Patient Registration

Today's Date: _____ Ver 6/1/17

Patient's Name:	Spouse/Partner's Name:
Birth date: Age:	Birth date: Age:
Race: ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Hispanic or Latino ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Other ❑Unknown	Race: ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Hispanic or Latino ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Other ❑Unknown
Employer: _____	Employer: _____
Home Address:_____ City/State/ Zip: _____	
Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried ❑ Single in a committed relationship ❑ Single	

Referral Source(s): ❒ Not Applicable

❑ PCP/ObGyn Physician (if applicable): _____

❑ Patient/Friend/Relative _____ ❑ Other _____

❑ Marketing: ❑ Google ❑ Yahoo ❑ Bing ❑ Facebook ❑ CDC/SART Website ❑ Other_____

❑ LGBT Media or Event _____ ❑ _____

❑ Phoenix Magazine ❑ _____

❑ Insurance: ❑ Banner ❑ Blue Cross/Shield ❑ United ❑ Aetna ❑ Cigna ❑ Humana ❑ _____

Email Address:

Phone Contact List: Please list all contact phone numbers below	Call Order	√ **if** NOT OKAY to leave detailed message
Home Phone:		❑
Work Phone:		❑
Cell Phone:		❑
Spouse/Partner:		❑

EMERGENCY CONTACT #	Name:	Relation:

Preferred Pharmacy Name: _____	Phone #: _____
Address or Cross Streets: _____	Fax #: _____
City: _____	

I agree that the above information is correct as listed or changed as indicated. I authorize my insurance company to make payments directly to Advanced Fertility Care (AFC), Arizona Advanced Surgery Center, LLC (AASC), and/or Arizona Advanced Reproductive Laboratory, LLC (AARL). I further authorize AFC, AASC, and AARL to release any information about my medical care to my insurance company. This includes diagnosis, treatment and other information contained within the medical record. I agree to pay for any medical services that are not covered under my insurance, unless specific arrangements have been made with AFC, AASC, and/or AARL in advance.

Date_____ Signature_____

NEW PATIENT HISTORY FORM

Date of Visit:_____ Location: ☐ Scottsdale ☐ Mesa ☐ Phoenix Ver. 06/01/2017

Physician: ☐ Dr. Nathaniel Zoneraich ☐ Dr. Frederick Larsen ☐ Dr. Nicole Kummer

Your Name:	Spouse/Partner's Name:
Birth date: Age:	Birth date: Age:
Occupation/ Employer:	Occupation/ Employer:
Race: ☐White ☐Asian ☐Black/African American ☐Hispanic/Latino ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Other ☐ Unk	Race: ☐White ☐Asian ☐Black/African American ☐Hispanic/Latino ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Other ☐ Unk
Ethnicity: ☐French Canadian ☐ Eastern European ☐Ashkenazi ☐Mediterranean	Ethnicity: ☐French Canadian ☐ Eastern European ☐Ashkenazi ☐Mediterranean
Are you: ☐ Married ☐ Single in a committed relationship ☐ Remarried ☐ Single ☐ Separated ☐ Divorced ☐ Widowed Length of relationship with current partner? _____ months / years	

Who referred you? ☐Physician:_____ ☐Other:_____

Who is your current Ob/Gyn? _____ ☐ I don't have one

What was the first day of your most recent menstrual period? LMP_____

Reason for your visit: _____

PHYSICIAN NOTES: _____

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☐ All records from outside source reviewed with patient.

FEMALE INFERTILITY HISTORY & PRIOR TESTING

How many months have you been having intercourse with your current partner without using any form of birth control? _____ months

Have you had prior infertility testing or treatment elsewhere? ☐No ☐Yes, If yes, please check all that apply below:

☐ Fallopian Tube Evaluation with hysterosalpingogram (HSG)? An x-ray test in which dye is injected into the uterus and tubes in order to see if tubes are open
Date: _____ ☐ NORMAL: Both tubes open ☐ ABNL: ☐One tube blocked ☐ Both tubes blocked ☐ Other_____

☐ Uterine Evaluation in which water is injected into uterus and vaginal ultrasound or camera is used to evaluate the uterus
Date: _____ ☐ NORMAL uterus ☐ ABNL uterus: ☐ Polyps ☐ Fibroids ☐ Scar tissue ☐ Other_____

☐ Other tests to specifically look at possible causes of infertility, miscarriage, or problems with menstrual cycle?

	Test	Date (Mo/Yr)	Results
☐	Day 3 FSH / Clomid Challenge Test		
☐	Ovulation predictor kits		Day of cycle it turns positive: _____
☐	Chromosome Analysis (Karyotype) - Female / Male		
☐	Recurrent Pregnancy Loss Labs		

Have you ever been tested for any genetic diseases? ❑ No ❑ Yes: Please specify: _____

MALE FERTILITY HISTORY (IF APPLICABLE)

Has your partner ever previously conceived with another woman? ❑ No ❑ Yes: How many times? ❑1 ❑2 ❑3 ❑4 ❑5
Has he had a vasectomy? ❑ No ❑ Yes If yes, has he had a vasectomy reversal? ❑ No ❑ Yes: Date _____
Has your partner(s) ever participated in fertility treatment with another woman in the past? ❑ No ❑ Yes: _____

Is he currently or has he ever used any steroid hormones (eg. testosterone)? ❑ No ❑ Yes When and what?:_____

Does he currently smoke cigarettes, use eCigarettes or other tobacco products? ❑ No ❑ Yes How much and how often?:_____

Does he currently use "recreational" drugs? ❑ No ❑ Yes: What type? ❑ Marijuana ❑ Cocaine ❑ Heroin ❑ Meth ❑ Other _____

Does he enjoy regular long hot baths or hot tub use, or participate in long distance cycling? ❑ No ❑ Yes

Has he ever been diagnosed with or experienced: (Check all that apply and if checked, please provide details below)
❑ Undescended testicles? ❑ Painful swelling of the testicles? ❑ Trauma to the testicles? ❑ Torsion (twisting) of the testicles?
❑ Testicular Cancer ❑ Difficulty with erections/ejaculation? ❑ Surgery on your testicles?
❑ Sexually transmitted disease? Check all that apply:❑ Gonorrhea ❑ Chlamydia ❑ Herpes ❑ Syphilis ❑ HIV/AIDS ❑ Hepatitis

Details:_____

Has he ever been seen by a urologist or male infertility expert? ❑ No ❑ Yes If yes, please respond to the following questions:

- Has he ever been diagnosed with a varicocoele? ❑ No ❑ Yes Was it surgically repaired? ❑ No ❑ Yes Date:_____
- Has he taken medication or hormone treatment to correct sperm / fertility problem? ❑ No ❑ Yes List: _____
- Has he had an ultrasound of the testicles? ❑ No ❑ Yes Details: _____
- Has he had blood tests for infertility? ❑ No ❑ Yes Details: _____
- Has he had a chromosome analysis (Karyotype) w/ Y deletion test? ❑ No ❑ Yes Result? ❑ Normal ❑ Abnormal

Have you had a semen analysis test? ❑ No ❑ Yes: If yes, please provide details for two most recent tests:

	Date (Mo/Yr)	Name of Lab that performed the analysis	Abstinence (Days)	Volume	Concentration (millions/ml)	Motility (%)	Progression	Morphology (%)
1								
2								

Any other pertinent information?

PAST FERTILITY TREATMENTS (CHECK ALL THAT APPLY)

☐ Clomiphene citrate (Clomid, Serophene) and/or Letrozole (Femara) Dates:________________________________

Clomid: # of cycles ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7-12 ☐ >12 Max dose: ☐ 50 mg (1 pill) ☐ 100 mg (2 pills) ☐ 150 mg (3 pills)

Femara: # of cycles ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7-12 ☐ >12 Max dose: ☐ 2.5 mg (1 pill) ☐ 5 mg (2 pills) ☐ 7.5 mg (3 pills)

How many with IUI (artificial insemination)? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7-12 ☐ >12

☐ In-Vitro Fertilization (IVF) cycles? # cycles ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ >6

Date: __________ ☐ Fresh Egg Retrieval: Embryo(s) Transferred ☐ Yes ☐ No ☐ PGS Testing ☐ Frozen Embryo Transfer

Outcome: ☐ Cancelled ☐ Not Pregnant ☐ Chemical Pregnancy ☐ Miscarriage ☐ Ectopic ☐ Delivered baby

Date: __________ ☐ Fresh Egg Retrieval: Embryo(s) Transferred ☐ Yes ☐ No ☐ PGS Testing ☐ Frozen Embryo Transfer

Outcome: ☐ Cancelled ☐ Not Pregnant ☐ Chemical Pregnancy ☐ Miscarriage ☐ Ectopic ☐ Delivered baby

Date: __________ ☐ Fresh Egg Retrieval: Embryo(s) Transferred ☐ Yes ☐ No ☐ PGS Testing ☐ Frozen Embryo Transfer

Outcome: ☐ Cancelled ☐ Not Pregnant ☐ Chemical Pregnancy ☐ Miscarriage ☐ Ectopic ☐ Delivered baby

Date: __________ ☐ Fresh Egg Retrieval: Embryo(s) Transferred ☐ Yes ☐ No ☐ PGS Testing ☐ Frozen Embryo Transfer

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Date: __________ ☐ Fresh Egg Retrieval: Embryo(s) Transferred ☐ Yes ☐ No ☐ PGS Testing ☐ Frozen Embryo Transfer

Outcome: ☐ Cancelled ☐ Not Pregnant ☐ Chemical Pregnancy ☐ Miscarriage ☐ Ectopic ☐ Delivered baby

Date: __________ ☐ Fresh Egg Retrieval: Embryo(s) Transferred ☐ Yes ☐ No ☐ PGS Testing ☐ Frozen Embryo Transfer

Outcome: ☐ Cancelled ☐ Not Pregnant ☐ Chemical Pregnancy ☐ Miscarriage ☐ Ectopic ☐ Delivered baby

☐ I have been a previous Egg Donor? # of times? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ >6 Dates:________________________

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY

At what age did you begin having periods (menarche)? ☐ <11 years old ☐ 11 yrs ☐ 12 yrs ☐ 13 yrs ☐ >13 yrs

Menstrual cycle pattern (check all that apply): ☐ Regular ☐ Irregular ☐ Spotting between periods ☐ Bleeding between periods ☐ No periods
☐ Heavy flow with period ☐ Moderate flow with period ☐ Light flow with period

☐ Severe cramping or Pelvic Pain with periods

If you do not get periods, at what age did you stop having them? ______________years old

Number of days between the start of one period (this is 1st day of real flow) to the start of the next period? ______________ days (ex. 28-30 days)

How many days of bleeding do you have? ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ ≥8 days of flow

Do you need to take medication in order to get a period? ☐ No ☐ Yes: What type? ______________________________

Have you ever been diagnosed with Polycystic Ovarian Disease? ☐ No ☐ Yes: How was it diagnosed? ☐ Symptoms ☐ Lab tests
Do you currently have acne, oily skin, or unwanted (facial, arm, etc.) hair growth? ☐ No ☐ Yes? ☐ acne ☐ oily skin ☐ unwanted hair growth
Have you ever been prescribed medication to treat irregular cycles/PCO? ☐ Yes ☐ No ☐ Glucophage (Metformin)

Have you been diagnosed with Endometriosis? ☐ No ☐ Yes: How were you diagnosed? ☐ At surgery ☐ By my symptoms
Do you often have pain with intercourse? ☐ No ☐ Yes: When does it occur? ☐ Deep penetration ☐ Superficial
Do you often have pain with bowel movements? ☐ No ☐ Yes
Do you have severe cramping or pelvic pain with your periods? ☐ No ☐ Yes: ☐ Always ☐ Sometimes ☐ Recently ☐ In the past
If yes, do you take medication for pain? ☐ No ☐ Yes: Does it relieve the pain? ☐ No ☐ Yes

SEXUAL HISTORY

What is your sexual orientation? ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Never been sexually active

How many times, on average, do you have intercourse per week (if applicable)? ☐ Rare/Never ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5

Do you have pain with intercourse? ☐ No ☐ Yes Do you use lubricants during intercourse? ☐ No ☐ Yes: Type?____________________

Have you ever been diagnosed with a sexually transmitted disease or pelvic infection? ☐ No ☐ Yes: Check all that apply
❑ PID (pelvic inflammatory disease) ❑ Gonorrhea ❑ Chlamydia ❑ Herpes ❑ Genital Warts/HPV ❑ Syphilis ❑ HIV/AIDS ❑ Hepatitis
Details:____

Have you ever been a victim of sexual abuse? ☐ No ☐ Yes: Have you received counseling? ☐ No ☐ Yes

TUBAL SURGERY HISTORY

☐ Tubal Ligation (Tubes tied): Date________________ ☐ Tubal Reversal (Tubes untied): Date________________

PAP'S SMEAR HISTORY

When was you last Pap smear? ________________ Results: ☐ Normal ☐ Abnormal ______________________________

Have you ever had an Abnormal Pap? ☐ No ☐ Yes: What was the abnormality? ____________________________________

Have you undergone any procedure as a result of an abnormal Pap's Smear? ☐ No ☐ Yes: check all that apply
☐ Colposcopy ☐Cryosurgery (freezing of cervix) ☐Laser of cervix ☐Cone Biopsy or LEEP procedure

BREAST SCREENING HISTORY

Have you ever had a mammogram? ☐ No ☐ Yes: Most Recent Date:_______________ Results: ☐ Normal ☐ Abnormal ___________________

Are there any outstanding issues related to your breasts for which further follow-up has been recommended prior to conceiving? ☐Yes ☐ No

OBSTETRICAL HISTORY

Total # of pregnancies: ______	# Term births: _______ (greater than 37wks)	# Pre-term births: _____ (less than 37 wks)	# Miscarriages: ______ # Abortions: ______ # Ectopics: ______	# of Living children ______

Date of Delivery or Loss (Mo/Yr)	Outcome	Delivery Type	Any Complications?	Conceived w/ Current Partner?	Months To Conceive	Fertility Treatment used to conceive?
_______	❑ Miscarriage _______wks ❑ Abortion ❑ Ectopic Pregnancy ❑ Preterm ❑ Full Term ❑ Living	❑ Vaginal ❑ C-Section ❑ D&C Needed ❑ Cytotec		❑ Yes ❑ No		❑ Yes: What Type ________________________ ❑ No
_______	❑ Miscarriage _______wks ❑ Abortion ❑ Ectopic Pregnancy ❑ Preterm ❑ Full Term ❑ Living	❑ Vaginal ❑ C-Section ❑ D&C Needed ❑ Cytotec		❑ Yes ❑ No		❑ Yes: What Type ________________________ ❑ No
_______	❑ Miscarriage _______wks ❑ Abortion ❑ Ectopic Pregnancy ❑ Preterm ❑ Full Term ❑ Living	❑ Vaginal ❑ C-Section ❑ D&C Needed ❑ Cytotec		❑ Yes ❑ No		❑ Yes: What Type ________________________ ❑ No
_______	❑ Miscarriage _______wks ❑ Abortion ❑ Ectopic Pregnancy ❑ Preterm ❑ Full Term ❑ Living	❑ Vaginal ❑ C-Section ❑ D&C Needed ❑ Cytotec		❑ Yes ❑ No		❑ Yes: What Type ________________________ ❑ No
_______	❑ Miscarriage _______wks ❑ Abortion ❑ Ectopic Pregnancy ❑ Preterm ❑ Full Term ❑ Living	❑ Vaginal ❑ C-Section ❑ D&C Needed ❑ Cytotec		❑ Yes ❑ No		❑ Yes: What Type ________________________ ❑ No

MEDICATIONS AND ALLERGIES

List CURRENT MEDICATIONS, including over-the-counter medicines, herbal medicines, or vitamins? ☐ Not currently taking any medications

	Medications	Dosage	Reason / Comments / Duration / Dates taken
1			
2			
3			
4			

List ALLERGIES or any adverse reaction to any Medications? ☐ No Known Drug Allergies

	Medications	Reaction / Comments
1		
2		
3		
4		

Are you ALLERGIC to or have any sensitivity to:

Iodine/ Dyes / Shellfish ☐ No ☐ Yes: ☐ Rash ☐ Hives ☐Throat swelling Latex: ☐ No ☐ Yes: ☐ Rash ☐ Hives ☐Throat swelling

MEDICAL HISTORY

Height: _____ ft _____ inches Weight: _____ pounds

Have you been diagnosed with any of the following MEDICAL CONDITIONS? ❑ Check here if No Medical Problems

Medical Condition	YES	Details	Medical Condition	YES	Details
Blood / Clotting Disorders	☐		Asthma	☐	
Factor V Leiden Mutation	☐		Cancer of Breast	☐	
Heart Disease / Stroke	☐		Cancer of Cervix	☐	
Hypertension	☐		Cancer of Ovary	☐	
Migraine Headaches	☐		Cancer of Uterus	☐	
Diabetes	☐		Other Cancer	☐	
Depression / Mental Illness	☐		Pituitary Tumor	☐	
Endometriosis	☐		Birth Defects	☐	
Polycystic Ovarian Syndrome	☐		Recurrent Pregnancy Loss	☐	
Hyperthyroid	☐		Hepatitis	☐	
Hypothyroid	☐		HIV/AIDS	☐	
Other:					

SURGICAL & HOSPITALIZATION HISTORY

Have you had any SURGERIES or HOSPITALIZATIONS other than for pregnancy? ❑ No ❑ Yes If yes, please list:

	(Mo/Yr)	Reason for Admission or Type of Surgery	Findings
1			
2			
3			
4			
5			
6			
7			

Did you have any problems with anesthesia? ❑ No ❑ Yes: Describe: _____

Have you had any problems with excessive bleeding or slow clotting? ❑ No ❑ Yes: Describe: _____

FAMILY & GENETIC HISTORY

Family Member	Living YES NO	Current Age – or- Cause & Age of Death	Family Member	Living YES NO	Current Age –or- Cause & Age of Death	Family Member	Living YES NO	Current Age –or- Cause & Age of Death
Mother	☐ ☐		Brother(s)	☐ ☐		Mat Grandma	☐ ☐	
Father	☐ ☐			☐ ☐		Mat Grandpa	☐ ☐	
Children	☐ ☐			☐ ☐		Pat Grandma	☐ ☐	
	☐ ☐		Sister(s)	☐ ☐		Pat Grandpa	☐ ☐	
	☐ ☐			☐ ☐				
	☐ ☐			☐ ☐				

Does anyone in your family have any of the following medical conditions? ☐ No ☐ Yes: please check all that apply:

Medical Conditions	Yes	Relationship to you	Medical Conditions	Yes	Relationship to you	Medical Conditions	Yes	Relationship to you
Factor V Mutation	☐		Blood Disorder	☐		Liver Disease	☐	
Cancer of Breast	☐		Bone/Skeletal Defects	☐		Thyroid Disorder	☐	
Cancer of Cervix	☐		Deafness/Blindness	☐		Psychiatric Issue	☐	
Cancer of Ovary	☐		Delayed Development	☐		Diabetes	☐	
Cancer of Uterus	☐		Early Puberty	☐		Hypertension	☐	
Early menopause <age 45	☐		Heart defect from birth	☐		Neurologic (brain/spine)	☐	
Endometriosis	☐		Heart Disease	☐		Pituitary Tumor	☐	
Recurrent Miscarriage	☐		Problems with smell	☐		Stroke	☐	
Carrier or affected by any genetically inherited mutations		Provide details:						

SOCIAL HISTORY

Do you currently smoke/vape ecigarettes? ☐ No ☐ Yes: How many per day? ☐ 1-5 ☐ 5-10 ☐ 1 pack ☐ >1 pack How many years: _____

Have you ever smoked? ☐ No ☐ Yes: When did you quit? ☐ 3 mos ago ☐ 3-6 mos ago ☐ 6-12 mos ago ☐ >1 yr ago

Do you drink alcohol? ☐ No ☐ Yes: ☐ Beers # per week _____ ☐ Wine # per week _____ ☐ Liquor # per week _____

Do you consume caffeinated beverages? ☐ No ☐ Yes: How much? ☐ 1-2 per day ☐ 3-4 per day ☐ More than 5 per day

Do you use "recreational" drugs? ☐ No ☐ Yes: What type? ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Meth ☐ Other_____

REVIEW OF SYSTEMS

BLOOD TYPE What is your blood type? ❑ Unknown Blood type: ☐A+ ☐A- ☐B+ ☐B- ☐AB+ ☐AB- ☐O+ ☐O-

What is your partner's blood type? ❑ Unknown Blood type: ☐A+ ☐A- ☐B+ ☐B- ☐AB+ ☐AB- ☐O+ ☐O-

Please mark any of the following conditions listed below that you currently have or have had in the past: ☐ **None Apply**

General
- ☐ Appetite change
- ☐ Unintended Weight change
- ☐ Difficulty concentrating ☐ Fatigue
- ☐ Hot flashes / Night sweats

Central Nervous System
- ☐ Dizziness ☐ Seizures ☐ Head Trauma
- ☐ Chronic/Migraine Headaches
- ☐ Poor sense of smell

EENT:
- ☐ Problems with head, eyes, ears, nose or throat
- ☐ Visual problems ☐ Other:_____

Others Issues Not Listed: _____

_____

Genitourinary
- ☐ Bladder / Kidney infections (cystitis)
- ☐ Other kidney or bladder problems

Musculoskeletal
- ☐ Auto-immune disorder
- ☐ Tremors
- ☐ Rheumatoid arthritis/joint pain

Lung/Cardiovascular:
- ☐ High/low blood pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Heart/Vascular disease
- ☐ Lung Dz, Chronic Bronchitis, Asthma

Hematological
- ☐ Anemia ☐ Sickle cell anemia or trait
- ☐ Blood clotting / Bleeding tendency

Endocrinology
- ☐ Excessive hair growth
- ☐ Heat or Cold intolerance (circle)
- ☐ Unexplained rash
- ☐ Excessive thirst or hunger
- ☐ Diabetes mellitus (high blood sugar)
- ☐ Hypoglycemia (low blood sugar)
- ☐ Thyroid Disorder ☐ Nipple Discharge

Gastrointestinal
- ☐ Hepatitis/Liver Disease
- ☐ Stomach or Intestinal problems, Ulcers

I certify that the above filled-in information is accurate to the best of my knowledge:

PATIENT'S SIGNATURE_____ DATE:_____

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

HIPAA PATIENT PRIVACY NOTICE

(Effective Date: December 19, 2005, Revised April 15, 2016)

The HIPAA Privacy Rule gives an individual a right to adequate notice of the uses and disclosures of protected health information (PHI) that may be made by this office, and of the individual's rights and the office's legal duties with respect to the PHI.

Patient Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our HIPAA Compliance Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Advanced Fertility Care, PLLC (AFC), Arizona Advanced Surgery Center, LLC (AASC), and Arizona Advanced Reproductive Laboratory (AARL) are required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the reception room or at our website at www.azfertility.com. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the reception room or at our website at www.azfertility.com. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

1. **For Treatment:** We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail, electronic mail or facsimile. We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example,

your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

2. **For Payment:** We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

3. **For Health Care Operations:** We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities.

In addition, we may also call you by name in the waiting room when your physician/provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of appointments by telephone, text messaging or email.

4. **Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include transcription, billing and collections, document shredding, quality assurance and software support. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract.

Other Permitted and Required Uses and Disclosures That May Be Made WITH Your Consent, Authorization or Opportunity to Object.

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object (i.e. revoke permission) to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, will determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

1. Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

2. Future Communications: We may communicate to you via newsletters, mailings or other means both hard copy and electronic regarding treatment options, information on health-related benefits or services; to remind you that you have an appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our HIPAA Compliance Officer.

3. Patient Portal: AFC, AASC, and AARL use an electronic secure Patient Portal operated by eClinical Works electronic medical records system. We encourage our patients to embrace the use of this system for means of electronic communication between you and our office. This system is largely relied upon during the course of In- Vitro Fertilization (IVF) and Injectable IUI treatment cycles to relay concise medication instructions to patients as well as providing timely responses to non-urgent patient inquires. This system is integrated through your email account

and the email address you provide to the practice. You will receive notification via email advising you of the need to log into the secure patient portal to view your new message.

4. Baby Photographs: AFC is proud to share encouraging examples of patient success stories by displaying non-identifiable baby photos that are voluntarily submitted to us by birth announcement, holiday card, etc.

By voluntarily submitting photos you as parents understand, agree, and authorize that your submitted photograph(s) become the property of AFC or it's representatives, will not be returned, and may be disclosed, used, or displayed in materials used by AFC including but not limited to in-office baby boards/displays, the website for AFC (www.azfertility.com) and printed materials.

5. Electronic Appointment Confirmations: AFC, AASC, and AARL may use a number of electronic means for appointment confirmations and reminders for patient convenience. Text messaging would be the primary method of notification. If you select text messaging as your preferred option you agree all individuals associated with your account may receive alerts referencing the account guarantor. Text message charges and/or data rate from your cell phone provider may appl; contact your wireless provider for specific information regarding text usage and charges.

By selecting the option of text messaging you represent, warrant, and agree that you are the person legally responsible for all use of the account, you are at least 18 years of age, you agree and consent to the use of personal information to provide the text notification message including but not limited to your name, address, cell phone number, AFC provider office and location, appointment dates and times, account information, and customized content by AFC. AFC is not liable for any delays that may be experienced during the transmission of any message as delivery is based on your wireless provider.

Should you desire to change your method of appointment notifications you must send written notification of the requested change to AFC.

Other Permitted and Required Uses and Disclosures That May Be Made WITHOUT Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

1. As required by law. We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

2. Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

3. State-Specific Requirements: Many states have requirements for reporting, including population-based activities relating to improving health or reducing health care costs.

Your Health Information Rights

Although your health record is the physical property of AFC, AASC, and AARL that compiled it, you have the right to:

1. **Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Advanced Fertility Care, PLLC in writing. There is no charge for your first request however the practice charges $10 for each additional search and $10 for the cost of copies and postage for copies of the medical record.

2. **Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

3. **An Accounting of Disclosures:** You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. AFC, AASC, AARL will provide the first accounting to you in any 12- month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be $10.00. We ask that you submit these requests in writing.

4. **Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

5. **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

6. **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

7. **Restrict Disclosures When You Have Paid For Your Care Out-Of-Pocket**: You have a right to restrict certain disclosures of Protected Health Information (PHI) to a health plan (insurance company) when you have paid out-of-pocket in full for services at AFC.

8. **Notification If There Is A Breach Of Your Unsecured Protected Health Information (PHI):** You have the right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards: and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

To exercise any of your rights, please obtain the required forms from the HIPAA Compliance Officer and submit your request in writing.

Questions and Complaints

If you have questions or concerns about this notice or believe your privacy rights have been violated, you may contact our HIPAA Compliance Officer at (480) 874-2229 or 9819 N. 95th Street, Suite 105, Scottsdale, AZ 85258. **All complaints must also be submitted in writing.** You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have specific rights under the Privacy Rule. Your provider/Advanced Fertility Care will not retaliate against your for exercising your right to file a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

HIPAA Compliance Officer: Kristen Ouwerkerk
Telephone Number: 480-874-2229

This notice first became effective on December 19, 2005. It was most recently revised on April 15, 2016.

Advanced Fertility Care
Arizona Advanced Surgery Center

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

HIPAA PATIENT PRIVACY ELECTIONS & SIGNATURE FORM

By signing below, I acknowledge that I have been offered and/or provided a copy of the "HIPAA Patient Privacy Notice" that is applicable for Advanced Fertility Care, PLLC (AFC), Arizona Advanced Surgery Center, LLC (AASC), and Arizona Advanced Reproductive Laboratory, LLC (AARL) and have therefore been advised of how health information about me may be used and disclosed by AFC, AASC, and AARL, and how I may obtain access to and control of this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates

Under HIPPA Guidelines, I hereby authorize release of my medical records to my physician(s), surgeon(s), anesthesiologist, or any other medical/laboratory care providers who have aided in my care at Advanced Fertility Care PLLC, Arizona Advanced Surgery Center, LLC, and/or Arizona Advanced Reproductive Laboratory, LLC.

In addition to the above, I also permit you to discuss my protected health information for any purpose with the following person(s):

❑ Partner/Spouse: _____ Tel #_____

❑ Ob-Gyn and/or PCP Physician(s): 1. _____

2. _____

❑ Other: _____ Relationship: _____ Tel #_____

❑ I do not permit discussion of anything related to my care with any other person, except where mandated by legal authority.

***While not mandated under the HIPPA privacy act, in order to safeguard your privacy, our internal practice policy requires a signed written authorization for release of medical records to either yourself or any outside party, **regardless** of your selections above.

Print Name: _____ DOB:_____

Signature: _____ Today's Date: _____

ADVANCED FERTILITY CARE

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PATIENT COMMUNICATION POLICY

SECURE PATIENT WEB PORTAL & HEALOW APPLICATION

As part of our continuing effort at Advanced Fertility Care to bring our patients the latest in customer service and convenience, we have implemented a feature of our electronic medical record system (eClinicalworks) which offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

HEALOW App

This is a tool that may be used by our patients to easily access their medical records and schedule appointments either on mobile devices or directly on their computer desktop. This tool allows you to integrate multiple patient portals from participating medical practices into one place and provides you access to the same information available through our secure internal Patient Portal which is directly accessible through our website or through the portal login script you will be provided. The HEALOW App can be downloaded from the Apple Store or Google Play Store, or may be accessed and setup directly through its website: **http://www.healow.com**. **Your use of the HEALOW App constitutes that you have agreed to the specific privacy policy and limitations outlined during the initial set-up of your HEALOW account.**

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) the secure message must reach the correct email address, and
2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.** You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone.

In using the secure Patient Portal/HEALOW, we will be able to provide you another means of communicating with our administrative and clinical staff more efficiently. Future versions are anticipated to also allow the uploading of documents to individual patient portal accounts.

We highly recommend that our patients embrace use of the patient portal for means of communication between you and our office as it allows our Physicians and staff to send concise and detailed medication instructions and provides timely response to your non- urgent inquires.

Should you opt out of this method of communication it may result in delays of receiving message from the physician or the office in a timely manner. For patients undergoing either IVF or Injectable IUI cycles use of the Patient Portal will be REQUIRED as our clinical staff will use this method to send instructions and medications updates.

This system will be integrated through your email account. You will receive notices via email when there is new information to be reviewed on the secure patient portal.

The email sender address will read: *Advanced Fertility Care* and the subject line will usually read: *New Mail from your doctor's office*. The message will provide a link for you to follow to the secure portal webpage where you will enter the username and password provided to you by our staff at your new patient appointment.

SECURE and TRADITIONAL EMAIL

In addition to the Secure Patient Portal System, at times, we may also utilize both secured encrypted as well as standard email services to send documents and information to you.

Email communication provides for a fast and easy way to communicate with your healthcare team for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider/team relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records. We will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks inherent in electronic communication, we cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information.
- Standard email communication services, such as Gmail, GoDaddy, AOL, Yahoo and Hot Mail are NOT secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals. As a practice, we will refrain from sending any emails to you which may contain protected health information, via one of these unsecured email services.
- In the event that we need to contact you or send you documents electronically that cannot be accomplished through the Patient Portal System, we will utilize a Secure and Encrypted email service to do so. This will require you to set up a specific private password to retrieve messages or documents on your personal computer, and you will be prompted to do so with instructions upon opening the email in your in-box.
- Your email address will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice, however, the recipients email addresses will be hidden.

Healthcare Team Responsibilities

- Your provider may route your email messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your email.
- All clinical/medically related messages MUST be sent via the secure Patient Portal, NOT via email.
- Every attempt will be made to respond to your non-clinical email messages within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of emails sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For emergent or time sensitive situations, you should contact the practice by phone.
- Email messages should be concise. Please call our office and/or arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- The patient should NOT use standard e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, HIV, mental health, issues of abuse, developmental disability, or substance abuse.
- Please include your full name and the topic, (i.e. Billing Question, Signed Consents, etc) in the subject line. This will serve to identify you as the sender of the email.
- The patient is responsible for informing AFC in writing of any types of information the patient does not want to be sent by e-mail, in addition to those set out above.
- Please acknowledge that you received and read the message by return email to the sender.

VOICE AND TEXT MESSAGE APPOINTMENT REMINDERS

In addition to communication through the Patient Portal/HEALOW App as well as Secure Encrypted and Traditional Email Services, patients in our practice may be contacted via automated voice or text messaging to mainly remind you of an appointment, and more rarely to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

AFC offers this messaging service to our patients through a product called HEALOW which is a feature of our electronic medical record system (eClinicalworks) and is provided on an as-is basis. As mentioned earlier in this document, HEALOW is a tool that may be used by our patients to easily access their medical records and schedule appointments either on mobile devices or directly on their computer desktop. Data obtained from you in connection with the HEALOW message system may include, but not be limited to: your name, address, cell phone number, office and location, future appointment dates and times, and account information. AFC is not liable for any delays that may be experienced during the transmission of any messages, as delivery is based on the speed and effectiveness of your wireless provider. The HEALOW App can be downloaded from the Apple Store or Google Play Store, or may be accessed and setup directly through its website: **http://www.healow.com**.

Your use of the HEALOW App constitutes that: you are the person legally responsible for all use of the accounts, are at least 18 years of age, agree to all terms and conditions of use for the text messaging services, and have agreed to the specific privacy policy and limitations outlined during the initial set-up of your HEALOW account.

ADVANCED FERTILITY CARE

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

PATIENT COMMUNICATION AUTHORIZATION

Patient Acknowledgement and Agreement – Patient Communication Policy:

My signature and choices noted below verify my acknowledgement of the following:

- I was provided with, read, and fully understand the document titled "Patient Communication Policy" which details the policies regarding both voice and electronic communication between myself and Advanced Fertility Care and its associated entities and staff. I understand the risks associated with voice, online, email, and text message communications between my provider/provider's staff and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the Patient Portal log in screen, as well as any other instructions that my physician may impose to communicate with patients via online and alternate forms of communications.
- Commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I further agree to be held accountable and to comply with the patient responsibilities as outlined in the "Patient Communication Policy".
- In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my healthcare team, I hereby consent to electronic communication via both secure-encrypted and non-secure email services.
- I understand that I may revoke or alter my consent to communicate electronically at any time by notifying the practice in writing at the address below, but if I do, the revocation will not have an effect on actions my healthcare provider or team has already taken in reliance on my consent.
- I have been given the opportunity to discuss electronic communication with a representative of AFC and have had all my questions answered. I agree and release my provider and practice from any and all liability that may occur due to accidental misuse of electronic communication over both secure and non-secure networks.

I acknowledge the need for and grant permission to Advanced Fertility Care (and affiliates) to communicate lab results, health information, account/billing information, and appointment confirmations to me using the following means:

- **Secure Patient Portal and HEALOW Application** that is operated through eClinicalWorks Electronic Medical Record system. The email address provided will be used for the sole purpose of establishing an electronic patient portal account.
- **Secure/Encrypted Email** for messages and documents that may contain personal health information. Traditional Email for messages that do not contain personal health information.

  _____
  Email Address (please print)

- **Text and/or Voice Messaging** for appointment notifications and confirmations

  Mobile # _____ Carrier: _____

Print Name: _____ Signature: _____ Date: _____

ADVANCED FERTILITY CARE
ARIZONA ADVANCED REPRODUCTIVE LAB

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Reproductive Endocrinology & Infertility

CONSENT TO TREATMENT

Medical Treatment: The patient consents to the treatment, services, office visits and procedures which may be performed in the office, which may include but are not limited to multiple visits, laboratory procedures, ultrasound evaluation, x-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered under the general or specific instructions of the responsible physician or other health care providers.

The office may establish certain criteria which will automatically trigger the performance of specific tests which patient agrees may be performed without any further separate consent.

Legal Relationship between Healthcare Providers/Patients: The patient will be treated by his/her attending doctor, healthcare providers and be under his/her care and supervision.

I have read, understand, and agree to this treatment agreement.

I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement.

Signature: _____

Printed Name: _____

Date: _____

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AFC AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments for professional services are due at the time services are provided. We accept cash, personal checks Visa, MasterCard, Discover Card and financing through one of the companies on our website.

For patients who wish to use credit cards as form of payment for ART Treatments (IVF or FET/FBT), a 3% convenience fee will be assessed in addition to the treatment cycle cost.

INSURANCE

We are providing our professional services to you – not the insurance company, consequently you are ultimately responsible for payment of our fees. ***As the patient, it is your responsibility to know what your insurance covers and does not cover.***

Our staff will assist you in providing a good faith estimate for your portion of the fee for services based on the information provided to us by your plan however, we cannot guarantee what your insurance company will pay on a claim; as the patient, ***you are ultimately responsible for payment of all charges not covered by your insurance***.

Please be aware that filing of claims is a courtesy our office provides to our patients, it does not guarantee payment to us. If we have received all of your insurance information at least 48 hours prior to the day of the appointment and we are able to confirm eligibility, we will be happy to file claims to contracted health plans on your behalf for covered services at AFC (Advanced Fertility Care).

BENEFITS ARE NOT DETERMINED BY OUR OFFICE

Benefits quoted by your insurance plan are not a guarantee of coverage or payment. Coverage and payment is determined by your insurance when the claim is actually processed.

Some insurance plans limit the number of procedures they will cover within a treatment cycle, so there may be times when not all procedures done will be covered by your insurance.

Some insurance plans also limit the type of services covered for example; if your insurance states that they will cover diagnostic testing only, this mean that they will not pay for a mid cycle or follicular ultrasound of a treatment cycle. This particular type of ultrasound would be considered part of treatment, not diagnostic, and therefore would be self pay and not billable to your insurance plan.

You may have noticed that sometimes your insurance reimburses you or the doctor at a lower rate than the doctor's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your doctor's fee has exceeded the usual, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most doctors in the area charge for a certain service. This can be very misleading and is simply not accurate.
Insurance companies set their own fee schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit. Unfortunately, insurance companies imply that your doctor is "overcharging" rather than say that they

are "underpaying" or that their benefits are low. In general, a less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Once the physician has determined your treatment protocol, you will have a financial consultation to discuss the upcoming treatment and identify the estimated charges for expected procedures. However, once treatment begins, unique patient situations sometimes require additional procedures. These additional procedures may not be announced to you as “additional” by our clinicians, as they are providing you with care based solely upon your individual needs. (These procedures for example may relate to extra ultrasounds and blood tests to monitor effects of medication during ovarian stimulation.)

FEE FOR SERVICE AND PAYMENTS

All estimated prices quoted to you are quoted under a fee for service arrangement. Under the fee for service arrangement, you will be charged for all of the services provided by AFC, **and you will not be entitled to a refund in the event that, for any reason, the treatment is not successful.** This arrangement may not be modified by a verbal agreement.

You will be financially responsible for all services provided, even if such services were not anticipated when you began treatment and are not included in the financial visit. Charges that are patient responsibility and remain unpaid after 30 days are subject to an administrative fee of $15.00 per billing cycle.

Patients are required to pay ALL estimated deductibles, co-payments, and co-insurance amounts AT THE TIME OF SERVICE. In the cases of some types of treatment cycles, these amounts will be collected at the onset of the treatment cycle.

Should there be any cost difference resulting in an under or over payment of the provided estimate vs. the actual cost of services, the patient will be invoiced for any balances due or the account will be credited any over payment amount. Refunds are only considered at the conclusion of all treatment services with AFC.

ASSIGNMENT OF BENEFITS

If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to AFC or to the provider group rendering service, for application on my bill. However, **I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL**. In rendering treatment, AFC is relying on my agreement to pay the account.

I have read and understand the ***AFC AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS*** and agree to be responsible for all charges incurred by me and to pay my account balance. If my account is sent to an attorney or collection agency, I agree to pay attorney’s fees and/or collection agency expenses. The amount of the attorney’s fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.

My signature on this document confirms that I have read, understand, and agree to the AFC AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS.

Signature: _____ Date: _____

Printed Name: _____

ADVANCED FERTILITY CARE
ARIZONA ADVANCED REPRODUCTIVE LAB

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LABORATORY TESTING & FINANCIAL POLICY

We would like to inform all of our patients that a portion of your laboratory testing for fertility services will be performed by:

Arizona Advanced Reproductive Lab, LLC (AARL)

AARL **does not** hold contracts for reimbursement purposes with most insurance plans. However, many insurance plans may partially or fully reimburse for testing done through AARL, especially if the policy has coverage for out-of-network benefits.

There are certain hormone tests that must be preformed by AARL for infertility treatment due to the quality and consistency of the results as well as rapid access to these results. The following tests, if ordered, **WILL** be performed by AARL and may incur out-of-pocket costs in addition to the insurance coverage: **FSH, Estradiol, LH, Progesterone, and either serum or urine HCG**.

In addition to these, ALL andrology services (male testing including **Semen Analysis, Sperm Chromatin Structure Assay, IUI sperm preps, and biological tissue freezing**) will be performed by our certified andrologist and/or embryologist as part of AARL.

Finally, **all laboratory procedures done in connection with a fertility treatment** such as IVF, IUI, and Ovulation Induction **will be performed by AARL**.

For **ALL** AARL services, **FULL PAYMENT** will be collected prior to or on the day of service. We will be happy to supply you with an itemized statement for your insurance company for your reimbursement purposes.

The remainder of any additionally ordered blood work (general medical or infectious disease screening, endocrine screening or genetic testing) will be sent to a 3rd Party outside laboratory who will bill your insurance company or you directly if you are not covered by an insurance plan.

By signing below, I acknowledge that I understand that Nathaniel Zoneraich, MD has a financial interest in Arizona Advanced Reproductive Laboratory, LLC, and that I agree to have the above mentioned tests and any future endocrinology/embryology/andrology services performed at Arizona Advanced Reproductive Laboratory, LLC.

I have read the above information and understand the policy in regards to AARL and 3rd Party laboratory services.

Signature: _____ Date _____

AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments for outpatient treatment center facility fees and professional services are due at the time services are provided. We accept cash, personal checks, Visa, MasterCard, and Discover.

Insurance

BENEFITS ARE NOT DETERMINED BY OUR OFFICE. Benefits are not a guarantee of coverage or payment. Coverage and payment is governed and determined by your health insurance plan when the claim is actually processed.

Please be advised that our surgery center is considered **in network** for most insurance plans. We bill a facility fee for each of the following procedures; as long as there is coverage available on your plan:

-HSG	-Egg Retrieval	-Embryo Transfer	-Office Hysteroscopy
-Plastic Surgery	-ENT	-GYN Surgery	-PESA/MESA/TESA

Outside Testing: Arizona Advanced Surgery Center, LLC and the operating surgeon will send any required laboratory testing and/or tissue pathology to an appropriate CLIA Certified laboratory for testing. If radiological studies are required, an approved center will be used for testing. All effort will be made to provide insurance information to the performing lab/clinic, however if no insurance and/or coverage is available **then you, the patient, will be directly responsible for the total cost of the testing**.

This arrangement may not be modified by a verbal agreement.

****PLEASE NOTE: Patients will be required to pay ALL ESTIMATED deductible, co-pay, and co-insurance amounts AT THE TIME OF SERVICE. ****

I agree to be responsible for all charges incurred by me and to pay my account. If my account is sent to an attorney or collection agency, I agree to pay attorney's fees and/or collection agency expenses. The amount of the attorney's fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.

If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to Arizona Advanced Surgery Center (AASC) or to the provider group rendering service, for application on my bill. However I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL. In rendering treatment, AASC is relying on my agreement to pay the account.

I have read, understood, and agree to the AASC payment terms and conditions.

Signature: _____ Date _____

Printed Name: _____

Scottsdale
9819 North 95th St, Ste. 110
Scottsdale, AZ 85258

Phoenix
1701 E. Thomas Rd, Ste 202
Phoenix, AZ 85016

South East Valley
1550 S. Alma School Rd, Ste 100
Mesa, AZ 85210

ADVANCED FERTILITY CARE

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

ZIKA VIRUS INFORMATION SHEET

Zika is a mosquito transmitted infection caused by a virus that can be spread in several different ways:

1) via mosquito bite from a carrier mosquito into a non-infected person,
2) from an infected pregnant woman to her unborn baby,
3) sexual transmission of body fluids (female to female, male to female, male to male)
4) blood transfusion.

Many individuals infected with Zika will not have symptoms. The most common symptoms are fever, rash, joint pain, and conjunctivitis (red eyes). Other symptoms include headache and muscle pain. Viral transmission from a woman to her unborn child may result in severe congenital abnormalities, diseases of the nervous system, and/or developmental delay in the child.

For this reason, it is paramount that a person infected with Zika or who is at risk for infection should take precautions to not conceive for a specified duration after infection or potential exposure to Zika virus.

It is of critical importance and YOUR RESPONSIBILITY to inform your Advanced Fertility Care healthcare provider immediately if:

1) You have tested positive for the Zika Virus
2) You are at risk for Zika infection due to travel to Zika areas over the last 2 months, or 6 months for any male intimate partner.
3) You are exhibiting any of the above noted symptoms of the Zika Virus

Women and men who have a confirmed Zika infection should wait at least 6 months after onset of illness to conceive and should also avoid sex or use condoms until this 6 month period has elapsed. Women and men who have had a potential exposure to Zika virus but do not have symptoms should consider testing for Zika virus within 2 weeks of suspected exposure and wait at least 8 weeks after latest date of exposure to re-test. These individuals should attempt conception only after follow-up testing is negative.

NOTE: These recommendations are subject to change as new information is being discovered and released by the CDC on a regular basis. AFC will do its best to update our patients with the current information, however, all patients are expected to seek the most current information about Zika viral transmission, prevention, geographical at risk area, and pregnancy guidelines at the CDC website: https://www.cdc.gov/zika/index.html.

By signing below, you attest that you have read and fully understand the information above.

Patient (sign):	Print Name:	Date of Birth:	Today's Date:

ADVANCED FERTILITY CARE

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PHOTOGRAPHS AND SOCIAL MEDIA RELEASE

At Advanced Fertility Care, we cherish the ability to help our patients with their family building. In many cases, we receive birth announcements and photographs from thrilled parents who have benefitted from our services over the years, and wish to share their joy with us. In addition, we have also received thank you cards and journals documenting the many different paths to success.

We would like to share these photographs, and occasionally stories, with others as a means of gratitude and in hopes of providing comfort and motivation to others who are just beginning their fertility journey. Primarily, we would use your de-identified photos on the many baby boards you will see scattered around our offices. However, due to some changes in the laws, we need your express permission to do so.

We encourage you to continue sending the pictures our way, and if you would like us to share your joy by displaying pictures of your future sons and daughters, please indicate this below:

- ❑ I, as the legal parental guardian of my children and future children, hereby grant Advanced Fertility Care, PLLC (AFC) permission to share my de-identified photos (including those sent as or along with future holiday cards), and stories of our infertility journey on their AFC in-office baby photo boards, as well as web and social media sites.

- ❑ I, as the legal parental guardian of my children and future children, hereby grant Advanced Fertility Care, PLLC (AFC) permission to ONLY display de-identified photos (including those sent as or along with future holiday cards) on the in-office baby photo boards.

I understand this authorization and submission of items is completely voluntary and that once items are submitted they become the sole property of Advanced Fertility Care and will not be returned. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing this authorization form.

I hereby release AFC, their officers, directors, agents, employees and physicians from all liability and all claims of any nature whatsoever pertaining to the photograph(s) or the release of associated information about me.

Parent's Printed Name: _____

Parent's Signature: _____

Date: _____

ADVANCED FERTILITY CARE

ARIZONA ADVANCED REPRODUCTIVE LAB

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

Ver 3/25/2016

REQUEST/RELEASE FOR MEDICAL RECORDS

I hereby authorize the use or disclosure of my identifiable health information (medical records and test results, including HIV test results) as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Information to be Released

☐**To** ☐**From** **ALL** Mail and Fax Correspondence should be directed to:

Advanced Fertility Care, PLLC
9819 North 95th Street, Suite 105
Scottsdale, AZ 85258

Phone: (480) 874-2229
Fax: (480) 874-2231

☐**To** ☐**From**

NAME/MEDICAL FACILITY:	
ADDRESS:	
CITY, STATE, ZIP CODE:	
TELEPHONE NUMBER:	FAX NUMBER:

☐All available records ☐Past 12 months ☐ from _____ to _____

☐ Please specifically include:
_____
_____
_____

Purpose of Disclosure
❒ Medical Review ❒ Personal Use
❒ Transfer of Care ❒ Legal Review
❒ Insurance ❒ Other_____

I release you, your physicians, and employees from liability for following this authorization and request. I understand that it may take up to 15 business days for completion of this transaction.

I understand that I will ONLY be given copies of records created or ordered by this office. If you need records from other physicians, offices, or laboratories, please contact those offices for copies.

I understand that it is the policy of this office (Advanced Fertility Care) to release medical records directly to the patient. The fees charged by this office are set by the Arizona State Board of Medical Examiners. The first request for medical records is at no charge. Subsequent requests will be assessed a fee.

Patient's Name: _____
First Middle/Maiden Last

Address: _____
Street City State ZipCode

Date: _____ Patient Signature: _____ DOB:_____

Office Use: ❒ Faxed AFC Staff: _____ Date: _____
❒ Mailed
Approved: _____ Date_____ ❒ Picked Up By _____