



JIM THOMPSON, M.D.
201 Cedar Street SE, Suite 51-20 • 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.

A \$75.00 deposit was collected at the time you scheduled your appointment. This will be applied to your charges. We require a 48 hour notice to cancel or reschedule this appointment or the deposit will not be refunded.

We look forward to meeting you.

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



NEW PATIENT HISTORY QUESTIONNAIRE - FEMALE

Page 1 of 6

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? Yes No

Home Address _____ City/State _____ Zip _____

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

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

OK to discuss lab results or plan of care with your partner? Yes 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? Yes No Have you previously tried to get pregnant? Yes 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	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	_____ F/M	<input type="radio"/>	<input type="radio"/>	Y/N
2	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	_____ F/M	<input type="radio"/>	<input type="radio"/>	Y/N
3	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	_____ F/M	<input type="radio"/>	<input type="radio"/>	Y/N
4	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	_____ F/M	<input type="radio"/>	<input type="radio"/>	Y/N
5	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	_____ F/M	<input type="radio"/>	<input type="radio"/>	Y/N
6	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	_____ F/M	<input type="radio"/>	<input type="radio"/>	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? Yes No

C. CONTRACEPTIVE USE

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

D. MENSTRUAL (HORMONAL) HISTORY

Are your periods regular? Yes 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? almost always rarely never

Vigorous exercise? Yes No Type _____ Hours/Week _____

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

Pelvic pain/cramps are: mild moderate severe getting worse improving not changing
 on the right side on the left side 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 | <input type="radio"/> Yes <input type="radio"/> No | Vision problems | <input type="radio"/> Yes <input type="radio"/> No |
| Breast discharge | <input type="radio"/> Yes <input type="radio"/> No | Poor sense of smell | <input type="radio"/> Yes <input type="radio"/> No |
| Chronic headache | <input type="radio"/> Yes <input type="radio"/> No | Thyroid disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Head injury | <input type="radio"/> Yes <input type="radio"/> No | Excessive stress | <input type="radio"/> Yes <input type="radio"/> No |
| Seizures | <input type="radio"/> Yes <input type="radio"/> No | Increased facial or body hair | <input type="radio"/> Yes <input type="radio"/> No |
| Vomiting | <input type="radio"/> Yes <input type="radio"/> No | Weight gain (>10 pounds) | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Weight loss (<10 pounds) | <input type="radio"/> Yes <input type="radio"/> No |
| Increased acne | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric treatment | <input type="radio"/> Yes <input type="radio"/> No |
| Autoimmune disease | <input type="radio"/> Yes <input type="radio"/> No | Special dietary habits | <input type="radio"/> Yes <input type="radio"/> No |

If you answered yes to any questions, please explain _____

E. OPERATIONS AND HOSPITALIZATION

<u>Date</u>	<u>Diagnosis</u>	<u>Operation</u>	<u>Where performed</u>	<u>Physician</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

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

<u>Date</u>	<u>Dosage/frequency</u>	<u>From when to when</u>	<u>Reason for taking</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

G. ALLERGIES

<u>To what? (drug or substance)</u>	<u>When?</u>	<u>What type of reaction?</u>
_____	_____	_____
_____	_____	_____

H. PHYSICAL CONDITIONS/INFECTIONS

Do you have or have you had:

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

I. COMBINED

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

- | | | | |
|-----------------------------|--|--|--|
| Cervicitis | <input type="radio"/> Yes <input type="radio"/> No | Recurring vaginitis | <input type="radio"/> Yes <input type="radio"/> No |
| Genital herpes | <input type="radio"/> Yes <input type="radio"/> No | Abnormal pap smears | <input type="radio"/> Yes <input type="radio"/> No |
| Trichomonas | <input type="radio"/> Yes <input type="radio"/> No | Cryo (freezing) or surgery of the cervix | <input type="radio"/> Yes <input type="radio"/> No |
| Genital warts/
Condyloma | <input type="radio"/> Yes <input type="radio"/> 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? Yes No _____

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

J. OTHER MEDICAL HISTORY

Female – occupation _____

Partner – occupation _____

- | | |
|--|------------------------------------|
| Years of formal education _____ | Marijuana – amount _____ |
| Cigarettes – packs smoked per day _____ | Caffeine drinks per day _____ |
| Alcohol – type and number of drinks per week _____ | Ever used intravenous drugs? _____ |
| Radiation exposure _____ | Toxic exposure _____ |
| Hot tub or sauna use _____ | |
| 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? | <input type="radio"/> Yes <input type="radio"/> No |
| Black/African background? | <input type="radio"/> Yes <input type="radio"/> No |
| Mediterranean background? | <input type="radio"/> Yes <input type="radio"/> No |
| Asian background? | <input type="radio"/> Yes <input type="radio"/> No |
| French-Canadian background? | <input type="radio"/> Yes <input type="radio"/> No |

- Self-reported ethnicity:
- | | | |
|---|--|---|
| <input type="radio"/> Refused | <input type="radio"/> Unknown | <input type="radio"/> Not asked |
| <input type="radio"/> White | <input type="radio"/> Hispanic or Latino | <input type="radio"/> Black or African American |
| <input type="radio"/> Asian | <input type="radio"/> American Indian or Alaska Native | |
| <input type="radio"/> Native Hawaiian or other Pacific Islander | | |

J. OTHER MEDICAL HISTORY, continued

Have you, or your partner, or anyone in either family ever had:	<u>Myself</u>	<u>My partner</u>	<u>Either family</u>
A child with Down Syndrome or other chromosome problem?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
A child with mental retardation?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Open spine (spina bifida), skull defect or anencephaly?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Heart defect?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Muscle or neuromuscular disease (muscular dystrophy)?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
A baby that died shortly after birth or in the first year?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Cystic Fibrosis?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Hemophilia, sickle cell, thalassemia or other blood disorder?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Any birth defect or genetic disease not listed above?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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	<u>Result</u>		Approximate date	Values (if known)
		Normal	Abnormal		
Basal body temperature (BBT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Urine LH surge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Endometrial biopsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Blood tests:					
FSH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
LH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Prolactin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Thyroid tests (TSH, T4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
DHEAS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Testosterone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Estradiol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Progesterone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Postcoital test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Cervical mucus penetration test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Mycoplasma culture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Chlamydia culture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Antichlamydial antibodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Female antisperm antibodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Hysterosalpingogram (HSG)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Ultrasound	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
IVP (kidney x-ray)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Laparoscopy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Hysteroscopy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Karyotype	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Anticardiolipin antibodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Lupus anticoagulant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Antinuclear antibodies (ANA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____

K. PREVIOUS EVALUATION, continued

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

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: <input type="checkbox"/> Processed <input type="checkbox"/> Returned to Requester
	<input type="checkbox"/> Encounter
	<input type="checkbox"/> Chart Review <input type="checkbox"/> Return Letter Date: _____
	<input type="checkbox"/> 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:
<input type="checkbox"/> The Fertility Center of New Mexico	<input type="checkbox"/> The Fertility Center of New Mexico
<input type="checkbox"/> _____ Organization/Person Name	<input type="checkbox"/> _____ 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).

UNLESS THE RECORDS ARE BEING SENT TO A PHYSICIAN OR HEALTH CARE FACILITY THAT THIS OFFICE HAS REFERRED YOU TO, THERE WILL BE A CHARGE FOR YOUR RECORDS.

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)



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INSTRUCTIONS & IMPORTANT INFORMATION

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

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 not account for mailed records.

FEES

If you are referred to another provider (by this office), any requested records will be sent to that provider at no charge. For any other circumstances, the fee is \$30.00 for the first 15 pages and \$.25 for each page thereafter. If you need records for multiple providers, please obtain a copy of your records and distribute to your providers as needed.

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.

A \$75.00 deposit was collected at the time you scheduled your appointment. This deposit holds your appointment and will be applied to your charges. We require a 48 hour notice to cancel or reschedule this appointment or the deposit will not be refunded.

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: _____