The Fertility Center

William Dodds MD, James Young MD, Valerie Shavell MD, Mili Thakur, MD and Richard Leach MD

3230 Eagle Park Dr. NE, Suite 100
Grand Rapids MI 49525
616.988.2229
877.904.4483

317 S. Drake Rd., Suite B
Kalamazoo MI 49009
269.324.5100
877.500.1658

1100 S. Cedar St., Suite B
Mason MI 48854
877.904.4483

Appointment Date: _____ Office Location: _____

Female Patient

First Name: _____ Middle Initial: _____ Last Name: _____ Maiden Name: _____

Street Address: _____City: _____ State: _____ Zip: _____

A *detailed* voice message may be left at the following phone number: (___)_____

Date of Birth: _____ Age: _____ SS#: _____-_____-_____ Marital Status: _____

Email address: _____

Patient's Employer: _____Address:_____City:_____State:____Zip:_____

Phone: (___)_____Date Employed: _____to_____ Full Time/Part Time

Insurance Carrier: _____ **Name of Primary Insured**: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Contract/ID Number: _____**Group Number**: _____

Emergency Contact:_____Relationship to Patient: _____

Telephone Number: (___)_____Alternate Name/Number:_____

Referring Physician: _____Telephone Number: (____)_____

Family Physician: _____Telephone Number: (____)_____

Partner - Please select one of the following (Required): Male_____, Female_____, No Partner _____

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Age: ____ SS#: _____-_____-_____ Cell Phone: (____)_____ Home Phone: (____)_____

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

Phone: (___)_____ Date Employed: _____to _____ Full Time/Part Time

Insurance Carrier: _____**Name of Insured**: _____

Claims Address: _____ City: _____State:_____ Zip: _____

Contract Number: _____ **Group Number**: _____

Referring Physician: _____Telephone Number: (____)_____

Family Physician: _____Telephone Number: (____)_____

For Office Use Only:
Updated: _____ Init: _____
New patient demographic sheet/main/kpw 11-16

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Notice of Privacy Practices: I acknowledge that I have been offered a copy of the Notice of Privacy Practices: _____
patient initials

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Limited Patient Authorization for Disclosure of Protected Health Information to an Individual

(Please print all information. Authorization is in effect for 12 months with a mandatory requirement of updating annually, unless an earlier termination date is specified. (see below)

Patient Name: _____ **Partner to:** _____
'Patient' refers to the person completing this form

Patient Social Security Number: _____ **Patient Date of Birth:** _____

Purpose of request (who will be authorized to receive information) - I authorize ***the practice (identified below)*** to disclose or provide protected health information, about me to the individual(s) listed below.

Practice Name: Michigan Reproductive and IVF - dba – The Fertility Center

Who will be authorized to receive information (list each family member, friend, or other individual to receive PHI):

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ **Entire patient record; or check only those items of the record to be disclosed**:

☐ office notes ☐ lab results ☐ x-rays; hospital ☐ financial history report (previous 3 years only).

☐ record of HIV and communicable disease testing ☐ record of mental health or substance abuse treatment

Purpose of disclosure (please check patient request or record the purpose of the disclosure):

☐ Patient Request ☐Other (please specify): _____

Expirations or termination of authorization: This authorization will expire 12 months from the date of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the date of your last signature to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. ***Please list date of expiration if earlier than 12 months from date of last signature)***: _____.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. (You have the right to receive a copy of signed authorizations upon request.)

_____ _____(expires in 12 months)
patient signature date

FINANCIAL POLICY

Insurance coverage for infertility varies. Many insurance companies do not cover infertility. For this reason we ask that you pay all fees at the time of service. We do not offer payment arrangements for any services. Financing is available through Advance Care. Please contact the billing department for more information.

We will submit a claim as a courtesy for all services rendered except for Tricare, VA, BCN Lab Services, Medicaid, and Aetna. If you are an Aetna patient, we will issue an itemized receipt for you to submit to Aetna for reimbursement. Please provide us with your current insurance information. If your insurance changes, please update us as soon as possible to ensure your claim is submitted correctly and timely. **Please note that your insurance policy is a contract between you and your insurance company, therefore it is your responsibility to know and understand your contractual obligations and limitations.**

During the course of your treatment at The Fertility Center you may wish to have a telephone consult. Telephone consults are billed to insurance companies, are rarely covered, and will be the patient's responsibility.

During your treatment plan should you have an ultrasound at another facility, there is a $115 per cycle outside monitoring fee that is not billable to your insurance company.

Should you be interested in pursuing ART (Assisted Reproductive Technologies), you must initially pay a non refundable ART Case Management fee in order to reserve a month for your procedure. Your actual procedure **must** be prepaid prior to your procedure. A financial consult will be done so that you will have an approximate range for costs of your procedure.

In some cases surgery may be required to treat your condition. We will bill your insurance for this, however, if you have insurance we do not participate with, you will be required to pay in full for your surgery within 30 days of the procedure.

Any outstanding balances must be resolved prior to beginning each treatment cycle. However, in the event of an emergency, care will be provided regardless of outstanding financial obligations.

Failure to pay any balances in a timely manner will result in a referral to a collection agency. In addition to the effect collection action will have on your credit rating, future services by The Fertility Center will not be provided until the balance is paid in full.

There is a $35.00 charge for obtaining records.

For your convenience, we accept the following forms of payment: cash, check, credit card, and money order. We charge a service fee of $25.00 for all returned checks. **All office fees are approximate and subject to change without notice.**

No Show policy: We require 48 hours notice to cancel an appointment. You will be charged ½ the visit cost if you fail to show or contact the office. You will be charged $25.00 if you contact the office in less than 48 hours. There will be no charge if you cancel with a 48 hour notice. A credit card will be required to schedule a new patient appointment in event of a no show. There is a $50 no show fee for retrograde appointments in our lab.

Should you have any questions please feel free to contact our office at (616) 988-2229.

Acknowledgement of Payment Responsibility

I have read and understand the Financial Policy of The Fertility Center and agree to its terms. I understand that I am financially responsible for any services provided by The Fertility Center, including any items denied or not covered by my insurance and any yearly deductible or copayment amounts. I acknowledge all outstanding balances for services are to be resolved within 30 days.

Print Name: _____

Signature: _____ Date: _____

10/17 (Patient or Parent/Guardian if minor)

The Fertility Center

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CONSENT FOR TREATMENT

Knowing that I require diagnostic testing, medical treatment or hospitalization, I voluntarily consent to the medical treatment deemed necessary in the judgment of my treating physicians. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of examination, tests, or treatments. I understand that if major diagnostic studies or treatment procedures such as surgery are required, I will be asked to give specific consent to those procedures. If I am an obstetrical patient, I understand that my signature consents to the care and treatment of my fetus.

MY MEDICAL INFORMATION

I understand that The Fertility Center will keep my medical information according to state law, federal law, and policy. I also understand that my information will be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes treatments and medicine or prescription information about me, including drug or alcohol use. In some cases, The Fertility Center is required by law to report information to an agency like the health department. This may prevent other diseases. I understand I can ask additional questions before signing this consent.

I have read the above information or have had it explained to me, and indicate my understanding of same, by signing this document.

**Please note: 'Patient Name' refers to the person completing this form.*

_____ _____ _____
Patient Name (Please Print) Patient Signature Date

_____
Current Fertility Center Patient (Spouse/Partner – Please Print)

_____ _____
The Fertility Center Staff Witness Date

If this consent form is not signed in the presence of a member of The Fertility Center staff, form **must be notarized below:*

Notary Public _____ County, Michigan
Acting in the County of _____
Signature _____
My commission expires:

The Fertility Center

William Dodds MD, James Young MD,
Valerie Shavell MD, Mili Thakur MD, and Richard Leach MD

CONSENT FOR HIV TESTING

HIV (Human Immunodeficiency Virus) infection is a long-term illness that damages the body's immune system and its ability to fight diseases. HIV can cause AIDS (Acquired Immunodeficiency Syndrome), the stage of HIV when the body is weakened and less able to fight off germs. HIV spreads through blood, semen, vaginal fluids, and breast milk. You can get or give an HIV infection by having vaginal, anal, or oral sex without a condom or sharing needles or works when injecting drugs. An infected mother can pass HIV to her child during pregnancy, birth or breastfeeding. You cannot get HIV by donating blood or through casual contact like hugging or shaking hands.

People can have HIV for years and not know it unless they get tested. If you **are infected**, it can help you get proper treatment and learn how to avoid spreading HIV to other people. If you **are not infected**, it can help you learn how to reduce your risk of getting HIV.

HIV testing: A **negative result** means you are not infected with HIV or you have a recent infection, too early to show up positive. If you have been exposed to HIV in the last six weeks, the test may not detect a new infection. A **positive result** means you are living with HIV. This means you can pass your infection to others through sex, sharing needles, through birth or breastfeeding. You should take precautions to avoid infecting others.

I understand I can ask additional questions before signing this consent and may ultimately refuse to sign it. My physician will review my treatment options at The Fertility Center, should I refuse HIV testing. I understand HIV test results are confidential and shall not be released without my permission, except as permitted under state law. I understand that I have a right to have this test done without the use of my name at any Michigan Department of Health-approved HIV counseling and testing site.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results. I understand that I have the right to withdraw my consent for the test at any time before the test is complete. By my signature below, I consent to be tested for HIV.

☐ I consent to HIV Testing.
☐ I do not consent to HIV Testing

_____ _____
Patient Signature Date

**Please Note: Our credentialing agencies require that all In Vitro Fertilization (IVF) patients complete this test.*

I have read the above information or have had it explained to me, and indicate my understanding of same, by signing this document.

**Please note: 'Patient Name' refers to the person completing this form.*

_____ _____ _____
Patient Name (Please Print) Patient Signature Date

_____
Current Fertility Center Patient (Spouse/Partner – Please Print)

_____ _____
The Fertility Center Staff Witness Date

If this consent form is not signed in the presence of a member of The Fertility Center staff, form **must be notarized below:*

Notary Public _____ County, Michigan
Acting in the County of _____
Signature _____
My commission expires:

The Fertility Center

3230 Eagle Park Dr. NE Suite 100
Grand Rapids, MI 49525
616-988-2229

317 S. Drake Rd., Suite B
Kalamazoo, MI 49009
269-324-5100

1100 S. Cedar St., Suite B
Mason MI 48854
616-988-2229

Physicians: William Dodds, MD
James Young, MD
Valerie Shavell, MD
Mili Thakur, MD

Patient Name: _____

DOB: _____

Review of Systems/Medical History

Do you consistently have any of the problems listed below that are not currently being treated or evaluated by another physician? Please check **Yes** or **No** and explain any Yes answers in the space provided.

Constitutional Symptoms	YES	NO
Activity change	☐	☐
Appetite change	☐	☐
Chills	☐	☐
Sweating at night	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Unexpected weight loss	☐	☐
Other_____		

HEENT	YES	NO
Ear discharge	☐	☐
Hearing loss	☐	☐
Ear pain	☐	☐
Ears ringing	☐	☐
Nosebleeds	☐	☐
Congestion	☐	☐
Runny nose	☐	☐
Sneezing	☐	☐
Sore throat	☐	☐
Hoarse voice	☐	☐
Other _____		

Eyes	YES	NO
Eye discharge	☐	☐
Eye itching	☐	☐
Eye pain	☐	☐
Eye redness	☐	☐
Light sensitivity	☐	☐
Vision changes	☐	☐
Other _____		

Cardiovascular	YES	NO
Chest pain	☐	☐
Palpitations/racing heart	☐	☐
Difficulty breathing while lying down	☐	☐
Leg pain with walking	☐	☐
High cholesterol	☐	☐
Other _____		

Gastrointestinal	YES	NO
Trouble swallowing	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Fecal incontinence	☐	☐
Rectal pain	☐	☐
Rectal bleeding	☐	☐
Blood in stool	☐	☐
Other _____		

Genitourinary	YES	NO
Flank pain	☐	☐
Urinary incontinence	☐	☐
Blood in urine	☐	☐
Painful urination	☐	☐
Difficult urination	☐	☐
Urinary frequency	☐	☐
Menopausal symptoms	☐	☐
Heavy menses	☐	☐
Painful menses	☐	☐
Other _____		

Musculoskeletal	YES	NO
Neck pain	☐	☐
Back pain	☐	☐
Joint pain/swelling	☐	☐
Muscle pain	☐	☐
Gait problems/falls	☐	☐
Osteoporosis	☐	☐
Other _____		

Neurological	YES	NO
Headaches	☐	☐
Dizziness/light headed	☐	☐
Speech difficulty	☐	☐
Loss of consciousness	☐	☐
Seizures/tremors	☐	☐
Numbness/tingling	☐	☐
Weakness	☐	☐
Other _____		

Endo/Heme/Aller	YES	NO
Blood transfusions	☐	☐
Adenopathy	☐	☐
Bruise/bleed easily	☐	☐
Env. allergies	☐	☐
Excessive thirst	☐	☐
Frequent thirst	☐	☐
Other _____		

Psychiatric	YES	NO
Depression	☐	☐
Suicidal ideas	☐	☐
Anxiety	☐	☐
Hallucinations	☐	☐
Self-injury	☐	☐
Sleep disturbance	☐	☐
Hyperactivity	☐	☐
Behavior problems	☐	☐
Decreased concentration	☐	☐
Other _____		

Skin	YES	NO
Itching	☐	☐
Color change	☐	☐
New/changed spots	☐	☐
Rash	☐	☐
Wound	☐	☐
Nail changes	☐	☐
Hair changes	☐	☐
Breast pain	☐	☐
Breast mass/lump	☐	☐
Nipple discharge	☐	☐
Other _____		

Respiratory	YES	NO
Cough	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Chest tightness	☐	☐
Snoring	☐	☐
Choking	☐	☐
Sputum production	☐	☐
Other _____		

_____ _____

Patient Name (Print and Sign) Date

_____,MD _____

Signature of Physician Date

Patient Label

The Fertility Center

ZIKA ACKNOWLEDGEMENT
Possible Zika Exposure

Patient Name: _____ ("Patient") Date of Birth: _____

Partner Name: _____ ("Partner") Date of Birth: _____

The purpose of this document is to confirm that The Fertility Center, PC (The Fertility Center) has provided Patient (and Partner, if any) with information regarding Zika virus disease (Zika) and concerns about possible exposure to Zika during, or when planning for, pregnancy.

1. Zika is a disease caused by the Zika virus, which is spread to people primarily through the bite of an infected mosquito, but which can also be transmitted sexually through semen from infected males to sexual partners. Additional information about Zika, its symptoms, treatment and prevention, and various travel advisories issued by the United States Centers for Disease Control and Prevention (CDC), can be found at the following website: www.cdc.gov/zika.
2. It is not known whether infected men who never develop symptoms can transmit Zika virus to their sex partners. Sexual transmission of Zika virus from infected women to their sex partners has not been reported. Sexual transmission of Zika and many other infections, including those caused by other viruses, is reduced by consistent and correct use of condoms.
3. The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis (red eyes). Zika illness is usually mild with symptoms lasting for several days to a week. For this reason, many people may not realize that they have been infected.
4. **A Zika virus infection during pregnancy can cause a serious birth defect called microcephaly, as well as other severe fetal brain defects.** Additional information about microcephaly can be found on the CDC website at www.cdc.gov/ncbddd/birth defects/microcephaly. html.
5. As of November 2016, the majority of the regions affected by Zika are in Central and South America, but mosquito-borne spread of Zika also has been identified in areas of South Florida, as well as the Caribbean, including Puerto Rico. Please refer to the CDC website and Travel Heath Notices for an up to date list of places with Zika outbreaks: http://wwwnc.cdc.gov/travel/page/Zika-travel-information. It **is important to refer to the CDC website if the Patient or Partner is considering travel because the situation is constantly evolving.**
6. **The CDC has issued guidance for pregnant women, and women thinking about becoming pregnant.** Please see www.cdc.gov/Zika/specific-groups.html. The CDC and the American Society for Reproductive Medicine (ASRM) have also issued guidelines for US health care providers caring for pregnant women and women of reproductive age during active Zika virus transmission. The Fertility Center follows these guidelines and strongly encourages Patient (and Partner, if any) to continually monitor the CDC guidance if pregnant or planning to become pregnant.
7. **Based upon the information available regarding the risk to the unborn child and to patients, the physicians at The Fertility Center strongly advise Patient and any Partner NOT to travel to countries or areas with active Zika transmission while attempting pregnancy. Failure to comply with this advice may result in a delay of Patient's treatment.**
8. If Patient (or Partner, if any) has recently traveled to an area with active transmission of Zika virus, or has had sex *without* a condom with a man who has recently traveled to an area with active transmission of Zika virus or is infected with Zika, The Fertility Center will recommend that Patient wait to attempt pregnancy according to the timeframes currently suggested by the CDC and ASRM.

ACKNOWLEDGEMENT. By signing below, Patient (and Partner, if any) acknowledges having read and understood this ZIKA ACKNOWLEDGEMENT, including:

- the risks of Zika virus infection with respect to becoming pregnant and potential birth defects;
- the importance of consulting the CDC website for up-to-date information on Zika and affected areas; and
- The Fertility Center recommendations regarding planning pregnancy and infertility treatment for individuals infected, exposed, or possibly exposed to Zika virus.

Signature Page Follows

Patient Label

The Fertility Center

ZIKA ACKNOWLEDGEMENT
Possible Zika Exposure

A signature affirms that the signing individual has read this document and had all questions related to the document answered to the individual's satisfaction.

SIGNATURE(S):

Patient Printed Name	Patient Signature	Date	Time

Witnessed by The Fertility Center clinical staff member (photo ID of Patient required):

Printed Name of Staff Member	Signature of Staff Member	Date	Time

Notary required if consent <u>not</u> witnessed by and photo ID not presented to The Fertility Center clinical staff member:

STATE OF _____,

COUNTY OF _____ SS.: _____

On this _____ day of _____, 20_____, before me personally came

_____ to me known and known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

_____
Notary Public

Partner Printed Name	Partner Signature	Date	Time

Witnessed by The Fertility Center clinical staff member (photo ID of Patient required):

Printed Name of Staff Member	Signature of Staff Member	Date	Time

****

I have consulted with and explained the contents of this document to the patient and (where applicable) the patient's spouse/ sexually intimate partner.

All question(s) concerning the procedures have been answered.

Physician Printed Name	Physician Signature	Date	Time