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_____

SPOUSE/PARTNER HISTORY FORM
(IF APPLICABLE)

Date of Visit:_____ Ver. 07/13/17

Your Name: _____	Spouse/Partner's Name: _____

ALLERGIES & MEDICATIONS

Are you currently taking any medication? ❑ No ❑ Yes: please list:

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

Are you currently or have you ever taken any **steroid hormones** for weight gain or body building? ❑ No ❑ Yes Details:_____

Are you **ALLERGIC** to or have had any adverse reaction to any **Drugs**? ❑ No ❑ Yes If yes, please list:

	Medications	Reaction / Comments
1		
2		
3		
4		

MEDICAL HISTORY

Height: _____ ft _____ inches Weight: _____ pounds

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

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	☐		Testicular Infection	☐	
Heart Disease / Stroke	☐		Prostate Infection	☐	
High Blood Pressure	☐		Epididymitis	☐	
Migraine Headaches	☐		Testicular Cancer	☐	
Diabetes	☐		Prostate Cancer	☐	
Depression / Mental Illness	☐		Erectile Disorder	☐	
Hyperthyroid / Hypothyroid	☐		Penile Discharge	☐	
Birth Defect	☐		Cystic Fibrosis	☐	
Asthma	☐		Kleinfelter's Disease	☐	
Other:					

SURGICAL & HOSPITALIZATION HISTORY

Have you had any **SURGERIES or HOSPITALIZATIONS**? ❑ No ❑ Yes If yes, please list:

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

FAMILY HISTORY & GENETIC HISTORY

Does anyone in your family have any of the following medical conditions? 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 Ovary	☐		Deafness/Blindness	☐		Psychiatric Issue	☐	
Cancer of Prostate	☐		Delayed Development	☐		Diabetes	☐	
Cancer of Testicles	☐		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 cigarettes, use eCigarettes, or other tobacco products? ❑ No ❑ Yes: How much and how often? _____

Have you ever used tobacco products? ❑ No ❑ Yes: For how long? _____ yrs When did you quit? ❑ 3 mos ❑ 3-6 mos ❑ 6-12 mos ❑ >1 yr

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

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

Do you currently or have you ever taken any **steroid hormones** (eg. testosterone)? ❑ No ❑ Yes When and what?:_____

Do you enjoy regular long hot baths or hot tub use? ❑ No ❑ Yes

Do you engage in long distance cycling? ❑ No ❑ Yes: How often? ❑ 1-2 ❑ 3-4 ❑ >4 x per wk

Any recent fever in the last 3 months? ❑ No ❑ Yes

Are you aware of any radiation exposure other than X-rays? ❑ No ❑ Yes: Describe _____

Have any of your immediate family members had difficulty conceiving a child? ❑ No ❑ Yes: Describe_____

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

Signature: _____ **Date:** _____

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 HIPAA 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 <u>do not permit</u> discussion of anything related to my care with any other person, except where mandated by legal authority. If this option is selected it will *nullify* any other option selected above.

***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 AUTHORIZATION

Patient Acknowledgement and Agreement – Patient Communication Policy:

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

- I was provided with the opportunity to read the "Patient Communication Policy" document, which is available in the reception room or at www.azfertility.com, and fully understand its contents 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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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 and 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.

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.)

DISCLOSURE OF PHYSICIAN OWNERSHIP

The purpose of this notice is to inform you of the following:

- The physicians of Advanced Fertility Care have an ownership interest in *Fertility Pharmacy of America*. Some or all of your medication prescriptions written by your physician may be sent to this pharmacy. However, you have the option and may request to purchase prescription medication from an alternative pharmacy that is able to fill that prescription. You will not be treated any differently by AFC if you choose not to purchase your medications from Freedom Pharmacy of America.

- Dr. Nathaniel Zoneraich has a financial interest in *Arizona Advanced Surgery Center (AASC),* LLC. Some of your diagnostic procedures and/or surgical procedures will be performed in an AASC facility, however, in most instances, you may request to have these procedures performed at an outside radiologic facility or outpatient surgery center if you wish, and by doing so, will not alter your treatment here at AFC.

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 estimate. 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, and acknowledge that the disclosure of physician ownership has been made.

Signature: _____ Date: _____

Printed Name: _____

ADVANCED FERTILITY CARE

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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:

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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 _____

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Ver 11/03/17

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:

** If releasing records to self, please indicate if you would like records ☐ mailed **OR** to be available for ☐ pick up at the _____ location.

☐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 Last Date of Birth

Address: _____
Street City State Zip Code

Date: _____ Patient Signature: _____

OFFICE USE ONLY: Physician Approval: _____ Date: _____ / Processed by: _____ Date: _____ ❒Faxed ❒Mailed ❒Picked Up