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 complete the following forms (as applicable):

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

* Please complete the appropriate female/male questionnaire(s) 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

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

- ☐ PHYSICIAN*
- ☐ FRIEND/RELATIVE
- ☐ INTERNET/WEBSITE
- ☐ RADIO: _____
- ☐ OTHER: _____
- ☐ OTHER PATIENT
- ☐ RESOLVE/AIA
- ☐ INSURANCE DIRECTORY

*PHYSICIAN NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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.

By typing my name in the signature field below, I acknowledge that I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this form.

PATIENT TYPED SIGNATURE _____ DATE _____

PARTNER TYPED SIGNATURE _____ DATE _____

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 regarding 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: _____

FEMALE QUESTIONNAIRE

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

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

Height: _____ **Weight:** _____

Occupation: _____ **Referred By:** _____

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

OB/GYN Name and Phone: _____

Primary Care Provider Name and Phone: _____

Please indicate the reason for your visit:

☐ Infertility (difficulty getting pregnant)
☐ Interested in conceiving using sperm donor
☐ Other: _____
☐ Recurrent miscarriage
☐ Fertility Preservation (egg or embryo freezing)

MENSTRUAL AND GYNECOLOGIC HISTORY

Age at first period: _____ ***First day of last period:*** _____

Are your periods regular or irregular?

☐ Regular

Number of days between the start of one menses to the start of the next menses: _____

How many days do you bleed? _____

☐ Irregular

In the last year:
How many periods have you had? _____
How close have two periods been? _____
How far apart have two periods been? _____

Do you have?
☐ Extra hair growth on face/body
☐ Changes in weight
☐ Significant acne
☐ Breast discharge

When was your last:

Gynecologic Exam	Date: _____	Result: _____
Mammogram	Date: _____	Result: _____
Pap smear	Date: _____	Result: _____

With your period, do you experience any of the following?

☐ Very heavy periods
☐ Significant pain or cramping
☐ Other symptoms:

Have you ever had an abnormal Pap smear?

☐ No
☐ Yes - Please explain follow up and treatment:

Have you had any sexually transmitted infections (STIs)? If so, please provide date(s) of treatment.

☐ Gonorrhea: _____
☐ Chlamydia: _____
☐ Pelvic inflammatory disease (PID): _____
☐ Other STIs: _____

Do you track your menstrual cycles? Select all tracking methods used below:

☐ No tracking method used
☐ Ovulation predictor kit(s)
☐ Other: _____
☐ Calendar or App: _____
☐ Basal body temperature

Have you ever used contraception? Select all applicable methods and provide approximate date(s) of use.

- ☐ Birth control pills, vaginal ring, patch: _____
- ☐ Contraceptive implant: _____
- ☐ Condoms: _____
- ☐ Vasectomy: _____
- ☐ Withdrawal: _____
- ☐ Intrauterine device (IUD): _____
- ☐ Injection: _____
- ☐ Tubal ligation: _____
- ☐ Natural family planning: _____
- ☐ Other: _____

How long have you been having unprotected intercourse?

_____

How often do you have unprotected intercourse?

_____

Do you have pain with intercourse? If so, please explain: _____

FERTILITY TESTING AND TREATMENT

Please note prior fertility testing completed and results:

- ☐ Follicle Stimulating Hormone (FSH) _____
- ☐ Luteinizing Hormone (LH) _____
- ☐ Estradiol (E2) _____
- ☐ Anti-Müllerian Hormone (AMH) _____
- ☐ Thyroid Stimulating Hormone (TSH) _____
- ☐ Pelvic ultrasound/Follicle count _____
- ☐ Hysterosalpingogram (HSG) _____
- ☐ Saline sonogram _____
- ☐ Hysteroscopy _____
- ☐ Laparoscopy _____
- ☐ Other _____

Have you undergone any fertility treatment in the past? If so, please provide treatment information below.

TYPE	NUMBER OF CYCLES	DATES OF TREATMENT	CYCLE OUTCOME
Oral Medication (Clomiphene or Letrozole)			
Injectable Medication(s)			
Intrauterine Insemination (IUI)			
In-Vitro Fertilization (IVF)			

OBSTETRIC HISTORY

If you have been pregnant, please complete the chart below:

YEAR	LENGTH OF TIME TO CONCEIVE	WAS FERTILITY TREATMENT USED TO CONCEIVE? If so, what type of treatment?	PREGNANCY OUTCOME (Miscarriage, Termination, Ectopic pregnancy, Preterm birth, Term birth)	DESCRIBE COMPLICATIONS (If applicable)

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 consume caffeine?

- ☐ No
- ☐ Yes – Please describe daily intake: _____

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:

Do you exercise regularly?

- ☐ No
- ☐ Yes – Please note exercise type, frequency, and duration: _____

FAMILY HISTORY

Please list any medical issues for the following family members:

Father:

Mother:

Sibling(s):

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

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

Do you have a family history of:

- ☐ Ancephaly (opening in head/brain)
- ☐ Autism or autistic-like syndrome
- ☐ Blindness and/or deafness
- ☐ Blood disorder or clots
- ☐ Birth defects
- ☐ Cleft lip and/or cleft palate
- ☐ Cystic fibrosis
- ☐ Down Syndrome
- ☐ Fragile X
- ☐ Intellectual disability and/or cognitive impairments
- ☐ Genetic Disease(s) or other chromosome problem
- ☐ Heart defect at birth
- ☐ Huntington's Disease
- ☐ Menopause prior to age 40
- ☐ Muscular dystrophy or neuromuscular disease
- ☐ Neurofibromatosis
- ☐ Polycystic Kidney Disease
- ☐ Sickle cell anemia
- ☐ Skeletal disorder – such as dwarfism
- ☐ Spina bifida
- ☐ Stillborn baby or infant death after birth or within the first year
- ☐ 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: _____

FEMALE QUESTIONNAIRE

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

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

Height: _____ **Weight:** _____

Occupation: _____ **Referred By:** _____

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

OB/GYN Name and Phone: _____

Primary Care Provider Name and Phone: _____

Please indicate the reason for your visit:

☐ Infertility (difficulty getting pregnant)
☐ Interested in conceiving using sperm donor
☐ Other: _____
☐ Recurrent miscarriage
☐ Fertility Preservation (egg or embryo freezing)

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Number of days between the start of one menses to the start of the next menses: _____

How many days do you bleed? _____

☐ Irregular

In the last year:
How many periods have you had? _____
How close have two periods been? _____
How far apart have two periods been? _____

Do you have?
☐ Extra hair growth on face/body
☐ Changes in weight
☐ Significant acne
☐ Breast discharge

When was your last:

Gynecologic Exam	Date: _____	Result: _____
Mammogram	Date: _____	Result: _____
Pap smear	Date: _____	Result: _____

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☐ Very heavy periods
☐ Significant pain or cramping
☐ Other symptoms:

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☐ No
☐ Yes - Please explain follow up and treatment:

Have you had any sexually transmitted infections (STIs)? If so, please provide date(s) of treatment.

☐ Gonorrhea: _____
☐ Chlamydia: _____
☐ Pelvic inflammatory disease (PID): _____
☐ Other STIs: _____

Do you track your menstrual cycles? Select all tracking methods used below:

☐ No tracking method used
☐ Ovulation predictor kit(s)
☐ Other: _____
☐ Calendar or App: _____
☐ Basal body temperature

Have you ever used contraception? Select all applicable methods and provide approximate date(s) of use.

- ☐ Birth control pills, vaginal ring, patch: _____
- ☐ Contraceptive implant: _____
- ☐ Condoms: _____
- ☐ Vasectomy: _____
- ☐ Withdrawal: _____
- ☐ Intrauterine device (IUD): _____
- ☐ Injection: _____
- ☐ Tubal ligation: _____
- ☐ Natural family planning: _____
- ☐ Other: _____

How long have you been having unprotected intercourse?

_____

How often do you have unprotected intercourse?

_____

Do you have pain with intercourse? If so, please explain: _____

FERTILITY TESTING AND TREATMENT

Please note prior fertility testing completed and results:

- ☐ Follicle Stimulating Hormone (FSH) _____
- ☐ Luteinizing Hormone (LH) _____
- ☐ Estradiol (E2) _____
- ☐ Anti-Müllerian Hormone (AMH) _____
- ☐ Thyroid Stimulating Hormone (TSH) _____
- ☐ Pelvic ultrasound/Follicle count _____
- ☐ Hysterosalpingogram (HSG) _____
- ☐ Saline sonogram _____
- ☐ Hysteroscopy _____
- ☐ Laparoscopy _____
- ☐ Other _____

Have you undergone any fertility treatment in the past? If so, please provide treatment information below.

TYPE	NUMBER OF CYCLES	DATES OF TREATMENT	CYCLE OUTCOME
Oral Medication (Clomiphene or Letrozole)			
Injectable Medication(s)			
Intrauterine Insemination (IUI)			
In-Vitro Fertilization (IVF)			

OBSTETRIC HISTORY

If you have been pregnant, please complete the chart below:

YEAR	LENGTH OF TIME TO CONCEIVE	WAS FERTILITY TREATMENT USED TO CONCEIVE? If so, what type of treatment?	PREGNANCY OUTCOME (Miscarriage, Termination, Ectopic pregnancy, Preterm birth, Term birth)	DESCRIBE COMPLICATIONS (If applicable)

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 consume caffeine?

- ☐ No
- ☐ Yes – Please describe daily intake: _____

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:

Do you exercise regularly?

- ☐ No
- ☐ Yes – Please note exercise type, frequency, and duration: _____

FAMILY HISTORY

Please list any medical issues for the following family members:

Father:

Mother:

Sibling(s):

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

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

Do you have a family history of:

- ☐ Ancephaly (opening in head/brain)
- ☐ Autism or autistic-like syndrome
- ☐ Blindness and/or deafness
- ☐ Blood disorder or clots
- ☐ Birth defects
- ☐ Cleft lip and/or cleft palate
- ☐ Cystic fibrosis
- ☐ Down Syndrome
- ☐ Fragile X
- ☐ Intellectual disability and/or cognitive impairments
- ☐ Genetic Disease(s) or other chromosome problem
- ☐ Heart defect at birth
- ☐ Huntington's Disease
- ☐ Menopause prior to age 40
- ☐ Muscular dystrophy or neuromuscular disease
- ☐ Neurofibromatosis
- ☐ Polycystic Kidney Disease
- ☐ Sickle cell anemia
- ☐ Skeletal disorder – such as dwarfism
- ☐ Spina bifida
- ☐ Stillborn baby or infant death after birth or within the first year
- ☐ 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?

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.

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.

By typing my name in the signature field below, I acknowledge that I am signing this document electronically.
I agree that my electronic signature is the legal equivalent of my manual signature on this form.

PATIENT TYPED SIGNATURE DATE

PARTNER TYPED SIGNATURE DATE

FINANCIAL POLICY

Shady Grove Fertility ("SGF") is made up of a network of individual medical practices under one management company.

Each SGF practice is in a distinct geographic location and may be a participating provider with several insurance carriers.

- Not all SGF practices participate with the same insurers.
- It is important for you to verify with your individual insurance plan that your SGF practice is recognized as a participating provider.
- If you choose, for whatever reason, to receive services at another SGF practice and that SGF practice is not recognized as a participating provider with your insurance, you will be responsible for the costs associated with this appointment.

It is important to recognize your insurance policy is a contract between you and your employer.

- Review your insurance policy to understand your infertility benefits and limitations.
- Most infertility coverage is based on treatment cycles and an annual or lifetime benefit maximum.
- Insurance coverage is designed to assist you with your financial obligation with respect to infertility treatments – not eliminate it.

Your financial obligations are to:

- Make payments to your SGF practice at or before the time of service depending on coverage criteria.
- Pay all applicable deductibles, co-pays, co-insurance.
- Pay for all non-covered services.

You must inform your SGF practice of any circumstances that could impact claim submission or processing; otherwise, you will be responsible for all outstanding charges. Examples include:

- You have exhausted your policy benefit or lifetime maximum
- Your insurance policy has changed or has not been updated
- Your insurance company requires you to provide additional information within a specified time

SGF has financial counselors who will help guide you through the process of obtaining your benefit information.

- Our financial counselors will provide an estimate of your financial obligation in advance of treatment.
- SGF assumes no responsibility for representations made to us by your insurance company.
- SGF cannot guarantee that any payment will or will not be made by your insurance carrier until the claim is processed.

Patient deposits may be required prior to treatment because of the complexity of fertility coverage.

- You will receive an estimate of your financial obligation to be paid in advance of treatment. This is only an estimate and SGF makes no representations that this will be your only financial obligation with respect to your infertility treatments.
- If any overpayment is made by you, such overpayment will be refunded after all insurance claims have been processed and all other charges have been paid in full.

Many insurance companies require the patient and/or provider to obtain referrals, pre-authorizations or enroll in plan specific case management programs before they will cover infertility services. In these cases:

- Treatment may not begin until you receive a confirmation from SGF that all referrals and authorizations are on file.
- If you chose to start treatment without any required referral, authorization, or program enrollment, you will not be allowed to use your insurance coverage and will be considered self-pay for the services. This means full payment will be required before services are rendered.
- If you are receiving services at an SGF practice but are under the care of a medical practice outside of the SGF network, you will be required to adhere to all SGF financial policies for the services received at the SGF practice.

If your SGF practice is a non-participating or out of network provider with your insurance carrier:

- We will provide you the courtesy of submitting a claim for your services and require payment in full at the time service.
- In the event you have dual coverage and your SGF practice does not participate with your primary insurance, SGF will require payment in full for all treatment.

Utilizing non-SGF services, such as pharmacy, anesthesia, or laboratory services, requires you to:

- Understand the impact the cost has on your infertility maximum, both yearly and lifetime.
- Determine if your laboratory services are covered under your plan and your financial obligation to that laboratory.
- Understand that medication benefits vary between payors and its impact on your benefit level.
- Understand your anesthesia benefits.
- If required, make payment for these non-SGF services directly to those providers and work with their staff to determine the financial obligation.

Understanding and managing your financial obligations is extremely important to us. You should receive a monthly statement identifying any outstanding balance.

Settling your financial obligations:

- Your statement will provide a secure link to make payments on-line or you may call our central billing office at (301) 545-1355 to process payments utilizing a credit card (Visa, Amex, MasterCard, Discover).
- You may also pay by check. In the event a check is returned, a $50 handling charge will be added to your account balance.
- All outstanding balances that remain unpaid after 120 days may be referred to an outside collection agency or attorney.
- If we refer the claim to an attorney to collect the debt, you are responsible to pay any reasonable attorneys' fees and legal expenses SGF may incur in attempting to collect payment from you.
- Any further treatment may be delayed until your outstanding balance is resolved.

I have read and understand all the terms and conditions presented in this financial policy. I agree to be financially responsible for services rendered.

For services that have not been paid in full or those requested by me to be submitted to insurance, I hereby consent to allow SGF to release information regarding my/our services to the insurance carrier(s) whose information has been provided by me/us.

I assign to the applicable SGF practice any and all benefits from any insurance plan where my/our SGF practice is a participating provider, and I authorize and direct such benefits to be paid directly to the applicable SGF practice for services rendered.

By typing my name in the signature field below, I acknowledge that I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this form.

PATIENT TYPED SIGNATURE DATE

PARTNER TYPED SIGNATURE DATE

PATIENT MPI

PARTNER MPI

INSURANCE WAIVER

Please initial the applicable selection(s) below:

_____ INITIALS

Patients who present an updated insurance card

- I acknowledge that SGF has not performed a verification of coverage determining my level of benefits and the identification of services that require the appropriate initial referral or authorization from my insurance carrier.
- I assume full financial responsibility and will pay for all services today.

_____ INITIALS

Patients who present new insurance coverage

- I acknowledge that SGF has not performed a verification of coverage determining my level of benefits and the identification of services that require the appropriate initial referral or authorization from my insurance carrier.
- I assume full financial responsibility and will pay for all services today.

_____ INITIALS

Patients requiring enrollment with third party Infertility Benefits Administrator

- I have not enrolled with any third-party Infertility Benefits Administrator, which may provide infertility coverage benefits through my employer group benefit. I acknowledge that such enrollment may be required prior to my insurance providing coverage for my infertility treatments.
- I waive the use of my infertility benefit coverage and assume full financial responsibility for all charges incurred today and all future visits due to not properly enrolling in infertility coverage benefits.

_____ INITIALS

Patients requiring referrals

- I acknowledge that I have not obtained an authorized referral from my insurance plan or designated provider based on plan requirements.
- I waive the use of my insurance coverage and assume full financial responsibility for all charges incurred today and all future visits without an authorized referral.

_____ INITIALS

Patients requiring authorization

- I acknowledge that I have not obtained the necessary authorization from my insurance plan.
- I understand that I am responsible for all charges incurred from this point forward or until authorization is obtained for future services.
- I acknowledge that there is no guarantee that my insurance company will backdate my authorization for the required dates of service.

_____ INITIALS

Patients with or without insurance

- I acknowledge that I have elected to be seen as a self-pay patient.
- I agree to assume full financial responsibility to pay in full today for all services rendered.

_____ INITIALS

Out of network insurance coverage

- I understand that I have an insurance plan that may require me to seek treatment from physicians or laboratories within my insurance carrier's network of providers. I am aware that my Shady Grove Fertility practice and physician are out-of-network with my insurance plan. I have chosen not to use my insurance benefits by seeking treatment at Shady Grove Fertility. I agree to assume full financial responsibility for all services rendered.

By signing this form, I agree to be financially responsible for all services determined by my physician and me to be appropriate. I understand and agree that Shady Grove Fertility will not seek reimbursement from my insurance company or plan.

In accordance with my understanding of the above, I hereby agree to payment at time of service or prior to the start of my global cycle, as applicable.

By typing my name in the signature field below, I acknowledge that I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this form.

PATIENT SIGNATURE DATE

INSURANCE CARRIER

MPI

MEDICAID AND MEDICARE INSURANCE WAIVER

Please initial the applicable selection(s) below:

_____
INITIALS

Medicaid Coverage

- I have been informed by, and hereby acknowledge that, Shady Grove Fertility is not a participating provider in the state's Medicaid Program or any Medicaid contracted managed care plan, and therefore (a) the services to be provided by Shady Grove Fertility are not covered by my insurance plan, and (b) I am financially responsible for all services rendered on my behalf for which a charge is associated. I further acknowledge and understand the following:
- Shady Grove Fertility and I have discussed the reasons for requesting non-covered services and what my alternatives are, including seeking treatment from a participating provider;
- Shady Grove Fertility has allowed me to make the final decision regarding such services;
- I have been advised that the services will not be covered by my health plan and I will be solely responsible for payment of the services; and
- By signing the authorization below, I am agreeing to pay as a private pay patient for the services being rendered.

_____
INITIALS

Medicare Coverage

- I have been informed by, and hereby acknowledge that, Shady Grove Fertility does not participate in any Medicare medical plan and therefore Shady Grove Fertility does not provide services of any kind to any patients who are covered under such medical plans. I confirm that I have fully disclosed to Shady Grove Fertility that I do not have coverage under any such medical plans.

By signing this form, I agree to be financially responsible for all services determined by my physician and me to be appropriate. I understand and agree that Shady Grove Fertility will not seek reimbursement from my insurance company or plan.

In accordance with my understanding of the above, I hereby agree to payment at time of service or prior to the start of my global cycle, as applicable.

By typing my name in the signature field below, I acknowledge that I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this form.

PATIENT SIGNATURE DATE

INSURANCE CARRIER

MPI

NOTICE OF PRIVACY PRACTICES

Introduction
This Notice of Privacy Practices is being provided to you on behalf of Shady Grove Fertility with respect to the reproductive medical services provided at Shady Grove Fertility's centers (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information". Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

Your Rights
Although your health record is the physical property of Shady Grove Fertility, you have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by applicable law
- Obtain a paper copy of this Notice of Privacy Practices upon request
- Inspect and copy your health record as provided for by applicable law
- Request an electronic copy of your electronic health record
- Request to amend your health record as provided by applicable law
- Obtain an accounting of disclosures of your health information as provided by applicable law
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information to your health insurer for services for which you pay "out of pocket" in full
- Transmit copies of your health information to third parties when requested by you, in writing

Our Responsibilities
We are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Where required by law, notify you in the event that there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at, *www.shadygrovefertility.com*, as well as our offices and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which we receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect except where we have already relied upon your authorization.

Permitted Uses and Disclosures
We will disclose and use your health information for ***treatment****.*
For example: information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record that actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

We will use your health information for ***payment****.*
For example: A bill may be sent to you or a third-party payer, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. If you indicate your interest in participating in the Shared Risk Refund Program, we will provide relevant information concerning your medical condition to US Fertility, LLC for determination of your qualifications for this payment assistance program.

*We will use and disclose your health information for our **health care operations**.*
For example: Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and the reproductive medicine service we provide.

We will collect health information on you and your spouse/significant other.
For example: Although health information in your medical record belongs to you, it will contain some information pertaining to your spouse/significant other. This is because the treatment of infertility may focus on the couple, rather than the individual. We will share information with either partner, unless you indicate otherwise.

Other Uses or Disclosures of Protected Health Information

- ***Business Associates:*** There are some services provided at Shady Grove Fertility through contacts with business associates. For example: the management services of US Fertility, LLC, certain laboratory tests, and the services of transcription companies. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do, and bill your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.
- ***Notification:*** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- ***Communication with Spouse/Family:*** Health professionals, using their best judgement, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.
- ***Research:*** We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- ***Marketing:*** Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.
- ***Food and Drug Administration (FDA):*** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.
- ***Public Health:*** As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.
- ***Electronic Prescribing:*** We may use and disclose your health information to SureScripts, an electronic prescribing network, for the purposes of continued treatment.
- ***Law Enforcement:*** We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

  Note: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

For More Information or to Report a Problem/Complaint
If you believe your privacy rights have been violated, you should immediately contact:

Karen Calabrese, RN, MHA
Shady Grove Fertility Privacy Officer
9600 Blackwell Road, Suite 500
Rockville, MD 20850
(301) 545-1216
karen.calabrese@sgfertility.com

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

If you have any questions or would like further information about this notice, please contact the Shady Grove Fertility Privacy Officer above. This notice is also available on our website at, *www.shadygrovefertility.com.*

This notice is effective as of June 1, 2013.

ACKNOWLEDGEMENT OF RECEIPT
JOINT NOTICE OF PRIVACY PRACTICES

I/we acknowledge that I/we have received a copy of Shady Grove Fertility's Joint Notice of Privacy Practices.

By typing my name in the signature field below, I acknowledge that I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this form.

PATIENT TYPED SIGNATURE DATE

PARTNER TYPED SIGNATURE DATE

PERMISSION FOR VOICEMAIL

Our communication process with our patients includes leaving detailed voice messages with lab results, instructions, protocol information, and other information related to your treatment.

Can we leave detailed messages on your voicemail using the phone number(s) that you provide?
Please initial your selection below:

PATIENT SELECTION		PARTNER SELECTION	
_____ Yes INITIALS	_____ No INITIALS	_____ Yes INITIALS	_____ No INITIALS

By typing my name in the signature field below, I acknowledge that I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this form.

PATIENT SIGNATURE DATE

PARTNER TYPED SIGNATURE DATE

NOTE: This document must be made a part of the patient's medical record.