THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE

Dear New Patient:

Welcome to The Nevada Center for Reproductive Medicine, a specialty clinic for the diagnosis and treatment of infertility problems. We sincerely hope that we are successful in assisting you in your goal of conceiving.

We would like to briefly outline our billing arrangements with you. Our initial office consultation fee ranges from $230.00 to $335.00 . This does not include any laboratory or special tests that our physician may deem necessary for your particular situation. You will be given a new patient packet of information during your first visit that includes a fee schedule.

We are participating providers in several types of insurance. We will bill your insurance **if** we are contracted with the insurance, and the consultation is a covered benefit under your plan. PLEASE NOTE: We do not bill insurances that we are not contracted with. Your deductible, co-pay or co-insurance amount is due at the time of your visit. If you are covered by insurance that requires a referral from your primary care physician (PCP), it is **your** responsibility to obtain the referral prior to being seen in our office. If you do not have your referral, you will be asked to re schedule your appointment.

For our patients without insurance, payment is required at the time of each visit. We do not have payment plans available. We do have a financial grant available for patients that meet certain income criteria. You must apply and qualify for the reduced fee. For information please contact our financial counselor.

It is necessary that all prior balances be paid before you start any new diagnostic or treatment cycles. Even if your insurance has been billed, the ultimate responsibility of payment of your bill is your obligation.

Cancellation policy: If you are unable to make your appointment, you must give us a 48 hour notice, or there will be a $50.00 fee charged to your account. We will be unable to reschedule your appointment until the fee is paid.

If you have any questions regarding our office policy or our billing procedures, please do not hesitate to ask.

Thank you,

The Nevada Center for Reproductive Medicine
645 Sierra Rose Dr. Suite 205 Reno, Nevada 89511 (775) 828-1200

I acknowledge that I have read, understand, and agree to abide by the above information.

Signature ________________________________ Date ____________________________

THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE

FEMALE NAME____
FIRST MIDDLE LAST

ADDRESS____
STREET CITY STATE ZIP

HOME PHONE # ________________ **CELL PHONE #** ________________

E-MAIL____________________________ **BIRTHDATE**______________

SOCIAL SECURITY NUMBER ____________ **MARITAL STATUS**________

RACE__________________ **OCCUPATION**________________________
(Optional)

EMPLOYER____________________________ **WORK PHONE #** _________

ADDRESS____
STREET CITY STATE ZIP

SPOUSE OR PARTNER____
FIRST MIDDLE LAST

BIRTHDATE __________ **SOCIAL SECURITY #** ___________ **RACE**________
(Optional)

EMPLOYER ____

ADDRESS____
STREET CITY STATE ZIP

WORK PHONE ____________ **OCCUPATION** __________ **CELLPHONE**______

****

PRIMARY INSURANCE______________________________________

GROUP NAME________________ **GROUP #**___________ **ID#**____________

INSURANCE ADDRESS____________________________ **PHONE** __________

POLICYHOLDERS NAME______________________________________

DOES INSURANCE COVER BOTH PATIENT AND SPOUSE ? YES OR NO

SECONDARY INSURANCE______________________________________

GROUP NAME______________ **GROUP #**____________ **ID#**______________

ADDRESS__________________________ **PHONE #**____________________

POLICYHOLDER'S NAME ______________________________________

DOES INSURANCE COVER BOTH PATIENT AND SPOUSE ? YES OR NO

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME__________________ **RELATIONSHIP**___________ **PHONE #**________

REFERRED BY____
NAME ADDRESS Phone

PRESENT PHYSICIAN______________________ **PHONE #**________________

Do you have an advanced directive ? yes no With whom is it filed? ___________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE INFORMATION: I hereby authorize payment directly to the undersigned physician for medical and/or surgical benefits, if any, otherwise payable to me for his services as desscribed below but not to exceed the reasonable and customary charge for these services. I also authorize the undersigned physician to release any information acquired in the c ourse of my examination or treatment. This may include electronic transmission (i.e., fax) of medical records.

DATE __________ **PATIENT** ________________ **PARTNER**______________

The Nevada Center for Reproductive Medicine

MALE PATIENT HISTORY

Name ____________________

Are you, or have you ever, been exposed to any of the following during employment or military service? If so, explain:

Heat ____________________ Toxic Fumes ____________________

Chemicals ____________________ Nuclear Radiation ____________________

Other ____________________

What medications do you regularly take? (Prescription and/or over the counter drugs)

____

____

Do you frequently take saunas or steam baths? ____________________

Do you, or have you ever, used:

Alcohol? How many drinks per week? ____________________

Cigarettes? How many packs per day? ____________________

Illicit or recreational drugs? ____________________

Do you, or have you ever, had (circle all that apply):

Allergies? (Circle) Yes or No

If Yes, please list: ____________________

Anemia
Appendicitis
Arthritis
Blood Transfusions
Breast Milky Discharge
Breast Soreness
Breast Tenderness
Cancer (Specify) ____________________
Chlamydia
Chronic Bronchitis

Chronic Headaches
Colitis
Cystic Fibrosis
Diabetes
Dizziness
Epilepsy
Fever
Gallbladder Problems
Gonorrhea
Heart Disease
Hepatitis
Herpes
High Blood Pressure
Kidney Infection
Liver Problems
Loss of Balance
Measles : German
Measles: Regular

Mumps
Mumps w/Testes Involved
Neurological Problems
Nongonococcal Urethritis
Parasitic Infection
Pneumonia
Prostatitis
Rheumatic Fever
Scarlet Fever
Seizures
Syphilis
Testes Infection
Testes Injury
Testes Tumor
Thyroid Problems
Tuberculosis
Visual Disturbances
Weight Loss

Have you ever been treated for infertility in the past? ____________________

If yes, review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone: ____________________

____

____

____

The Nevada Center for Reproductive Medicine

FEMALE PATIENT HISTORY

Name____________________ Weight________ Height________ Blood Type ________

When was the first day of your last period? ____________________

Are your periods regular? ____________________

If yes, what is the usual number of days between periods? ____________________

If no, how many times per year do you menstruate? ____________________

What is the usual duration of your period? ____________________

What medications do you regularly take? (Prescription and/or over the counter drugs?

____

____

Do you, or have you ever, used:

Alcohol? How many drinks per week? ____________________

Cigarettes? How many packs per day? ____________________

Illicit or recreational drugs? ____________________

How long have you been trying to get pregnant? ____________________

	Year?	Abortion?	Miscarriage?	Ectopic?	Born Alive?	Fertility Drugs Required?	Current Partner Father?
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

Do you, or have you ever, had (circle all that apply):

Allergies? (Circle) Yes or No

If Yes, please list:____________________

____

____

____

____

Anemia
Appendicitis
Arthritis
Blood Transfusions
Breast Milky Discharge
Breast Soreness
Breast Tenderness
Cancer (Specify)____________________

____

____

Chlamydia
Chronic Bronchitis
Chronic Headaches

Colitis
Color Blind
Diabetes
Dizziness
Endometriosis
Epilesy
Fever
Gallbladder Problems
Gonorrhea
Heart Disease
Hepatitis
Herpes
Hirsutism (Excessive Hair Growth)
High Blood Pressure
Immunized: German Measles
Kidney Infection
Liver Problems
Loss of Balance
Measles: German

Measles: Regular
Neurological Problems
Nongonoccal Urethritis
Ovarian Cysts
Parasitic Infection
Pelvic Infection
Pneumonia
Poor Sense of Smell
Rheumatic Fever
Scarlet Fever
Seizures
Syphilis
Thyroid Problem
Tuberculosis
Ulcers
Vaginitis (Trichomoniasis, Yeast)
No. of Episodes ________
Visual Disturbances
Weight Loss

Has your partner ever fathered a child with another woman? ____________________

Have you ever been treated for infertility in the past? ____________________

If yes, review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone: ____________________

____

____

NEVADA CENTER FOR REPRODUCTIVE MEDICINE

HIPAA PRIVACY RULE AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, ______________________________ authorize the specified person(s) or
(Male Patient)
company to disclose protected health information as follows:

1. **Company authorized to make disclosure: NCRM**
2. **Person authorized to receive the disclosed information:**
   Partner____________________ Other____________________
3. **Specific description of the protected health information that may be used or disclosed:______________________________**
   ____
   ____
4. **I understand that the information received pursuant to this authorization <u>may</u> be disclosed by the recipient and might lose its protected status.**
5. **I understand that I may revoke this authorization by giving written notice to a representative of The Nevada Center For Reproductive Medicine.**
6. **I understand that I am entitled to receive a copy of this authorization.**
7. **I understand that after this information is disclosed, federal law might not protect it, and the recipient might re-disclose it.**
8. **I give authorization to representatives of NCRM to leave protected health, information on the following:**

	Circle one		Initial here
1. Home answering machine	yes	no	________
2. Cell phone voice mail	yes	no	________
3. Work voice mail	yes	no	________

NAME: ______________________________ DATE:______________

SIGNATURE OF PATIENT : ______________________________

WITNESS:______________________________

NEVADA CENTER FOR REPRODUCTIVE MEDICINE

HIPAA PRIVACY RULE AUTHORIZATION
FOR RELEASE OF HEALTH INFORMATION

I, ______________________________________ authorize the specified person(s) or
(Female Patient)
company to disclose protected health information as follows:

1. **Company authorized to make disclosure: NCRM**
2. **Person authorized to receive the disclosed information:**
   Partner____________________________Other____________________________
3. **Specific description of the protected health information that may be used or disclosed:____**
   ____
   ____
4. **I understand that the information received pursuant to this authorization <u>may</u> be disclosed by the recipient and might lose its protected status.**
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	Circle one		Initial here
1. Home answering machine	yes	no	__________
2. Cell phone voice mail	yes	no	__________
3. Work voice mail	yes	no	__________

NAME: ____ **DATE:**________________

SIGNATURE OF PATIENT : ____

WITNESS:____

Patient-Healthcare Provider Electronic Communication Agreement

Electronic communications, including, but not limited to, emails, internet-based video conferencing through such applications as Skype and "FaceTime" through iPhones and iPads, for example (hereinafter "Electronic Communications") provide an opportunity to communicate with your healthcare provider relative to issues that are **non-emergent, non-urgent or non-critical**. Electronic Communications are not a replacement for the interpersonal contact that is the very basis of the doctor-patient relationship.

The following is intended to assist you with your determination of whether you wish to supplement your healthcare experience by electronically communicating with members of the healthcare team at The Nevada Center For Reproductive Medicine.

General Considerations

- Your Healthcare Provider will treat Electronic Communications with the same degree of privacy and confidentiality as written medical records. Your Healthcare Provider has taken reasonable steps with internal information technology systems to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1992, as amended (HIPAA.)
- Standard email services, including, but not limited to, AOL, Optonline, Hotmail, and Gmail, are not secure. This means that the email messages are not encrypted and can be intercepted and read by unauthorized individuals.
- Electronic communication via internet based video conference providers, including, but not limited to, Skype, claim to have safeguards in place to protect your personal information from unauthorized disclosure. However, there is the possibility that viruses, Trojans or other malicious software may obtain your private information on your computer system and release and/or use your information without your knowledge. There may be other risks associated with internet communication which are unknown at this time.
- Transmitting email that contains protected health information through an email system that is not encrypted do not meet and electronic communication via internet based video conference providers may not meet the security guidelines as required by the HIPAA.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with Healthcare Provider. I acknowledge that commonly used Electronic Communications are not secure and fall outside of the security requirements set forth by HIPAA.

I understand that I can withdraw this consent authorizing Healthcare Provider to communicate with me via Electronic Communications at any time by written notification to Healthcare Provider.

I release and hold harmless Healthcare Provider, its physicians and their staff, employees, affiliates, agents, officers, directors and shareholders from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses, of any kind that I may have resulting from Electronic Communications between Healthcare Provider and me based on this authorization given to Healthcare Provider to communicate with me via Electronic Communications.

Having been informed of the risks associated with Electronic Communications, I still desire to communicate with Healthcare Provider via electronic communications. In consideration for my desire to use Electronic Communications as an adjunct to in-person office visits with Healthcare Provider, I hereby authorize Healthcare Provider to engage in Electronic Communication with me.

____ ________________

Patient Signature Date

Current E-Mail Address ____

____ ________________

Partner Signature Date

Current E-Mail Address ____

Nevada Center for Reproductive Medicine

Nevada Center for Reproductive Medicine (NCRM)
Notice of Privacy and Security Practices

This following information explains how your personal health information might be used or discloses and how you can attain access to this information. Please review this information carefully.

Uses and Disclosures

Medical Action: Your health information may be used by NCRM or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Health Care Operations: Your protected health information may be used as necessary to support the day-to-day activities and management of NCRM. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Law Enforcement Officials: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting and Officials: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Egg Donors. The following information, all or in part, may be disclosed to potential egg recipients: year of birth, photos, personal and family medical history, personal and family physical characteristics, personal interests, education, hobbies, and athletic activities.

Attain. If requested by you, your demographic and health information will be used by our staff to see if you qualify for the Attain IVF program.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Consent to Use and Disclosure of Protected Health Information
Use and Disclosure of Your Protected Health Information

Your protected health information will be used by NCRM or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You can read the NCRM Security and Privacy Policy for a more complete description of how your protected health information may be used or disclosed. You may review the policy prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. NCRM may or may not agree to restrict the use or disclosure of your protected health information. If NCRM agrees to your request, the restriction will be binding on the practice.

Cancellation of Consent
You may abrogate this consent to the use and disclosure of your protected health information. You must cancel this consent in writing. Any use or disclosure that has already occurred prior to the date on which your cancellation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
NCRM reserves the right to modify the privacy practices outlined in the notice.

The Nevada Center For Reproductive Center
Notice of Privacy and Security Practices
Signature Page

I have reviewed this consent form and give my permission to NCRM to use and disclosure my health information in accordance with it.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient