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

FAX TRANSMITTAL MEMO

Please fax, mail or email (medrec@mrivf.com) new patient paperwork to the Grand Rapids office for appointments in Grand Rapids, Traverse City or Mason and to the Kalamazoo office for appointments in Kalamazoo.

DATE:___________________________

TO: **The Fertility Center – New Patient Paperwork Processing**

FAX #: **Grand Rapids – (616) 988-2010**
Kalamazoo – (269) 324-5041

FROM:______________________________

NUMBER OF PAGES INCLUDING THIS COVER:_____

Notes:____
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Please be advised that you are electing to send sensitive information to our office through methods that may not be secure. There is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. The Fertility Center cannot be responsible for material sent from unsecure servers. If you have any questions, please contact our office at 616-988-2229.

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#: XXX-XX-________ Marital Status: ______________________

Race (optional): ______________ Ethnicity (optional):_________________ Military Status/Branch: __________________

Email address: ____

Patient's Employer: _________________________Address:____________________City:_________State:____Zip:_______

Phone: (___)______________________________Date Employed: ____________to____________ Full Time/Part Time

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: __________________ Maiden Name: ____________

Street Address: ____City: _________ State: _____ Zip: _________

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

Date of Birth: ___________________ Age: ________ SS#: XXX-XX-________ Marital Status: ______________________

Race (optional): ______________ Ethnicity (optional):_________________ Military Status/Branch: __________________

Email address: ____

Patient's Employer: _________________________Address:____________________City:_________State:____Zip:_______

Phone: (___)______________________________Date Employed: ____________to____________ Full Time/Part Time

Emergency Contact:____Relationship to Patient: _____________

Telephone Number: (___)_________________Alternate Name/Number:____________________________________

Referring Physician: ______________________________________Telephone Number: (____)___________________

Family Physician: ____Telephone Number: (____)___________________

How did you hear about The Fertility Center? (Please check all that apply)

☐ **Referred by a Physician**
Physician Name: _____________________
Specialty: _________________________
City: ____________________________

☐ **Friend/Family Member**

☐ **Internet Search**

☐ **Social Media**
☐ Facebook ☐ Instagram

☐ **Other:** ____

New patient demographic sheet/main/kpw 1-20

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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: XXX-XX-______________ **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 are not able to offer payment arrangements for any services. Financing is available through Advance Care Card. 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 your insurance and are sometimes not covered and would then be your 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 Cycle 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.

When obtaining a copy of your personal medical record for services rendered by The Fertility Center, we do not institute a monetary charge for the dissemination of a single copy of your record. A request for two or more copies of your personal medical record is subject to a $25.00 administrative fee. There is a $35.00 charge for FMLA paperwork.

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. For self-pay and non-par insurances, a $100 deposit is required when making a new patient appointment. 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, option 5.

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 co-payment amounts. I acknowledge all outstanding balances for services are to be resolved within 30 days.

Print Name: ______________________________________ DOB: _________________

Signature: ______________________________________ **Date:** __________________

(Patient or Parent/Guardian if minor)

Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices: ____________

Patient initials

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) DOB

____ ____________
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) DOB

____ ______________
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

The Fertility Center
Families Happen Here

Introduction to our Reproductive Genomics Program

We strive to provide excellent patient-centered care and recognize that genomics is a vital part of personalized medicine. Therefore, we are pleased to offer in-house genetic services to our patients. While there are many causes of infertility and the vast majority of babies are born healthy, there can be great value in identifying potential genetic factors prior to conceiving when your options are greatest. The goal of genetic counseling is to provide you with accurate, comprehensive information and to support your decision-making process as you build your family.

All patients are offered the option of carrier screening for certain genetic conditions, including cystic fibrosis, spinal muscular atrophy, thalassemia, sickle cell disease, and several others. We encourage you to review information about carrier screening prior to your visit at https://www.fertilitycentermi.com/rgp-carrier-screening/ to help you make an informed decision on this testing.

While not every person will need or desire genetic counseling, we want you to be aware of some reasons a genetic consult may be recommended or considered.

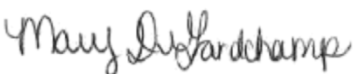
- Personal or family history of a known or potential genetic condition
- Carrier of a genetic condition or chromosome abnormality
- Interested in preimplantation genetic testing (PGT) of embryos
- History of congenital absence of the vas deferens
- Primary ovarian insufficiency
- History of recurrent miscarriages
- Desire to discuss age-related reproductive risks
- Undergoing treatment with an egg, sperm, or embryo donor with questions about the donor's genetic test results or family history
- Further questions about a genetic test that was recommended or offered by your physician

If any of the above factors apply to you, please make your physician aware at your initial visit. If you have undergone genetic testing, providing a copy of those results is most helpful.

If your main reason for coming to The Fertility Center is related to a genetic diagnosis or interest in reproductive options due to a known genetic risk, please make our schedulers aware or reach out directly to our genetic counselor to assure you are scheduled appropriately.

Our genetic counselor, Mary DeGrandchamp, works out of our Grand Rapids location daily, in suite 201. If you are interested in setting up a genetic counseling appointment, please call our scheduling department at 616-988-2229, ext. 122.

To find out more about our Reproductive Genomics Program, please visit our website or reach out to Mary directly for additional information.



Mary DeGrandchamp, MS, CGC
Certified Genetic Counselor
Phone: 616-988-2229 ext.128
Email: tfcgenetics@mrivf.com

Questions for your TFC Physician

We understand that this process can be overwhelming. You have so many thoughts and questions running through your mind that it's easy to forget to ask some of the big things you were hoping to have answered.

In an effort to prevent that from happening and making the best use of your time at your new patient appointment, we wanted to provide a space for you to compile your thoughts and questions while you have the time to think it through thoughtfully.

This form is for your use only. You do not need to return this with your new patient paperwork.