were menses regular after stopping the pills ___ yes ___ no

How long after stopping the pills did menses start _____

Previous use of IUD (intrauterine device) ___ yes ___ no ___ # years

When was IUD removed (date) _____ reason _____

Circle previous use of:

diaphragm condom foam rhythm sponge patch
 tubal ligation
 depo-provera



Obstetrical History

Have you been pregnant before? ____ yes ____ no

Do you have children: ____ yes ____ no _____ ages

How long to conceive: _____

RECORD ALL PREGNANCIES

Pregnancy #	Date	Full term	Preterm	Miscarriage	Termination	Complications	Fertility Treatment	Pregnancy weight	Is current partner the father

Occupation/Leisure History

Yes No Dates/Comments

Occupation: _____

Exposed to chemical or x-rays in work or hobby

Please list

Amount per day or week

Caffeine

Smoking

Alcohol

Marijuana

Nutritional supplements, herbs, etc.

Drugs

Please describe exercise (frequency, length of time, etc.) _____



Family History:

Father's age if alive _____ If no longer living, cause of death _____

Medical problems: _____

Mother's age if alive _____ If no longer living, cause of death _____ Age at menopause _____

Medical problems: _____

Sister(s) ages _____ medical problems: _____

Brother(s) ages _____ medical problems: _____

Is there a family history of:	Yes	No	Comments
Birth defects or genetic diseases	_____	_____	_____
Infertility	_____	_____	_____
Hormone problems	_____	_____	_____
Miscarriages/stillbirths	_____	_____	_____
Pregnancy problems	_____	_____	_____
Cancer	_____	_____	_____
Stroke	_____	_____	_____
Heart disease	_____	_____	_____
Lung disease	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid/endocrine problems	_____	_____	_____
High blood pressure	_____	_____	_____
Sickle Cell Disease	_____	_____	_____
Hemochromatosis	_____	_____	_____
Blood clots	_____	_____	_____
Obesity	_____	_____	_____
Tuberculosis	_____	_____	_____
Endometriosis	_____	_____	_____
Hemophilia	_____	_____	_____
Mental retardation	_____	_____	_____
Any women who have never menstruated	_____	_____	_____
Any men who have never had to shave	_____	_____	_____

Any additional comments you would like to make that you feel may be pertinent and have not already been addressed:

Ancestry:

Are you or your partner of the following ethnic group:

	Y	N	There is increased risk for:
Caucasion	Y	N	Cystic fibrosis
English/Irish	Y	N	Neural Tubal Defects
Meditereanean (Greek, Italian, Middle East)	Y	N	Thallasemia
Ashkemazi Jewish	Y	N	Tay Sachs, Canavan
French/Canadian	Y	N	T-Sachs
Asian (SE Asia, Chinese, Philipino, Indian)	Y	N	Thallasemia
African desent	Y	N	Sickles cell, Thallasemia



Medical/Surgery History	Yes	No	Dates/Comments
Mumps	_____	_____	_____
Measles	_____	_____	_____
Chicken Pox	_____	_____	_____
Rubella (German Measles)	_____	_____	_____
Rheumatic fever	_____	_____	_____
Elevated Blood pressure	_____	_____	_____
Heart murmur	_____	_____	_____
Heart disease	_____	_____	_____
Diabetes	_____	_____	_____
Lung disease	_____	_____	_____
Liver or gall bladder disease	_____	_____	_____
Jaundice	_____	_____	_____
Kidney infections	_____	_____	_____
Hepatitis	_____	_____	_____
Kidney stones	_____	_____	_____
Gout	_____	_____	_____
Urinary tract abnormalities	_____	_____	_____
Thyroid disease	_____	_____	_____
Arthritis	_____	_____	_____
Auto immune diseases (lupus, rheumatoid arthritis, etc.)	_____	_____	_____
Other serious or chronic diseases _____	_____	_____	_____
Any surgery (list type and year) _____	_____	_____	_____

Do you have any allergies to medications: Yes _____ No _____ Latex Y N Seafood Y N
If yes, which medications. _____

Please list any medications including over the counter and herbs you are now taking or have taken in the past.
Current: _____ Past: _____

Any history of therapeutic x-ray treatment or anti-cancer drugs?
Current: _____ Past: _____

Have you ever been involved in psychotherapy or counseling? Yes _____ No _____
If yes, please indicate why, when, with whom, and any other pertinent information. _____

Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches	_____	_____	Increased thirst	_____	_____	Excessive Fatigue	_____	_____
History of head injury	_____	_____	Increased sweating	_____	_____	Tremors	_____	_____
Convulsion history	_____	_____	Intolerance to heat	_____	_____	Desire for extra salt	_____	_____
Visual problems	_____	_____	Intolerance to cold	_____	_____	Excess Loss of scalp hair	_____	_____
Dizziness	_____	_____	Difficulty swallowing	_____	_____	Growth of hair on face	_____	_____
Rapid weight change	_____	_____	Change in voice or			or body in new places	_____	_____
Acne	_____	_____	hoarseness	_____	_____	Change in size of clitoris	_____	_____
Change of appetite	_____	_____	Difficulty sleeping	_____	_____	Discharge from nipples	_____	_____



Please include any other information which you believe may be pertinent to your infertility problem

Pre-conceptual Health Screening

Have you ever been tested for:	Yes	No	If yes, give dates/results
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____
TB (Tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Type	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gaucher Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Canavan Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle cell	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia or Thallasemia	<input type="checkbox"/>	<input type="checkbox"/>	_____

Previous Infertility Testing

Length of time currently attempting pregnancy _____ Yrs _____ Mths Length of time not using contraceptives _____

	Yes	No	Year	Normal	Abnormal	If yes, give dates/results
Temperature charts	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterosalpingogram (x-ray of tubes and uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sonohysterogram (water in uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysteroscopy (look inside uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometrial biopsy (take tissue from inside uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-coital test (test sperm in cervical mucus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laparoscopy (look inside the pelvis/abdomen)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Tests						
Day 3 FSH	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day 3 Estradiol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clomid Challenge Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosome tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____



Previous Infertility Treatment

Treatment with Clomiphene (Clomid, Serophene) Yes No

If Yes:

Cycles **without** Intrauterine Insemination (IUI) Yes No #Cycles / Dates _____

Cycles **with** Intrauterine Insemination (IUI) Yes No #Cycles / Dates _____

Pregnant Yes No Dates _____

Treatment with Gonadotropins (Follistim, Gonal-F, Repronex, Humegon, Pergonal) Yes No

If Yes:

Cycles **without** Intrauterine Insemination (IUI) Yes No #Cycles / Dates _____

Cycles **with** Intrauterine Insemination (IUI) Yes No #Cycles / Dates _____

Pregnant Yes No Dates _____

Treatment with IVF or other Reproductive Technologies (GIFT, ZIFT)

Cycle #	Protocol (if known)	Dose of FSH or LH	Estrogen Level at retrieval	# Eggs Retrieved	# Embryos Transferred	Pregnant?	Delivery?
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other comments on Infertility treatments:



General Information

Name _____ Date _____

Address _____

Home _____ Work _____ Cell _____

Birth date _____ Age _____

Occupation _____

Ethnic Background _____

Height _____ Weight _____

Highest Education _____

Wife's Name _____

Marriage date _____

Referred by: _____

Infertility History

Have you ever fathered a pregnancy? ___ yes ___ no

If yes, when (year of birth) _____

Have you ever been told you are infertile? ___ yes ___ no

If yes, when and by whom? _____

Length of time attempting pregnancy ___ Years ___ Months

Length of time not using contraceptives _____

Did your mother take DES or other medications while pregnant with you?

___ yes ___ no ___ don't know

If yes, list: _____

Have you ever been treated for: _____ Dates _____

Syphilis _____

Gonorrhea _____

Chlamydia (non-specific urethritis) _____

Prostatitis (infection of the prostate) _____

Infection of the testicles _____

Infection of the seminal vesicles _____

Do you have a history of genital herpes ___ yes ___ no

Sexual History

Has there been any change in your libido or sexual drive?

___ yes ___ no

Is there any difficulty in maintaining an erection?

___ yes ___ no

Do you.....

ejaculate into the vagina without difficulty?

___ yes ___ no

have any pain or burning with urination or ejaculation?

___ yes ___ no

have/had any discharge from the penis?

___ yes ___ no

have or have you ever had scrotal or testicular pain?

___ yes ___ no

Frequency of sexual intercourse per week? _____



Medical/Surgery History	Yes	No	Dates/Comments
Mumps (after puberty)	_____	_____	_____
Measles	_____	_____	_____
Chicken Pox	_____	_____	_____
Rubella (German Measles)	_____	_____	_____
Rheumatic fever	_____	_____	_____
Elevated Blood pressure	_____	_____	_____
Heart murmur	_____	_____	_____
Heart disease	_____	_____	_____
Multiple Sclerosis	_____	_____	_____
Diabetes	_____	_____	_____
Lung disease	_____	_____	_____
Liver or gall bladder disease	_____	_____	_____
Jaundice	_____	_____	_____
Prostate infections	_____	_____	_____
Kidney infections	_____	_____	_____
Hepatitis	_____	_____	_____
Kidney stones	_____	_____	_____
Gout	_____	_____	_____
Urinary tract abnormalities	_____	_____	_____
Thyroid disease	_____	_____	_____
Arthritis	_____	_____	_____
Auto immune diseases (lupus, rheumatoid arthritis, etc.)	_____	_____	_____
Cancer	_____	_____	_____
Other serious or chronic diseases _____			
Any surgery including vasectomy or vascular repair (list type and year) _____			

Do you have any allergies to medications: Yes _____ No _____
If yes, which medications. _____

Please list any medications you are now taking or have taken in the past. Current: _____ Past: _____

Any history of therapeutic x-ray treatment or anti-cancer drugs? Current: _____ Past: _____

Have you ever been involved in psychotherapy or counseling? Yes _____ No _____
If yes, please indicate why, when, with whom, and any other pertinent information. _____

Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches	_____	_____	Increased thirst	_____	_____	Fatigue	_____	_____
History of head injury	_____	_____	Increased sweating	_____	_____	Tremors	_____	_____
Convulsion history	_____	_____	Intolerance to heat	_____	_____	Desire for extra salt	_____	_____
Visual problems	_____	_____	Intolerance to cold	_____	_____	Rapid weight change	_____	_____
Dizziness	_____	_____	Difficulty sleeping	_____	_____	Change of appetite	_____	_____



Please include any other information which you believe may be pertinent to your infertility problem: _____

Pre-conceptual Health Screening

Have you ever been tested for:	Yes	No	If yes, give dates/results
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____
TB (Tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Type	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gaucher Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Canavan Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle cell	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	_____

Previous Infertility Testing

Previous urological exam? yes no

Results: _____

Previous semen analysis? yes no

Results:	<u>Date</u>	<u>Count (million/cc)</u>	<u>Motility (% moving)</u>	<u>Morphology (% normal shape)</u>
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Specialized sperm testing? yes no

(Acrosome reaction, sperm penetrating assay, antibody testing)

Results (which tests): _____

Specific treatment for Male Infertility? yes no

Details: _____



Occupation/Leisure History	Yes	No	Dates/Comments
Have you ever been employed in an occupation with sustained high temperature?	_____	_____	_____
Do you drive long distances as part of your employment?	_____	_____	_____
Do you use hot tubs, saunas, etc.?	_____	_____	_____
Exposed to chemical or x-rays in work or hobby	_____	_____	_____
Please list			Amount per day or week
Caffeine	_____	_____	_____
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Drugs (not prescribed), list	_____	_____	_____

Please describe recreational/sports activities (frequency, length of time, etc.) _____

Family History

Father's age if alive _____ If no longer living, cause of death _____

Medical problems: _____

Mother's age if alive _____ If no longer living, cause of death _____

Medical problems: _____

Sister(s) ages _____ medical problems: _____

Brother(s) ages _____ medical problems: _____

Is there a family history of:	Yes	No	Comments
Birth defects or genetic diseases	_____	_____	_____
Infertility	_____	_____	_____
Hormone problems	_____	_____	_____
Miscarriages/stillbirths	_____	_____	_____
Pregnancy problems	_____	_____	_____
Cancer	_____	_____	_____
Stroke	_____	_____	_____
Heart disease	_____	_____	_____
Lung disease	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid/endocrine problems	_____	_____	_____
High blood pressure	_____	_____	_____
Any women who have never menstruated	_____	_____	_____
Any men who have never had to shave	_____	_____	_____

Any additional comments you would like to make that you feel may be pertinent and have not already been addressed:



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires as medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill to your insurance company for your visit.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer services. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternate means or at alternate locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

FERTILITY CENTER OF COLORADO
6160 Tutt Blvd., Suite 210
Colorado Springs, CO 80923
719-636-0080 ☎ FAX 719-636-3030

**AUTHORIZATION FOR RELEASE
OF MEDICAL RECORDS**

Patient name _____
Birth Date _____
SSN _____

I hereby authorize:

Name _____
Address _____
City _____
Phone _____ Fax _____

to release medical records to:

Name _____
Address _____
City _____
Phone _____ Fax _____

Information to be released (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Past 3 years | <input type="checkbox"/> Radiology/ultrasound |
| <input type="checkbox"/> Emergency Room Reports | <input type="checkbox"/> Genetic information |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> HIV/Communicable disease reports |
| <input type="checkbox"/> Operative report | <input type="checkbox"/> Mental health treatment |
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Drug/alcohol treatment |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Embryology Reports |
| <input type="checkbox"/> Ovulation Induction Records | <input type="checkbox"/> All Records |

Please understand that "all records" means that only records generated by this facility will be released. We cannot forward copies of records that we have received from any other physician. You will need to obtain these records directly from the physician providing your care at the time of treatment.

Reason to release information _____

I understand this authorization is voluntary and there may be a fee to copy these records. I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information in physician dictation. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

Date _____ Signature _____



PHONE MESSAGING INFORMATION

Please tell us how you would like the office staff to contact you regarding medical information when we are not able to speak to you directly. We would like to leave a message where/when possible.

In order to protect your privacy, we have developed the following policy on leaving messages:

- We will not leave messages with anyone except the patient.
We will not leave any information on an answering machine.
We will not leave any messages on a voice mail system.

Unless:

We have your written permission to leave messages for you. Please read the information below and consider carefully whom you want to have access to your medical information such as lab and x-ray results.

Thank you for your understanding of our policy.

I, _____ give The Fertility Center of Colorado and/or its representatives my permission to leave phone messages regarding my medical care with the following: (Enter phone number and initial for each one you wish to have your messages.)

Home answering machine: # _____ initial
Office phone voice mail: # _____ initial
Spouse _____ # _____ initial
Other _____ # _____ initial

Patient Signature

Date

Review of Systems

Name: _____ Date: _____

Date of Birth: _____

**PLEASE REVIEW ALL OF THESE SYSTEMS-CIRCLE ANY PROBLEM AREAS;
ELABORATE IF NECESSARY.**

Eyes: Blurred vision, pain, discharge, other: _____

Ears, Nose, Mouth, and Throat: Hearing loss, obstruction, pain, lesions, other: _____

Constitutional: Fatigue, unexplained weight loss or gain, other: _____

Heart & Vascular: Heart attack, heart disease, chest pain, rheumatic fever, high blood pressure, aneurysm, stroke, rapid or irregular heart rate, other: _____

Liver: Hepatitis, jaundice, gall bladder disease, other: _____

Urinary system: Loss of urine with coughing, sneezing, or exercising, urgency, frequent urination, burning with urination, stones, frequent kidney and/or bladder infections, other: _____

Gynecological system: Vaginal discharge, itching, fullness or pressure in vaginal area, painful intercourse, heavy periods, clots, bleeding between periods, unpredictable periods, missed periods; Cramps-mild, moderate, or severe; fibroids, "dropped" uterus, vulvar pain, lesions or growth, pelvic infection, herpes, gonorrhea, Chlamydia, syphilis, abnormal pap smears, ovarian growths, tumors, or cysts, tubal infection or obstruction, infertility, other: _____

Musculoskeletal: Osteoporosis, loss of height, fractures after age 45, muscle weakness or tenderness, other: _____

Skin: Rashes, skin diseases or lesions, skin cancer or melanoma, other: _____

Breast: Swelling, pain, lump, change in skin contour or nipple, nipple discharge or bleeding, breast biopsy (how many? _____), cancer, other: _____

Endocrine: Thyroid disease, diabetes, hypoglycemia, excessive thirst, frequent urination, hot flashes, trouble sleeping, unusually emotional, vaginal dryness, PMS, other: _____

Neurological: Headaches, migraines, seizures, weakness, numbness, other: _____

Psychiatric: Depression, anxiety, personality disorder, psychiatric admission, suicidal thoughts and/ or attempts, other: _____

Hematological / Lymphatic: Anemia, easy bruising, abnormal platelets, clots in deep veins, clots in lungs, thalassemia, sickle cell, hemophilia, swollen lymph nodes, leukemia, lymphoma, other blood diseases: _____

Allergic / Immune Systems: Drug allergies (should be listed on other form), food allergies, hay fever, autoimmune diseases such as lupus, HIV, or AIDS.

ZUNG SELF-RATING DEPRESSION SCALE

Patient's Initials _____

Date of Assessment _____

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Adapted from Zung, A self-rating depression scale, *Arch Gen Psychiatry*, 1965;12:63-70.

Presented as a service by

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Research Triangle Park, NC 27709
Web site: www.glaxowellcome.com