the Fertility Center of New Mexico

JIM THOMPSON, M.D.
201 Cedar Street SE, Suite S1-20 • Albuquerque, NM 87106
PH: 505-248-0000 • Fax: 505-842-0000
Infertility • Reproductive Endocrinology
NMFertility.com

Dear Patient:

Welcome to our office. We want to thank you for choosing The Fertility Center of New Mexico for your healthcare needs. We have a dedicated team of professionals who are available and committed to serving you. Our goal is to provide you with the highest quality services in a timely manner.

Included in this packet are forms that need to be printed and filled out by you and your partner (if applicable). Please bring the *completed* paperwork to your appointment along with picture ID and your insurance card(s).

A Medical Records Release form is enclosed to assist you in obtaining any relevant records from other providers for your appointment. Complete and forward to providers as needed.

*Please plan to arrive 15 minutes prior to your scheduled appointment time.*

*(Presbyterian Hospital offers Valet Parking for your consideration and convenience.)*

A representative from our office will call you prior to the appointment to discuss your benefits as they relate to care in this office.

If you do not keep the appointment and have not cancelled prior to the day of the appointment you will be charged a $75.00 fee. This must be paid prior to scheduling a future appointment.

We look forward to meeting you.

If you need any additional assistance, please do not hesitate to call.

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## NEW PATIENT HISTORY QUESTIONNAIRE - FEMALE



**A. IDENTIFYING DATA** Date this form completed _____ Appointment Date _____

Name _____ Age _____ Birth Date _____ SS# _____
Height _____ Weight _____

Partner's name _____ Age ___ Birth Date _____ SS# _____

Type of relationship: Married or Significant Other Duration of Relationship _____ Duration of Infertility _____
Are you and your partner sexually intimate? O Yes O No

Home Address _____City/State _____ Zip _____

Best daytime contact #_____ (home/cell/other) OK for detailed message? O Yes O No

Other contact # _____ (home/cell/other) OK for detailed message? O Yes O No

OK to discuss lab results or plan of care with your partner? O Yes O No E-Mail Address _____

Female's Employer _____ Work Phone _____

Partner's Employer _____ Work Phone _____

**Emergency Contact _____ Phone _____**

Insurance Carrier – Primary: _____ Group # _____
Identification # _____ Plan # _____

Secondary: _____ Group # _____
Identification # _____ Plan # _____

Reason for your visit today? _____
_____

Primary Care Physician or GYN/OB Physician _____
Referred by _____

**By signing below, I confirm that the information above is, to the best of my knowledge, true and accurate. I am aware that TFCNM is a specialty clinic, and the short-term, focused nature of the care I receive at the clinic does not afford for long-term follow-up. I understand that I need to have a primary-care provider (PCP), and that routine care, such as PAP smears, breast exams, annual exams, and physicals need to be performed and followed by my PCP or gynecologist.**

**I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN**

_____ _____
**Signature (Insured or authorized person)** **Date**

## B. PREGNANCY HISTORY

How long have you been trying unsuccessfully to get pregnant? _____years _____months

Have you previously been pregnant? O Yes O No Have you previously tried to get pregnant? O Yes O No

How many times pregnant? _____ Term births? _____ Premature births? _____ Miscarriages? _____
Still born? _____ Elective abortion? _____ Adopted children? _____

| Pregnancy | Date (year) | Mis-carriage | Elective abortion | Ectopic | How long to conceive | Infertility treatment | Wt. & Sex | C-section | Complications? | Is current partner the father? |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | _____ | O | O | O | _____ | O | _____ F/M | O | O | Y / N |
| 2 | _____ | O | O | O | _____ | O | _____ F/M | O | O | Y / N |
| 3 | _____ | O | O | O | _____ | O | _____ F/M | O | O | Y / N |
| 4 | _____ | O | O | O | _____ | O | _____ F/M | O | O | Y / N |
| 5 | _____ | O | O | O | _____ | O | _____ F/M | O | O | Y / N |
| 6 | _____ | O | O | O | _____ | O | _____ F/M | O | O | Y / N |

Complications during or after your pregnancies? Explain. _____

_____

Did your mother have any difficulty with conception or pregnancy? Explain. _____

_____

Did your mother take diethylstilbestrol (DES) when she was pregnant with you? O Yes O No

## C. CONTRACEPTIVE USE

| | Type | From when to when | Reason discontinued |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |

## D. MENSTRUAL (HORMONAL) HISTORY

Are your periods regular? O Yes O No How many days from onset to onset? _____

Date your last menstrual period began _____ Your age at your first period _____

How many days does your period last? _____ Do you bleed between periods? _____

Do you have premenstrual symptoms? O almost always O rarely O never

Vigorous exercise? O Yes O No Type _____ Hours/Week _____

Pelvic pain/cramps: O none O during your period O before your period O after your period O at mid-cycle
O during intercourse O with urination O with bowel movements

Pelvic pain/cramps are: O mild O moderate O severe O getting worse O improving O not changing
O on the right side O on the left side O in the middle
What medications do you take for pain/cramps? _____

**D. MENSTRUAL (HORMONAL) HISTORY, continued**

If you have a hormonal disorder, please specify type and treatment _____

_____

Do you have or have you had:

| | | | |
|---|---|---|---|
| Hot flashes | O Yes O No | Vision problems | O Yes O No |
| Breast discharge | O Yes O No | Poor sense of smell | O Yes O No |
| Chronic headache | O Yes O No | Thyroid disorder | O Yes O No |
| Head injury | O Yes O No | Excessive stress | O Yes O No |
| Seizures | O Yes O No | Increased facial or body hair | O Yes O No |
| Vomiting | O Yes O No | Weight gain (>10 pounds) | O Yes O No |
| Diabetes | O Yes O No | Weight loss (<10 pounds) | O Yes O No |
| Increased acne | O Yes O No | Psychiatric treatment | O Yes O No |
| Autoimmune disease | O Yes O No | Special dietary habits | O Yes O No |

If you answered yes to any questions, please explain _____

_____

_____

**E. OPERATIONS AND HOSPITALIZATION**

Date Diagnosis Operation Where performed Physician

1. _____
2. _____
3. _____

**F. MEDICATIONS:** Please list all prescriptions and over-the-counter drugs used during the past year.

Date Dosage/frequency From when to when Reason for taking

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

**G. ALLERGIES**

To what? (drug or substance) When? What type of reaction?

_____

_____

## H. PHYSICAL CONDITIONS/INFECTIONS

Do you have or have you had:

| | | | |
|---|---|---|---|
| Pelvic infection | O Yes O No | Antichlamydial antibodies | O Yes O No |
| Chlamydia | O Yes O No | Colitis or enteritis | O Yes O No |
| Gonorrhea | O Yes O No | Endometriosis | O Yes O No |
| Syphilis | O Yes O No | Pelvic adhesions | O Yes O No |
| Mycoplasma | O Yes O No | Uterine fibroids or myomas | O Yes O No |
| Ureaplasma | O Yes O No | Abnormal uterus (shape, etc.) | O Yes O No |
| Tuberculosis | O Yes O No | Ovarian cysts | O Yes O No |
| Appendicitis | O Yes O No | Toxoplasmosis | O Yes O No |
| | | Cytomegalovirus (CMV) | O Yes O No |

## I. COMBINED

Do you, or your partner, have or have had:

| | | | |
|---|---|---|---|
| Cervicitis | O Yes O No | Recurring vaginitis | O Yes O No |
| Genital herpes | O Yes O No | Abnormal pap smears | O Yes O No |
| Trichomonas | O Yes O No | Cryo (freezing) or surgery of the cervix | O Yes O No |
| Genital warts/ Condyloma | O Yes O No | | |

How many times per week do you have sexual intercourse? _____ Do you use lubricants for intercourse? _____

How many times do you have intercourse around ovulation? _____ Do you douche before or after intercourse? ____

Have you ever had unwanted sexual experiences? O Yes O No _____

Do you have any sexual problems at this time? O Yes O No _____

## J. OTHER MEDICAL HISTORY

Female – occupation _____

Partner – occupation_____

Years of formal education _____
Cigarettes – packs smoked per day _____
Alcohol – type and number of drinks per week _____
Radiation exposure _____
Hot tub or sauna use _____
Marijuana – amount _____
Caffeine drinks per day _____
Ever used intravenous drugs? _____
Toxic exposure _____
Other drugs – type and amount _____

Are you and your partner related in any way? (other than by marriage)? _____

Are you or your partner of:

| | |
|---|---|
| Jewish background? | O Yes O No |
| Black/African background? | O Yes O No |
| Mediterranean background? | O Yes O No |
| Asian background? | O Yes O No |
| French-Canadian background? | O Yes O No |

Self-reported ethnicity:

O Refused O Unknown O Not asked
O White O Hispanic or Latino O Black or African American
O Asian O American Indian or Alaska Native
O Native Hawaiian or other Pacific Islander

## J. OTHER MEDICAL HISTORY, continued

| Have you, or your partner, or anyone in either family ever had: | Myself | My partner | Either family |
|---|---|---|---|
| A child with Down Syndrome or other chromosome problem? | O Yes O No | O Yes O No | O Yes O No |
| A child with mental retardation? | O Yes O No | O Yes O No | O Yes O No |
| Open spine (spina bifida), skull defect or anencephaly? | O Yes O No | O Yes O No | O Yes O No |
| Heart defect? | O Yes O No | O Yes O No | O Yes O No |
| Muscle or neuromuscular disease (muscular dystrophy)? | O Yes O No | O Yes O No | O Yes O No |
| A baby that died shortly after birth or in the first year? | O Yes O No | O Yes O No | O Yes O No |
| Cystic Fibrosis? | O Yes O No | O Yes O No | O Yes O No |
| Hemophilia, sickle cell, thalassemia or other blood disorder? | O Yes O No | O Yes O No | O Yes O No |
| Any birth defect or genetic disease not listed above? | O Yes O No | O Yes O No | O Yes O No |

If you answered "Yes" to any of the above questions, it may indicate that a pregnancy is at higher risk for certain hereditary or non-hereditary problems, and genetic counseling may be of value to you. Not all birth defects are preventable or detectable before birth, but this questionnaire may help the physician to determine whether or not referral for genetic counseling or testing is appropriate for you.

## K. PREVIOUS EVALUATION

| Have you had: | Not Done | Result: Normal | Result: Abnormal | Approximate date | Values (if known) |
|---|---|---|---|---|---|
| Basal body temperature (BBT) | O | O | O | _____ | _____ |
| Urine LH surge | O | O | O | _____ | _____ |
| Endometrial biopsy | O | O | O | _____ | _____ |
| Blood tests: | | | | | |
| FSH | O | O | O | _____ | _____ |
| LH | O | O | O | _____ | _____ |
| Prolactin | O | O | O | _____ | _____ |
| Thyroid tests (TSH, T4) | O | O | O | _____ | _____ |
| DHEAS | O | O | O | _____ | _____ |
| Testosterone | O | O | O | _____ | _____ |
| Estradiol | O | O | O | _____ | _____ |
| Progesterone | O | O | O | _____ | _____ |
| Postcoital test | O | O | O | _____ | _____ |
| Cervical mucus penetration test | O | O | O | _____ | _____ |
| Mycoplasma culture | O | O | O | _____ | _____ |
| Chlamydia culture | O | O | O | _____ | _____ |
| Antichlamydial antibodies | O | O | O | _____ | _____ |
| Female antisperm antibodies | O | O | O | _____ | _____ |
| Hysterosalpingogram (HSG) | O | O | O | _____ | _____ |
| Ultrasound | O | O | O | _____ | _____ |
| IVP (kidney x-ray) | O | O | O | _____ | _____ |
| Laparoscopy | O | O | O | _____ | _____ |
| Hysteroscopy | O | O | O | _____ | _____ |
| Karyotype | O | O | O | _____ | _____ |
| Anticardiolipin antibodies | O | O | O | _____ | _____ |
| Lupus anticoagulant | O | O | O | _____ | _____ |
| Antinuclear antibodies (ANA) | O | O | O | _____ | _____ |

**K. PREVIOUS EVALUATION, continued**

| Have you had: | Not Done | Result: Normal | Result: Abnormal | Approximate date | Values (if known) |
|---|---|---|---|---|---|
| Coagulation screen | O | O | O | _____ | _____ |
| Biochemistry/hematology panel | O | O | O | _____ | _____ |
| Blood type | O | O | O | _____ | _____ |
| Has your partner had: | | | | | |
| Semen analysis | O | O | O | _____ | _____ |
| Hamster egg penetration assay | O | O | O | _____ | _____ |
| Semen antisperm antibodies | O | O | O | _____ | _____ |

List causes of infertility previously diagnosed _____

_____

_____

**L. PREVIOUS TREATMENT**

| | How many months? | Dose (if known) | Approx. dates taken |
|---|---|---|---|
| Antibiotics | _____ | _____ | _____ |
| Clomiphene (Clomid, Serophene) | _____ | _____ | _____ |
| hMG (Pergonal, Gonal-F, Follistim) | _____ | _____ | _____ |
| hCG (Profasi, Pregnyl) | _____ | _____ | _____ |
| Progesterone | _____ | _____ | _____ |
| Dexamethasone | _____ | _____ | _____ |
| GnRH agonist (Synarel, Lupron) | _____ | _____ | _____ |
| Danazol | _____ | _____ | _____ |
| Intrauterine insemination | _____ | _____ | _____ |
| Insemination with donor sperm | _____ | _____ | _____ |
| IVF (in vitro fertilization) | _____ | _____ | _____ |
| GIFT | _____ | _____ | _____ |

Other: _____

Please use the back of this page to explain any additional information you feel your doctor may need.

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**Internal Use Only**

MRN: _____

ROI Status: ❑ Processed ❑ Returned to Requester
❑ Encounter
❑ Chart Review ❑ Return Letter Date: _____

❑ Document(s) released in accordance with scope of patient request
Date records were provided: _____

# AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

**Please read all information and instructions before completing and signing the authorization form.**

Patient's Name _ Birth date (Please Print) LAST FIRST MI

_____ _____

Are medical records filed under another name? _____ Phone Number _____

| INFORMATION TO BE RELEASED ***BY:*** | INFORMATION TO BE RELEASED ***TO:*** |
|---|---|
| ❑ The Fertility Center of New Mexico | ❑ The Fertility Center of New Mexico |
| ❑ _____ Organization/Person Name | ❑ _____ Organization/Person Name |
| _____ Street Address City, State, Zip | _____ Street Address City, State, Zip |
| _____ Phone Fax | _____ Phone Fax |

TYPE OF MEDICAL INFORMATION REQUESTED:

❑ Complete Record (includes: Physician Orders, Annual, Chart Notes, Medication List, Treatment Plans, Labs, or X-Rays)
❑ Only Labs ❑ Medication List ❑ Hospital Dictation
❑ Self-Pay Records ❑ STD or HIV Results ❑ Mental Health or Psychiatric Conditions ❑ Substance Abuse (Drug or Alcohol)
❑ My health information relating only to the following treatment or condition: _____
❑ My health information only for the following date(s): _____
❑ Other: _____

**REASON FOR REQUEST:** ❑ Personal • Transfer of Care ❑ Disability ❑ Insurance ❑ Legal Review ❑ Continuing Care

❑ Other (please explain): _ You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

**MINORS AGE 13-17:** A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older).

**I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).**

**THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.**

**This authorization expires _____ (date or event). Authorization will expire in 90 days if not otherwise specified.**

**Patient signature**
**-OR-** _____ Date _____
**Parent or Legal Guardian/ Relationship to patient, if other than patient** (You may be required to provide legal documentation as proof for power of attorney or guardianship)

_____

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

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# INSTRUCTIONS & IMPORTANT INFORMATION

**Please read all information and instructions before completing and signing the authorization form.**

## THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

**Many patients ask The Fertility Center of New Mexico to communicate by fax. It is the policy of The Fertility Center to use fax transmissions when necessary for treatment, payment or healthcare operations to other Physicians or Healthcare Facilities only. The Fertility Center will not fax medical records to any personal or other business fax number that has not affiliated with an established Healthcare Entity or Facility.**

**By providing The Fertility Center of New Mexico with a fax telephone number, you are consenting to the use of that number for communicating by fax to another Physician or Healthcare Facility only.**

### PATIENT RIGHTS

You have the right to revoke or cancel this authorization, in writing, at any time.

### REQUEST PROCESSING NOTICE

Please allow ten business days to process your records request. Processing time does no account for mailed records.

### CANCELLATION NOTICE

According to the Uniform Health Information Act for the State of New Mexico, records shall be released within fifteen days after receipt of a signed, dated release form. Since records are usually handled within 2 – 3 days after receipt, Fertility Center of NM will not be held responsible for any release of medical information accomplished before receipt of a written notice of cancellation. Revocation takes place from the date of receipt of written request in the Health Information Management department.

**Instructions for Canceling a Request:**

1. You must provide a written request to the Health Information Management department asking for revocation/cancellation of the original record release.
2. We need to have your complete name, date-of-birth, telephone number (home/work) and the name of the person/agency that you authorized to receive the medical information.
3. After receipt of the notice by the Health Information Management department, telephone confirmation will acknowledge your withdrawal of authorization.
4. If the release has been accomplished, you will be notified by a representative of the Health Information staff. The release will be revoked for any further disclosure.
5. If you have any questions concerning the cancellation process, call the Health Information Management Medical Record Department (505) 248-0000.

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# ADVANCE BENEFICIARY NOTICE

Patient's Name: _____

Insurance Carrier: _____ Member ID: _____

**NOTE: You need to make a choice about receiving these health care items or services**.
We expect that your insurance will not pay for the item(s) or service(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Insurance probably will not pay for –**

| | |
|---|---|
| **Items or Services:** | Any services rendered at The Fertility Center of NM |
| **Because:** | May not be a covered benefit |
| **Estimated Cost: $** | Provided as requested for specific services |

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.** Ask us to explain, if you don't understand why insurance probably won't pay.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while insurance is making its decision. If insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal the insurance company's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.** I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that insurance won't pay.

_____

**Signature** **Date** **Print Name**

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# Financial Policy for Office/Surgical Care

We are committed to providing you with the best possible care. If you have health insurance, we are prepared to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance, and your understanding of our payment policy. We suggest you get a written copy of your insurance benefits, especially your Infertility, GYN and Maternity benefits.

We provide many services in this office which **may not be covered by *your* insurance**.

Payment for service is due, in full, at the time the services are rendered. We accept cash, checks, Discover, Master Card or Visa and American Express. If you have Insurance benefits, we will submit your insurance for payment (directly to our office in most cases). You will be responsible for all copays, deductibles and charges for treatment for non-covered services at the time of each visit. Requested payment is based on the insurance information you have provided and our best understanding of your benefits. Your insurance may require a Prior Authorization, or referral, before you see us. Please check with your insurance carrier prior to your visit.

We are available to discuss any proposed treatment and answer questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer and the insurance company. As health care providers our relationship is with you, not your insurance company. All charges for care rendered are ultimately your responsibility. Some services may also have related charges from entities such as a facility or laboratory. These are separately billed by these providers.

As a courtesy to our patients we perform an insurance benefit verification prior to your initial visit. You will receive a call from our office prior to your first appointment to discuss the information obtained from your carrier, as they apply to care in this office. We do our best to obtain full, accurate information on your behalf. We do encourage you to contact your insurance company as well, to fully understand your policy benefits and any limitations.

Please be prepared to provide us with a copy of your insurance card at the beginning of each appointment. If you change plans or insurance companies we need to be notified immediately, and be given a copy of your new card as soon as you receive it.

Failure to keep your first scheduled appointment, or cancellation of an appointment the day of the appointment, will result in a $75.00 charge. This fee is not payable by your insurance and must be paid prior to scheduling another appointment.

If you have any questions about the above information or any uncertainty regarding payment, PLEASE, do not hesitate to ask us. We are here to help you.

Signed: _____ Date: _____

Revised 6/17/16 MKH