



## 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 <i>IF YOU ARE UNDER 18</i> 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:		Copay Amount:	Deductible:
Policy Holder Name:	Policy Holder DOB:	ID #:	Group #:
Secondary Insurance Company (if Applicable):		Copay 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 <b>detailed message</b> for you at and/or with:			
<b>Home?</b> Y or N	<b>Work?</b> Y or N	<b>Cell?</b> Y or N	<b>Family/Spouse?</b> 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 8:30 a.m. to 12:00 p.m. and 1:30 p.m. to 4:30 p.m., except Fridays which are 8:30 a.m. to 12:00 p.m.
- Our office hours are 8:00 a.m. to 4:30 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.

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Patient Signature

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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"> <li>• Aetna</li> <li>• Anthem BC/BS</li> <li>• Affordable</li> <li>• Beechstreet PPO</li> <li>• Blue Advantage HMO</li> <li>• CCN PPO</li> <li>• Choice Care PPO</li> <li>• Cigna (all plans)</li> <li>• First Health PPO</li> <li>• Great West Healthcare</li> <li>• M-Care</li> <li>• Medical Network</li> <li>• Mountain Medical Affiliates</li> </ul>	<ul style="list-style-type: none"> <li>• One Health Plan</li> <li>• PacifiCare HMO/PPO/Indemnity</li> <li>• Private Healthcare Systems (PHCS)</li> <li>• Rocky Mountain Healthcare HMO</li> <li>• Sloans Lake Managed Care</li> <li>• TriCare Prime/Standard/Extra</li> <li>• Total Healthcare</li> <li>• Unicare</li> <li>• United Healthcare (all plans)</li> <li>• Many more-check with your plan!</li> </ul>
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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



**Must be completed for all authorizations**

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Persons/organizations providing the information:

Person/organizations receiving the information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If these are not marked we can not release them.

\_\_\_ Drug Abuse (if any)

\_\_\_ Substance Abuse (if any)

\_\_\_ Psychological or Psychiatric Conditions (if any)

\_\_\_ AIDS/HIV (if any)

We can only copy our records; we can not forward copies of your records that we have received from any other physician or facility. You will need to obtain these records directly from the physician providing your care at the time of treatment.

Please release the following records:

\_\_\_ All records generated in this office.

\_\_\_ Other: \_\_\_\_\_  
(specific dates of treatment or specific description of information requested)

Are you leaving our practice? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

**Must be completed for all authorizations**

1. I understand that this authorization will expire 90 days from the date of signature.
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient's representative

\_\_\_\_\_  
Relationship to the patient



**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

	Yes	No	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
Mediterranean (Greek, Italian, Middle East)	Y	N	Thalassemia
Ashkenazi Jewish	Y	N	Tay Sachs, Canavan
French/Canadian	Y	N	T-Sachs
Asian (SE Asia, Chinese, Philipino, Indian)	Y	N	Thalassemia
African descent	Y	N	Sickle cell, Thalassemia



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			<b>Amount per day or week</b>
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:**

\_\_\_\_\_

\_\_\_\_\_



The  
Fertility Center  
Of Colorado

## 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.