Patient Registration

Today's Date: _____ Ver 8/15/19

Patient's Name:	Spouse/Partner's Name:
Birth date: Age: Gender Identification:	Birth date: Age: Gender Identification:
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 Ver. 8/15/2019

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

Your Name:	Spouse/Partner's Name:
Birth date: Age: Gender Identification:	Birth date: Age: Gender Identification:
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

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

☐ 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	Living NO	Current Age – or- Cause & Age of Death	Family Member	Living YES	Living NO	Current Age –or- Cause & Age of Death	Family Member	Living YES	Living 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:_____

ADVANCED FERTILITY CARE

ARIZONA ADVANCED SURGERY CENTER

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

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: _____

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: _____

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. Zoneraich also has a financial interest in *Arizona Advanced Surgery Center (AASC)*. A portion of your diagnostic procedures and/or future surgical procedures will be performed in conjunction with an outpatient surgery and/or treatment center (AASC) which is licensed by the Arizona Dept of Health Services. Due to Dr. Zoneraich's direct financial interest in AASC, the physicians of AFC are able to provide the optimum care possible for their patients that utilize the surgery/treatment center. Therefore, patients receive both a professional and personal experience with the preoperative and surgical care. However, in most circumstances, you may request to have these procedures performed at an outside radiologic facility or outpatient surgery center where our physicians have privileges, 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
ARIZONA ADVANCED REPRODUCTIVE LAB

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

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

PATIENT RIGHTS AND RESPONSIBILITIES

Your Rights as Our Patient: We are committed to delivering quality healthcare consistent with our patients' needs. With this as our goal, we honor and attest to your right as a patient, to:

Access

- Receive appropriate medical care without discrimination based on race, national origin, religion, gender, sexual orientation, age, disability, marital status and diagnosis
- Receive treatment that supports and respects your individuality, choices, strengths and abilities
- Communicate and receive a timely response to your complaints by contacting our Practice Administrator.

Respect, Dignity and Consideration

- Receive privacy in treatment and care for personal needs
- Receive assistance from a family member, your representative or other individual in understanding, protecting or exercising the patient's rights
- Be treated with dignity, respect and consideration
- Have your spiritual needs respected

Coordination of Care

- Receive a referral to another healthcare institution if the outpatient treatment center is not authorized or not able to provide physical health services needed
- Participate or have your representative participate, in the development of or decisions concerning treatment
- Except in an emergency you or your representative can consent to or refuse treatment
- Refuse or withdraw consent for treatment before treatment is initiated
- Except in an emergency, be informed of alternatives to a proposed psychotropic medication or surgical procedure and the associated risks and possible complications of the proposed psychotropic medication or surgical procedure

Information, Education and Communication

- Review, upon written request, your own medical record according to A.R.S.12-2293, 12-2294 and 12-2294.01
- Informed of policies and procedures on health care directives and the patient complaint process
- Consent to photographs before you are photographed except that you may be photographed when admitted to an outpatient surgical center for identification and administrative purposes
- Except otherwise permitted by law, provide written consent to the release of information to your medical record or financial record
- Participate or refuse to participate in research or experimental treatment

Physical Comfort and Safety

- Not subject you to: abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, seclusion, restraint, retaliation for submitting a complaint to the department or another entity or misappropriation of personal and private property by the outpatient surgical center's medical staff, personnel members, employees, volunteers or students

As a partner of our health care team, we ask that you:

- Provide complete and accurate information about your current and past state of health, including past illnesses, hospitalizations and the medications you are taking
- Inform us if you perceive there may be a problem with your care
- Talk to us about your pain and options for minimizing it
- Ask questions when you do not understand what we are saying or asking you to do
- Follow the treatment plan that you developed with your caregivers
- Accept responsibility for your health outcome, if you choose not to follow your treatment plan
- Follow the rules and regulations of our facility, which have been put in place for your safety and the safety of others
- Assist our facility in providing a safe environment by sharing your observations if you perceive unsafe conditions or practices
- Show respect and consideration for your caregivers and other patients and families by controlling noise and disturbances, refraining from smoking and respecting others' property
- Respect that our facility is an Equal Opportunity Employer and reserves the right to assign a competent caregiver with skills that match your clinical needs. It is our policy that employees and their work environment be free from all forms of discrimination.

If a complaint is not resolved to your satisfaction you have the right to contact:

AZ Department of Health Services
Bureau of Medical Licensing
150 N 18th Ave # 450
Phoenix, Arizona 85007
602-364-3030

ADVANCED FERTILITY CARE

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

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: _____