shady grove fertility

WELCOME

Dear Patient,

Thank you again for choosing Shady Grove Fertility.

This packet contains the necessary paperwork for your initial appointment. In order to make your initial consultation the most productive, and to provide for a comprehensive review of your personal and family medical history, we require the following completed forms prior to your initial consultations.

Please review and complete the following forms (as applicable):

- Patient Registration Form
- Email Authorization Form
- Male Questionnaire *
- Telehealth Informed Consent (if applicable)
- Financial Policy
- Notice of Privacy Practices
- Acknowledgement of Receipt of Privacy Practices / Permission for Voicemail

* Please complete a questionnaire for each partner.

Completed forms may be brought in when you check in for your consultation or sent back via the SGF Patient Portal's secure messaging system. To access the SGF Patient Portal, please visit: *sgf.myhealthpatientportal.com*.

We look forward to working with you!

Shady Grove Fertility

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HOW DID YOU HEAR ABOUT US? (Please select all that apply).

- ☐ Physician*
- ☐ Other Patient
- ☐ Friend/Relative
- ☐ Resolve/AIA
- ☐ Internet/Website
- ☐ Insurance Directory
- ☐ Radio: _____
- ☐ Other: _____

***Physician Name:** _____
Address: _____
City: _____ **State:** _____
Phone: _____
Specialty: _____

PATIENT		PARTNER	
SOCIAL SECURITY NUMBER	PATIENT ID NUMBER	SOCIAL SECURITY NUMBER	PATIENT ID NUMBER
LEGAL NAME (FIRST - MIDDLE INITIAL - LAST)		LEGAL NAME (FIRST - MIDDLE INITIAL - LAST)	
ADDRESS		ADDRESS	
CITY / STATE / ZIP		CITY / STATE / ZIP	
HOME PHONE	WORK PHONE	HOME PHONE	WORK PHONE
CELL PHONE	DATE OF BIRTH	CELL PHONE	DATE OF BIRTH
EMAIL ADDRESS		EMAIL ADDRESS	
☐ SINGLE ☐ MARRIED	DATE OF MARRIAGE	☐ SINGLE ☐ MARRIED	DATE OF MARRIAGE

PATIENT'S EMPLOYMENT		PARTNER'S EMPLOYMENT	
COMPANY NAME	OCCUPATION	COMPANY NAME	OCCUPATION
ADDRESS		ADDRESS	
CITY / STATE / ZIP		CITY / STATE / ZIP	

PATIENT PRIMARY INSURANCE		PARTNER PRIMARY INSURANCE	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
POLICY HOLDER NAME	RELATIONSHIP	POLICY HOLDER NAME	RELATIONSHIP
POLICY NUMBER	GROUP NUMBER	POLICY NUMBER	GROUP NUMBER

PATIENT SECONDARY INSURANCE		PARTNER SECONDARY INSURANCE	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
POLICY HOLDER NAME	RELATIONSHIP	POLICY HOLDER NAME	RELATIONSHIP
POLICY NUMBER	GROUP NUMBER	POLICY NUMBER	GROUP NUMBER

EMERGENCY CONTACT		EMERGENCY CONTACT	
NAME		NAME	
PHONE	RELATIONSHIP	PHONE	RELATIONSHIP

I authorize the release of any medical information necessary to process a claim to the above named insurance carrier(s). I hereby assign my medical benefits to, and direct that payments be made to Shady Grove Fertility (SGF). I/We have disclosed all insurance policies including insurance policies that SGF is a non-participating provider. I/we understand that if we choose not to disclose all insurance policies, we waive our insurance coverage and will be financially responsible to pay for all services.

PATIENT TYPED SIGNATURE _____ DATE _____

PARTNER TYPED SIGNATURE _____ DATE _____

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EMAIL AUTHORIZATION

Patient Name: _____ MPI: _____

Partner Name (if applicable): _____ MPI: _____

The physicians and staff of Shady Grove Fertility (SGF) offer patients the opportunity to communicate electronically using secure messaging for general questions or concerns. In order to use secure messaging, we require an email address. Although secure messaging will be used for communication, there may be times when it is necessary to send an email. Because your privacy and security are some of our primary concerns, e-mail has certain risks that patients should consider before giving consent. These risks include but are not limited to:

1. E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
2. E-mail can occasionally be broadcast to both intended and unintended recipients.
3. E-mail senders can misaddress e-mail.
4. E-mail can be more easily falsified than handwritten or signed documents.
5. Backup copies of e-mail may exist, even after the sender or the recipient has deleted his or her copy.
6. E-mail can be altered, forwarded or used without authorization or detection.
7. E-mail can be used to introduce viruses into computer systems.

The physicians and staff of SGF will use reasonable means to protect security and confidentiality of e-mail information sent and received. Because of the risks outlined above, however, we cannot guarantee the security and confidentiality of e-mail communication and therefore you should not ever include your social security number or date of birth in any e-mail communications to us.

In addition, ***secure messaging should never be used to communicate acute and/or urgent clinical problems*** such as pain or abnormal bleeding. Our physicians and staff always try to respond to secure messages in a timely fashion, but for any clinical problems, you should follow proper guidelines by calling our office or the answering service after hours. In a medical emergency, call 911.

Please be advised that while it is not mandatory to provide an email dress, we will not be able to communicate via secure messaging without an email address on file.

By signing below, I/we authorize SGF to communicate with me/us by email in regards to my/our medical care and associated charges. I/We also agree to promptly notify SGF of change in my/our email address.

_____ _____

PATIENT EMAIL ADDRESS PARTNER EMAIL ADDRESS

_____ _____

PATIENT TYPED SIGNATURE DATE PARTNER TYPED SIGNATURE DATE

Date Completed: _____

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MALE QUESTIONNAIRE

Name: _____ **Date of Birth:** _____

Phone: ☐ Cell ☐ Home ☐ Work _____ **Email:** _____

Height: _____ **Weight:** _____

Occupation: _____ **Referred By:** _____

Partner Name: _____ **Date of Marriage** (if applicable)**:** _____

Primary Care Provider Name and Phone: _____

Please indicate the reason for your visit:

☐ Fertility consultation with female partner
☐ Vasectomy consultation
☐ Other: _____
☐ Fertility consult with same sex partner
☐ Sexual function concerns

FERTILITY AND UROLOGIC HISTORY

How long have you been having unprotected intercourse?

Have you ever conceived in your current relationship?
☐ No ☐ Yes – Outcome:

Have you used or are you currently on testosterone replacement or using anabolic steroids?
☐ No ☐ Prior Use ☐ Yes (current use)

Have you ever conceived in another relationship?
☐ No ☐ Yes – Outcome:

Do you have any issues with erection, ejaculation, or sex drive? If so, please explain:

Have you ever had testing and/or treatment by a urologist or endocrinologist (as a child, adolescent, or adult)? If so, please explain:

Have you completed a semen analysis? ☐ No ☐ Yes – If yes, please provide result(s) of prior semen analyses below:

	Result(s)
Volume (Milliliter)	
Concentration (Million sperm per milliliter of semen)	
Motility (%)	
Morphology (%)	

MEDICAL AND SURGICAL HISTORY

List all medication allergies:

Are you allergic to latex? ☐ No ☐ Yes

List non-medical allergies:

List all current prescription and over-the-counter medications, vitamins, and supplements:

Please check any medical problems that you currently have or have had in the past:

☐ Anxiety ☐ Asthma ☐ Blood clots (DVT or PE)
☐ Cancer ☐ Depression ☐ Diabetes
☐ High blood pressure ☐ Seizures ☐ Thyroid problems

Describe any other medical problems:

Describe prior medical problems and hospitalizations:

List any surgeries and include date(s) of procedure(s):

SOCIAL HISTORY

Do you consume alcohol? ☐ No ☐ Yes – Number of drinks per week:

Do you use tobacco or nicotine products? ☐ No ☐ Yes – Please specify type(s) and frequency of use:

Do you use recreational drugs (including marijuana)? ☐ No ☐ Yes – Please specify type(s) and frequency of use:

FAMILY HISTORY

Please list any medical issues for the following family members:

Father:	Mother:	Sibling(s):

Does your father have a history of prostate cancer? ☐ No ☐ Yes

What is your ethnic background? Please select all that apply.

- ☐ Asian or Southeast Asian
- ☐ Cajun or French Canadian
- ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese
- ☐ Jewish
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other: _____
- ☐ African American, African descent, or Black
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Native American
- ☐ Unknown

Do you have a family history of:

- ☐ Ancephaly (opening in head/brain)
- ☐ Blindness and/or deafness
- ☐ Birth defects
- ☐ Cystic fibrosis
- ☐ Fragile X
- ☐ Genetic Disease(s) or other chromosome problem
- ☐ Huntington's disease
- ☐ Muscular dystrophy or neuromuscular disease
- ☐ Polycystic kidney disease
- ☐ Skeletal disorder – such as dwarfism
- ☐ Stillborn baby or infant death after birth or within the first year
- ☐ Autism or autistic-like syndrome
- ☐ Blood disorder or clots
- ☐ Cleft lip and/or cleft palate
- ☐ Down Syndrome
- ☐ Intellectual disability and/or cognitive impairments
- ☐ Heart defect at birth
- ☐ Menopause prior to age 40
- ☐ Neurofibromatosis
- ☐ Sickle cell anemia
- ☐ Spina bifida
- ☐ Tay Sachs disease
- ☐ Other birth defect not listed above: _____
- ☐ Other inherited (genetic) condition not listed above: _____

Are you and your partner related to each other (blood relatives)? ☐ No ☐ Yes – Please explain relation:

Have you and/or your partner completed prior carrier testing for genetic diseases? ☐ No ☐ Yes – Results:

Is there anything else that you would like to discuss with your doctor?

Date Completed: _____

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MALE QUESTIONNAIRE

Name: _____ **Date of Birth:** _____

Phone: ☐ Cell ☐ Home ☐ Work _____ **Email:** _____

Height: _____ **Weight:** _____

Occupation: _____ **Referred By:** _____

Partner Name: _____ **Date of Marriage** (if applicable)**:** _____

Primary Care Provider Name and Phone: _____

Please indicate the reason for your visit:

☐ Fertility consultation with female partner
☐ Fertility consult with same sex partner
☐ Vasectomy consultation
☐ Sexual function concerns
☐ Other: _____

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Have you ever conceived in your current relationship?
☐ No ☐ Yes – Outcome:

Have you used or are you currently on testosterone replacement or using anabolic steroids?
☐ No ☐ Prior Use ☐ Yes (current use)

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Have you completed a semen analysis? ☐ No ☐ Yes – If yes, please provide result(s) of prior semen analyses below:

	Result(s)
Volume (Milliliter)	
Concentration (Million sperm per milliliter of semen)	
Motility (%)	
Morphology (%)	

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List all medication allergies:

Are you allergic to latex? ☐ No ☐ Yes

List non-medical allergies:

List all current prescription and over-the-counter medications, vitamins, and supplements:

Please check any medical problems that you currently have or have had in the past:

☐ Anxiety ☐ Asthma ☐ Blood clots (DVT or PE)
☐ Cancer ☐ Depression ☐ Diabetes
☐ High blood pressure ☐ Seizures ☐ Thyroid problems

Describe any other medical problems:

Describe prior medical problems and hospitalizations:

List any surgeries and include date(s) of procedure(s):

SOCIAL HISTORY

Do you consume alcohol? ☐ No ☐ Yes – Number of drinks per week:

Do you use tobacco or nicotine products? ☐ No ☐ Yes – Please specify type(s) and frequency of use:

Do you use recreational drugs (including marijuana)? ☐ No ☐ Yes – Please specify type(s) and frequency of use:

FAMILY HISTORY

Please list any medical issues for the following family members:

Father:	Mother:	Sibling(s):

Does your father have a history of prostate cancer? ☐ No ☐ Yes

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- ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese
- ☐ Jewish
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other: _____
- ☐ African American, African descent, or Black
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Native American
- ☐ Unknown

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- ☐ Ancephaly (opening in head/brain)
- ☐ Blindness and/or deafness
- ☐ Birth defects
- ☐ Cystic fibrosis
- ☐ Fragile X
- ☐ Genetic Disease(s) or other chromosome problem
- ☐ Huntington's disease
- ☐ Muscular dystrophy or neuromuscular disease
- ☐ Polycystic kidney disease
- ☐ Skeletal disorder – such as dwarfism
- ☐ Stillborn baby or infant death after birth or within the first year
- ☐ Autism or autistic-like syndrome
- ☐ Blood disorder or clots
- ☐ Cleft lip and/or cleft palate
- ☐ Down Syndrome
- ☐ Intellectual disability and/or cognitive impairments
- ☐ Heart defect at birth
- ☐ Menopause prior to age 40
- ☐ Neurofibromatosis
- ☐ Sickle cell anemia
- ☐ Spina bifida
- ☐ Tay Sachs disease
- ☐ Other birth defect not listed above: _____
- ☐ Other inherited (genetic) condition not listed above: _____

Are you and your partner related to each other (blood relatives)? ☐ No ☐ Yes – Please explain relation:

Have you and/or your partner completed prior carrier testing for genetic diseases? ☐ No ☐ Yes – Results:

Is there anything else that you would like to discuss with your doctor?

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Telehealth Informed Consent

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Responsibility for the patient care should remain with the patient's local clinician, if you have one, as does the patient's medical record.

Expected Benefits

- Improved access to medical care by enabling a patient to remain in his/her local healthcare site (i.e. home) while the physician consults and obtains test results at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the consultant may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By typing in your signature below, you acknowledge that you understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting healthcare provider.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

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5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.
7. I understand that billing will occur from my practitioner from the site from which I am presented.

Patient Consent to the Use of Telemedicine
I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction.

I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telemedicine visit under the terms described herein.

I hereby state that I have read, understood, and agree to the terms of this document.

PATIENT TYPED SIGNATURE DATE

PARTNER TYPED SIGNATURE DATE