The Center for
Reproductive Health
Infertility & Reproductive Specialists

2410 Patterson Street, Suite 401
Nashville, TN, 37203
Ph: (615) 321-8899
Fx: (615) 321-8877

Patient Contact Information

DATE: _____

How did you hear about us or who referred you

☐ Physician ☐ OB/GYN ☐ PCP ☐ Urologist ☐ FP

Name: _____

Address: _____

City / State / Zip: _____

Phone#: _____

☐ Internet / Website

☐ Healthlink / Channel 5

☐ Friend: _____

☐ Other: _____

Pharmacy Name: _____Pharmacy Phone#: _____ Fax #: _____

Pharmacy Address: _____

PATIENT'S NAME: _____ DOB: _____ SS# _____–_____–_____

Sex: ☐ M / ☐ F Marital Status: ☐ M / ☐ S / ☐ W / ☐ D

.

Race: ☐White / ☐African American / ☐Hispanic / ☐Native American / ☐Alaskan Native / ☐Asian / ☐Pacific Islander / ☐Other

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____ Cell: _____

Employer:_____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ EXT _____

PARTNERS'S NAME: _____ DOB: _____ SS# _____–_____–_____

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____ Cell: _____

Employer:_____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ EXT _____ DOB: _____

EMERGENCY CONTACT: _____ Phone: _____ Relationship: _____

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Patient Insurance Information

Patient: _____ **Medical Record #:** _____ **Partner**: _____

Patient's Primary Insurance

Primary Insurance: _____ Type: ☐HMO / ☐PPO

If HMO, provide the following: PCP: _____ Phone: _____

Does your Insurance require a referral? ☐YES / ☐NO

Claims Address: _____ Claims Phone: _____

Policyholder: _____ Policyholder DOB: _____ Relation to Policyholder: _____

I.D. _____ Group Number: _____ SS# _____–_____–_____

Is this insurance through your employer? ☐YES / ☐NO If yes, provide the company name: _____

Effective Date of Coverage: _____

Patient's Secondary Insurance

Secondary Insurance: _____ Type: ☐HMO / ☐PPO

If HMO, provide the following: PCP: _____ Phone: _____

Does your Insurance require a referral? ☐YES / ☐NO

Claims Address: _____ Claims Phone: _____

Policyholder: _____ Policyholder DOB: _____ Relation to Policyholder: _____

I.D. _____ Group Number: _____ SS# _____–_____–_____

Is this insurance through your employer? ☐YES / ☐NO If yes, provide the company name: _____

Effective Date of Coverage: _____

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Partner Insurance Information

Patient: _____ **Medical Record #:** _____ **Partner**: _____

Partner's Primary Insurance

Primary Insurance: _____ Type: ☐HMO / ☐PPO

If HMO, provide the following: PCP: _____ Phone: _____

Does your Insurance require a referral? ☐YES / ☐NO

Claims Address: _____ Claims Phone: _____

Policyholder: _____ Policyholder DOB: _____ Relation to Policyholder: _____

I.D. _____ Group Number: _____ SS# _____–_____–_____

Is this insurance through your employer? ☐YES / ☐NO If yes, provide the company name: _____

Effective Date of Coverage: _____

Partner's Secondary Insurance

Secondary Insurance: _____ Type: ☐HMO / ☐PPO

If HMO, provide the following: PCP: _____ Phone: _____

Does your Insurance require a referral? ☐YES / ☐NO

Claims Address: _____ Claims Phone: _____

Policyholder: _____ Policyholder DOB: _____ Relation to Policyholder: _____

I.D. _____ Group Number: _____ SS# _____–_____–_____

Is this insurance through your employer? ☐YES / ☐NO If yes, provide the company name: _____

Effective Date of Coverage: _____

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Authorization to Release Medical Records

Patient Name: _____ **Date of Birth:** _____ **SS#:**_____

Address: _____ **Phone#:** _____

By signing this form, I authorize you to release confidential health information about me by providing a copy of my medical records or a summary or narrative of my protected health information to **The Center for Reproductive Health** including its staff, physicians, or other authorized affiliates.

☐ **I have records to request from the office below** ☐ **I have no existing records**

Releasing office:

Physician's Name: _____

Office Phone: _____

Office Fax: _____

Records should include:

- H&P, Records related to pregnancy, Surgeries, Imaging (i.e., HSG, Hysteroscopies, laparoscopies, ultrasounds)
- Any infertility testing, treatment, stimulation sheets, IUI, IVF
- Embryology reports (if patient has previously undergone IVF)
- Any current (within one year) infectious disease screening
- Any genetic testing

Delivery method:
I would like my records sent to the provider indicated in the address below.

The Center for Reproductive Health
2410 Patterson Street, Suite 401, Nashville,TN 37203
FAX: (615) 334-4896
records@nashvillefertilitycare.com

I understand that the center is given ten (15) working days to process my request for access to my information. I further understand that my rights are limited to any information in my "designed record set: as defined in Section 164.501 of the Code of Federal Regulations.

I, the undersigned have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time to the extent that action has been taken in reliance upon it. Unless another date is specified, this consent shall be valid for sixty (60) days from the date it is signed. I understand that redisclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged on any liability and the undersigned will hold the facility harmless, for complying with this "Authorization to Release Medical Records".

Patient Signature	**Date**	**Provider's Witness Signature**	**Date**

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Basic History Information

Patient: _____ **Medical Record #:** _____ **Partner**: _____

Is your menstrual cycle regular? ☐YES / ☐NO

Have you had a tubal ligation/tubal reversal? ☐YES / ☐NO

Has your partner had a vasectomy / vasectomy reversal? ☐YES / ☐NO

Have you ever been treated with fertility drugs? ☐YES / ☐NO (i.e Clomid, etc.)

Have you had any fertility testing? ☐YES / ☐NO (i.e bloodwork, semen analysis, etc.)

Has your partner had any fertility testing? ☐YES / ☐NO (i.e bloodwork, semen analysis, etc.)

Have you had any infertility treatment such as IVF, IUI? ☐YES / ☐NO

Have you been diagnosed “infertile” by another physician? ☐YES / ☐NO

Have you had or do you have a prolonged cough greater than two weeks? ☐YES / ☐NO

Have you had or do you have a cough with production of sputum or blood? ☐YES / ☐NO

Are you experiencing fatigue, loss of appetite, weight loss, or fever? ☐YES / ☐NO

Have you ever been diagnosed or treated for Tuberculosis (TB)? ☐YES / ☐NO

Have any of your friends or family been diagnosed or treated for TB? ☐YES / ☐NO

Have you ever had a positive result to Tuberculosis (TB) skin testing? ☐YES / ☐NO

Infertility History & Previous Testing

Temperature Charts ☐YES / ☐NO Date: _____ Outcome: _____

Ovulation Predictor ☐YES / ☐NO Date: _____ Outcome: _____

Post Coital Test ☐YES / ☐NO Date: _____ Outcome: _____

SonoHysterosalpingogram ☐YES / ☐NO Date: _____ Outcome: _____

Laparoscopy ☐YES / ☐NO Date: _____ Outcome: _____

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Basic History Information

Patient: _____ **Medical Record #:** _____ **Partner**: _____

Previous Pregnancy:

Year	Weeks of Gestation	Outcome: Live Birth, Still Birth, Miscarriage, Ectopic, Elective Abortion	Types of Delivery: Vaginal Birth, C-Section	Complications

Menstrual History:

1. Shortest interval between cycles _____
2. Longest Interval between cycles_____
3. Number of days of flow _____
4. Do you ever have bleeding between cycles? _____
5. Do you take medication to regulate your cycles presently? _____
6. Have you taken medications to regulate your cycles in the past? _____

Contraception:
Please list all methods of contraception and dates used_____

_____

_____

_____

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Basic History Information

Patient: _____ **Medical Record #:** _____ **Partner**: _____

Previous Infertility Treatment:

Medication (dosage)	Treatment: Timed Intercourse (TI) Intrauterine Insemination (IUI) In Vitro Insemination (IVF)	Date	Outcome

Surgical History:

Year	Type of Surgery

Year	Type of Surgery

Medications: Please list all medications you are currently taking as well as allergies

Medications	Dosage

Allergens	Reaction

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PAST ILLNESSES OF YOURSELF AND FAMILY: PLEASE CHECK ALL THAT APPLY

	self	family		self	family		self	family
ALCOHOLISM	☐	☐	HEPATITIS	☐	☐	PHLEBITIS	☐	☐
ANEMIA	☐	☐	HIGH BLOOD PRESSURE	☐	☐	RHEUMATIC ARTHRITIS	☐	☐
ASTHMA	☐	☐	HIGH CHOLESTEROL	☐	☐	STROKE	☐	☐
CANCER/TUMOR	☐	☐	HIV/ IMMUNE DX	☐	☐	SUICIDE ATTEMPT	☐	☐
DIABETES	☐	☐	KIDNEY DISEASE	☐	☐	THYROID DISEASE	☐	☐
DRUG ABUSE	☐	☐	LIVER DISEASE	☐	☐	TUBERCULOSIS, TB	☐	☐
DEPRESSION	☐	☐	LUNG DISEASE	☐	☐	ULCER IN GI TRACT	☐	☐
EPILEPSY/SEIZURES	☐	☐	MENTAL ILLNESS	☐	☐	VENEREAL DISEASE	☐	☐
GLAUCOMA	☐	☐	OSTEOARTHRITIS	☐	☐			
HEART DISEASE	☐	☐	OSTEOPOROSIS	☐	☐	OTHER _____		

Past Surgical History (please include dates):

PLEASE CHECK "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL	YES	NO	**RESPIRATORY**	YES	NO	**HEMATOLOGY/LYMPH**	YES	NO
Weight Loss	☐	☐	Cough	☐	☐	Easy Bruising	☐	☐
Fatigue	☐	☐	Coughing Blood	☐	☐	Gums Bleed Easily	☐	☐
Fever	☐	☐	Wheezing	☐	☐	Enlarged Glands	☐	☐
EYES	☐	☐	Chills	☐	☐	**MUSCULOSKELETAL**	☐	☐
Glasses / Contacts	☐	☐	**GASTROINTESTINAL**	☐	☐	Joint Pain/Swelling	☐	☐
Eye pain	☐	☐	Heartburn / Reflux	☐	☐	Stiffness	☐	☐
Double Vision	☐	☐	Nausea / Vomiting	☐	☐	Muscle Pain	☐	☐
Cataracts	☐	☐	Constipation	☐	☐	Back Pain	☐	☐
EAR, NOSE, THROAT	☐	☐	Change in BMs	☐	☐	**SKIN**	☐	☐
Difficulty Hearing	☐	☐	Diarrhea	☐	☐	Rash/ Sores	☐	☐
Ringing in Ears	☐	☐	Jaundice	☐	☐	Lesions	☐	☐
Vertigo	☐	☐	Abdominal Pain	☐	☐	Itching / Burning	☐	☐
Sinus Trouble	☐	☐	Black or Bloody BM	☐	☐	**NEUROLOGICAL**	☐	☐
Nasal Stuffiness	☐	☐	**GENITOURINARY**	☐	☐	Loss of Strength	☐	☐
Frequent Sore Throat	☐	☐	Burning / Frequency	☐	☐	Numbness	☐	☐
CARDIOVASCULAR	☐	☐	Nighttime	☐	☐	Headaches	☐	☐
Murmur	☐	☐	Blood in Urine	☐	☐	Tremors	☐	☐
Chest Pain	☐	☐	Erectile Dysfunction	☐	☐	Memory Loss	☐	☐
Palpitations	☐	☐	Abnormal Discharge	☐	☐	**FEMALES ONLY**	☐	☐
Dizziness	☐	☐	Bladder Leakage	☐	☐	Date Last Mammogram: _____		
Fainting Spells	☐	☐	**ALLERGIC/IMMUNOLOGIC**	☐	☐	Normal _____ Abnormal _____		
Shortness of Breath	☐	☐	Hives / Eczema	☐	☐	Date Last PAP: _____		
Difficulty Lying Flat	☐	☐	Hay Fever	☐	☐	Normal _____ Abnormal _____		
Swelling Ankles	☐	☐	**PSYCHIATRIC**	☐	☐	Age Onset Periods: _____		
ENDOCRINE	☐	☐	Anxiety / Depression	☐	☐	Age Onset Menopause: _____		
Loss of Hair	☐	☐	Mood Swings	☐	☐	Regular Periods? YES NO		
Heat/Cold Intolerance	☐	☐	Difficulty Sleeping	☐	☐	Number of Pregnancies: _____		

Signature / Reviewer: _____

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Payment & Collection Policy

Patient: _____ **Medical Record #:** _____ **Partner**: _____

Please read carefully. If you have any questions, please ask prior to signing statement

I agree to pay for services provided by The Center for Reproductive Health and/or The Center for Assisted Reproductive Technologies. I also acknowledge that I am fully responsible for the balance which my insurance company does not reimburse the Center's. **I have been advised that verification of benefits and pre-certification is not a guarantee of payment.** Final claim determination will be made based on but not limited to, eligibility at the time of service, actual services rendered, and plan limitations. I am responsible for all non-covered services and agree to pay for all services. I understand that I should contact my insurance company if I have any concerns regarding insurance reimbursement. I understand if my insurance requires a referral, it is my responsibility to obtain the referral — the Center is not responsible for obtaining the referral for me. If I fail to obtain the referral, prior to services being rendered, the Center will not submit claims to my insurance company, and I will be responsible for 100% of charges.

I further acknowledge that I will be liable for any collection fees and/or court costs and attorney fees, should my account become delinquent and be forwarded to collections. This will include charges of 25% to 33.33% of the outstanding balance and all reasonable attorney fees for any balance over 60 days past due. Once an unpaid account is placed in collections, all office visits are on a cash only basis.

I further acknowledge that I will be charged monthly 1.5% interest on any balance over 30 days old. I understand that there is a separate $25 fee for all returned checks. Patient will be responsible for the check and the additional $25 fee which must be paid by cash, credit card, cashier check, or money order.

Refunds:

If you make a payment using a credit card and a refund is due, your credit card will be credited the amount due minus any applicable credit card fees.

I permit a copy of this authorization to be used in place of the original.

I have read and fully understand my responsibilities as stated above.

Patient Signature	**Date**	**Provider's Witness Signature**	**Date**

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Notice of Privacy Practices for Protected Health Information

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.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment using only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending or faxing us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

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Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Questions & Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to this medical practice's Privacy Officer:

Nancy Vasquez
The Center for Reproductive Health/The Center for Assisted Reproductive Technologies
2410 Patterson Street, Suite 401, Nashville, TN 37203
Telephone (615) 321-8899 Fax (615) 321-8877

You also may submit a written complaint to the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, HHH Building, Washington, D.C. 20201.

We support your right to the privacy of your health information. There will be no retaliation for filing a complaint with either the Center's Privacy Officer or the Office for Civil Rights.

Office Protocol For Returning Phone Calls

If you have an emergency, please call "911" or proceed immediately to the nearest emergency room. For immediate assistance during office hours, call our office number and press "0" at the prompt. After business hours the answering service will triage all non-emergency phone calls.

*Additional information that may assist you:

1. Appointments (other than procedures)	EXT: 110/116
2. IVF Coordinator/ Andrology/ Embryo Adoption	EXT: 129
3. Dr. Vasquez Nurse/prescriptions	EXT: 126
4. Financial Counselor	EXT: 119

Phone: Would you like us to leave a detailed message ☐YES / ☐NO

Email: Would you like us to leave a detailed message ☐YES / ☐NO

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Patient Signature **Date**

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Patient Authorization to Disclose Protected Health Information to Spouse or Partner

I, _____, hereby authorize the Center for Reproductive Health/The Center for Assisted Reproductive Technologies (the "Center") to disclose my protected health information to my spouse or partner. I have read this authorization and understand what information will be disclosed, who may disclose the information, and the recipient of that information. I specifically authorize any Center employee to disclose my protected health information as described on this form to the recipient listed below. I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply):

[ ] ALL Medical, Billing, & Insurance Information

[ ] Medical Data/Information as related to:

- [ ] Specific condition(s): _____
- [ ] Specific professional service(s): _____
- [ ] Specific medication(s): _____

[ ] Billing and Insurance Information

[ ] Other: _____

Person authorized by this form to receive patient's protected health information:

Name: _____ Relationship to Patient: _____

Phone Number: _____ Address: _____

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, the Center must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable.
- The effective date of this authorization and recipients of the information according to this authorization
- The patient's desire to revoke this authorization
- The date of the revocation, and the patient's signature

The Center will accept written revocations of this authorization via Certified U.S. Mail or Fax to 615-321-8877
All revocations must be sent to the Center to the attention of the Privacy Officer.

Nancy Vasquez
The Center for Reproductive Health/The Center for Assisted Reproductive Technologies
2410 Patterson Street, Suite 401, Nashville, TN 37203

This authorization shall expire one year from the date signed. After this date, the Center can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.
I fully understand and accept the terms of this authorization.

Patient Signature	**Date**	**Provider's Witness Signature**	**Date**

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Authorization to Release Medical Information & Assignment of Benefits

Patient: _____ **Medical Record #:** _____ **Partner**: _____

I hereby authorize the release of any medical information necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign benefits to which I and/or my dependents are entitled under my insurance plan to the Center for Reproductive Health, P.C. and/or the Center for Assisted Reproductive Technologies, LLC.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to the Center for Reproductive Health and/or the Center for Assisted Reproductive Technologies by any insurance policy, self insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered effective and valid as the original. I understand I have the right to receive a copy of this authorization.

REQUESTING COPIES OF MEDICAL RECORDS

Requests for copies of records must be **in writing**. Telephone requests are not acceptable, but requests may be faxed to the office. You may obtain a medical records release form from a member of our staff.

CRH shall furnish copies within 10 days of receipt of the written request. Because of the confidential nature of medical records, CRH shall not fax medical records to any location.

Cost of copying $0.50 per page up to 40 pages in length and $0.25 per page for each page copied after the first 40 pages plus postage.

Costs of copying must be paid prior to records being mailed.

_____ _____

Patient Signature **Date**