



Reproductive Partners Fertility Center - San Diego

Reproductive Partners Fertility Center | La Jolla, Inc.
9850 Genesee Avenue # 800, La Jolla, California 92037
Tel: (858)-552-9177 Fax: (858)-552-9188

⋮ Welcome to Reproductive Partners Fertility Center – La Jolla, Inc.

Thank you so very much for choosing us for your reproductive healthcare. We are confident we will exceed your expectations on all levels. The physicians and the staff here at Reproductive Partners Fertility Center – La Jolla, Inc. look forward to working with you and thank you for giving us the opportunity to take care of you.

⋮ Summary of the New Patient Appointment

- You will meet with the physician for 1 hour. Within this hour they will go over your history with you, perform an intravaginal ultrasound, and then regroup to make recommendations.
- Next you will meet with a nurse coordinator for about 20–30 minutes to go over the clinical details of the physician’s recommendations. She/he will become your point of contact for testing and treatment in our office.
- Lastly, you will meet with a financial coordinator for about 20–30 minutes to go over associated cost, insurance, and programs available based on the physician’s recommendations.

This packet contains some information to help you prepare for your initial consultation

Page 2..... Getting to Know Our Office
Page 3..... Map and Directions
Pages 4-7.....Notice of Privacy Practices
Pages 8-9.....Optional Fast Track Program

Please do not hesitate to call us with any questions at (858)-552-9177. We are here to help you in every way possible. We look forward to meeting you and helping you to achieve your dreams of creating your family.

Please visit <http://www.lifechoicesandfertility.com> for some great information on lifestyle habits and supplementation to optimize your fertility!

Sincerely,

The Physicians and Staff at Reproductive Partners Fertility Center – La Jolla, Inc.



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Getting to Know Our Office

Reproductive Partners Fertility Center – La Jolla, Inc. would like to welcome you to our practice. We appreciate the opportunity you have given us to care for you.

Every patient is assigned an IVF Coordinator. You will receive your IVF Coordinator's business card with his/her direct phone number. Your IVF Coordinator will be your main point of contact and will oversee your cycle. Please note that although you have a primary IVF Coordinator you will meet and work with all IVF Coordinators throughout the duration of your treatment. If your primary IVF Coordinator is out of the office or is unavailable and you need immediate assistance, any IVF Coordinator will be able to answer your questions.

Office Address:

9850 Genesee Ave. Suite #800 La Jolla, CA 92037

Office Hours:

Mon–Fri: 8:00 a.m.–4:30 p.m.
Sat: 8:00 a.m.–12:00 p.m.
Sun: Closed

Phone Number:

(858)-552-9177

Fax Number:

(858)-552-9188

We will make our best effort to accommodate your schedule. Please understand that due to the nature of our procedures, we do not know sooner than 48 hours in advance as to when egg retrievals are to be scheduled for our IVF patients. We appreciate your patience in advance when having to reschedule appointments.

Occasionally our physicians may take more time than scheduled to provide quality care for our patients. We appreciate your understanding when waiting for your examination. Be assured that this same standard will be provided for your care. Providing quality care is important to us. At the conclusion of your treatment, you may be asked to complete a patient satisfaction survey. We thank you in advance for your valuable feedback.

Again, we look forward to working with you during your treatment. Please do not hesitate to contact us if you have any questions or concerns regarding your treatment.

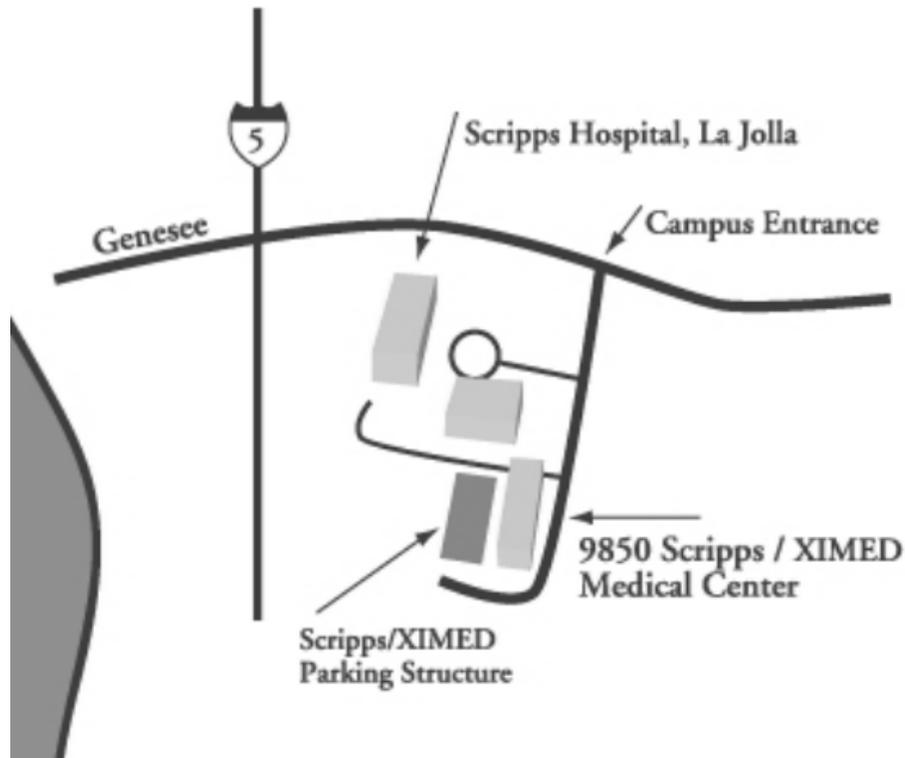


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Directions to Reproductive Partners Fertility Center – La Jolla, Inc.

9850 Genesee Ave. Ste. #800 La Jolla, CA 92037

(GPS Navigation May Not Work Properly)

Phone: (858)-552-9177

From the North:

If you are approaching La Jolla from the north on I-5, please exit on Genesee Avenue and turn left on Genesee. At the second light, please turn right onto Scripps La Jolla Hospital Drive. Please take a ticket and proceed straight past the hospital and past the Ximed building, and follow the drive around to the parking structures. We are located on the 8th floor of Scripps/XIMED.

From the South:

If you are approaching La Jolla from the south on I-5, please exit on Genesee Avenue and turn right on Genesee. At the first light, please turn right onto Scripps La Jolla Hospital Drive. Please take a ticket and proceed straight past the hospital and past the Ximed building, and follow the drive around to the parking structures. We are located on the 8th floor of Scripps/XIMED.



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⋮ Introduction

This Notice of Privacy Practices is being provided to you on behalf of Reproductive Partners Fertility Center – La Jolla, Inc. with respect to reproductive medical services provided at Reproductive Partners Fertility Center – La Jolla, Inc.’s facilities (collectively referred to herein as “We” or “Our”). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of “protected health information.” Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present, or future physical or mental health, the **health care** you have received, or payment for your **health care**.

⋮ Your Rights

Although your health record is the physical property of Reproductive Partners Fertility Center – La Jolla, Inc., you have the right to:

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



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Our Responsibilities

We are required to:

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

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

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

Permitted Uses and Disclosures

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

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

We will use your health information for payment. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you received. The bill may contain information that identifies you, your



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diagnosis, and treatment or supplies used in the course of treatment. If you indicate your interest in participating in the Attain IVF Program, we will provide relevant information concerning your medical condition to IntegraMed America's Attain Fertility Division for determination of your qualifications for this financing program.

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

⋮ Other Uses or Disclosures of Protected Health Information

Business Associates: There are some services provided at Reproductive Partners Fertility Center – La Jolla, Inc. through contacts with business associates. For example, the management services of IntegraMed America, Inc. and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.



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Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or postmarketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct, or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

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

⋮ For More Information or to Report a Problem/Complaint

If you believe your privacy rights have been violated, you should immediately contact:

Susan Strachan, RN, BSN

9850 Genesee Avenue, Suite 800, La Jolla, CA 92037

(858)-552-9177

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

If you have any questions or would like further information about this notice, please contact Susan Strachan at the above address. This notice is also available on our website at **www.fertilityclinicsandiego.com**.

This notice is effective as of January 1, 2014.



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Fast Track Program

The Fast Track Program is an optional program designed for patients who have not completed any diagnostic testing and want to make the most of their initial consultation.

Diagnostic Testing to Complete for New Patient Visit

Semen Analysis and Culture

The semen analysis examines the count, motility, and morphology of the sperm. This test MUST be completed in our laboratory Monday through Friday from 8:00 a.m. to 10:30 a.m.. For an adequate sample, you must have 2–4 days of abstinence. We prefer for the specimen collection is completed at our facility; however, if you wish to collect the sample at home, please let a member of our staff know in order to provide you with a collection kit. Please keep in mind that the sample must be brought to our office within 30 minutes of the collection time and an appointment is still needed. Results take approximately one week from the time of the collection. A semen culture is also performed using the same semen collection.

- Semen analysis cost: \$125
- Specimen handling for semen culture: \$16
- Semen culture bill from LabCorp: Varies, please contact LabCorp for billing.

Baseline Follicle Stimulating Hormone and Estradiol Levels (FSH/E2):

These tests are used to evaluate ovarian function. These tests are completed via blood draw on cycle day 3. To schedule this test, please wait until cycle day 1 (day of full flow bleeding) then call your Clinical Liaison. Results take up to 7 days from the date of collection. If you have completed these tests within the last six months, you do not need to repeat.

- FSH/E2 bill from LabCorp: \$107

Anti-Mullerian Hormone Level (AMH):

This test also evaluates ovarian function. This test can be done on any day of the cycle. This test is done at a LabCorp facility (visit www.labcorp.com for locations and hours). No fasting is necessary. Results take approximately 5 days from the date of collection. If you have completed this test within the last six months, you do not need to repeat it.

- AMH bill from LabCorp: \$57

Hysterosalpingogram (HSG):

This test uses x-ray imaging to indicate any damage or blockages in your fallopian tubes. It can also highlight the shape of the uterus. Radiopaque dye is injected into your uterus which then travels up



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through the fallopian tubes and spills out into the abdominal cavity. This test can be uncomfortable. In preparation for the exam, it is recommended to take 400–800mg of Ibuprofen approximately 1 hour prior to the procedure.

This test is completed through **Imaging Healthcare Specialists**. **To schedule this test, please call Imaging Healthcare Specialists directly at (619)-849-9729**. This test must be completed between cycle days 7–10 (after menstrual bleeding has stopped but before ovulation). Your treatment coordinator will give you an antibiotic prescription of doxycycline to take in preparation for this procedure. Results take approximately 2–3 days from the date of the exam. If you have completed this test within the last year, you do not need to repeat it.

- Hysterosalpinogram bill from Imaging **Healthcare** Specialist: \$650

Infectious Disease Screening (for both partners):

HIV I/II, HTLV I/II, Hepatitis B Surface Antigen, Hepatitis C Antibody, RPR

These tests are required prior to ANY treatment in our office. For the male, these tests are required by CA state law. We will not perform any insemination or IVF without these results. It is strongly recommended to have these labs completed as soon as possible to avoid any delays in your treatment. These tests are completed via blood draw and can be drawn at our office or LabCorp. All tests are sent to LabCorp for processing. Alternatively, your treatment coordinator can provide you with a requisition to take to your outside physician to have ordered; however, we cannot guarantee that your outside physician will order these tests or that they will be covered by your insurance. If you have completed these tests within the last year, you do not need to repeat them.

- Infectious Disease Screening bill from LabCorp: \$230

Preconception Screening (for female):

Rubella, Varicella, ABO/Rh (blood type), Cystic Fibrosis Carrier Screening

These tests are STRONGLY recommended prior to any treatment in our office. It is strongly recommended to have these labs completed as soon as possible to avoid any delays in your treatment. If your rubella and/or varicella tests come back with a negative (non-immune) result, you must wait one month from the time of vaccination until pregnancy (i.e., embryo transfer or IUI).

These tests are completed via blood draw and can be drawn at our office or LabCorp. All tests are sent to LabCorp for processing. Alternatively, your treatment coordinator can provide you with a requisition to take to your outside physician to have ordered; however, we cannot guarantee that your outside physician will order these tests or that they will be covered by your insurance. If you have completed these tests within the last five years, you do not need to repeat them.

- Preconception screening bill from LabCorp: \$450



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Pt Acct # (New) _____
(Old) _____
By GG BF AD IS HCA MD
This section interoffice use only

Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Age		
Home Address			City	State	Zip	Home Phone Number
E-Mail Address			Social Security Number		Work Phone Number	
Driver's License	Marital Status S M D <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Birthplace	Ethnic Origin	Cell Phone Number	
Patient's Employer (name and address)			Occupation		Pager Number	

Spouse's/Partner's Name	Ethnic Origin	Date of Birth	Age	Social Security Number
Spouse's/Partner's Employer (name and address)		Occupation		Work Phone Number

Name of Relative/ Friend (not living with you) EMERGENCY CONTACT	Relationship	Phone Number
-------------------------------------------------------------------------	---------------------	---------------------

How did you hear about us?
If physician, complete address:
Physician's phone number:

- *I understand that Reproductive Partners Medical Group – La Jolla, Inc. may bill my insurance as a courtesy. I will be held financially responsible for claims my insurance does not process in a timely manner.
- *I understand if my account is delinquent after 60 days, I will be subject to collection proceedings, including but not limited to court costs and attorney's fees.
- *Services desired that are not a covered benefit or are not authorized will be the financial responsibility of the patient at the time services are rendered.
- *I authorize Reproductive Partners Medical Group – La Jolla, Inc. to release the requested and necessary information to my insurance company to complete my claim.
- *I hereby authorize my insurance carrier to pay all my medical benefits, otherwise payable to myself, directly to Reproductive Partners Medical Group – La Jolla, Inc.

PHONE CONSULTATIONS:

*I understand that Reproductive Partners Medical Group – La Jolla, Inc. physicians are licensed only in the State of California. I expressly agree that exclusive jurisdiction for any dispute with Reproductive Partners Medical Group – La Jolla, Inc. resides in the courts of the State of California; and I further agree and expressly consent to the exercise of personal jurisdiction in the courts of the State of California in connection with any such dispute including, without limitation, any claim involving Reproductive Partners Medical Group – La Jolla, Inc. and its affiliates, employees, contractors, agents, licensors, and suppliers.

*Phone consultation fee must be paid in advance and will not be refunded unless the appointment is cancelled more than 24 hours in advance. I confirm that I have read this entire form and the information provided above is true and correct. I understand and agree to the conditions stated above.

Signature: _____ Date: _____

Please provide your driver's license and insurance card so that we may make a photocopy



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

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So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct, or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

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



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If you believe your privacy rights have been violated, you should immediately contact:

Susan Strachan, RN, BSN
9850 Genesee Avenue, Suite 800, La Jolla, CA 92037
(858) 552-9177

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

If you have any questions or would like further information about this notice, please contact Susan Strachan at the above address. This notice is also available on our website at fertilityclinicsandiego.com.

This notice is effective as of January 1, 2014



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ACKNOWLEDGEMENT FORM REPRODUCTIVE PARTNERS MEDICAL GROUP – LA JOLLA, INC. JOINT NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Reproductive Partners Medical Group – La Jolla, Inc.’s Joint Notice of Privacy Practices.

Patient ID Number: _____

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Spouse/Significant Other Name (please print): _____

Spouse/Significant Other Signature: _____ Date: _____

I authorize Reproductive Partners Fertility Center – La Jolla, Inc. to leave confidential information regarding my healthcare as follows:

Phone Number _____ and/or

E-Mail Address _____

I understand and agree that this will not be secure and that confidentiality could be breached. This is also true in the event that I/we e-mail Reproductive Partners Medical Group – La Jolla, Inc. from a non-secure e-mail address.

Patient Signature

Date

Authorization for the release of medical information to spouse/significant other.

Authorization for the release of medical information to spouse/significant other.

Signature

Signature

Date

Date

FOR OFFICE USE ONLY:

Date Acknowledgement Received: _____ OR

Reason Acknowledgement Was Not Obtained: _____

Disposition: This document should be filed in the patient’s medical record.



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PATIENT FINANCIAL POLICY / ASSIGNMENT OF BENEFITS

◆ Insurance Coverage

The patient or his/her legal guarantor is ultimately responsible for all services incurred. The fertility centers will bill participating insurance plans if the patient provides the required insurance information and signs an Assignment of Benefits statement. Some fertility centers may bill for non-participating insurance plans as a courtesy, however, the services must be paid in full at the time services are incurred. If you have dual coverage, and we do not participate with your primary, the services must be paid in full at the time services are incurred. All information given regarding the ability to pay, third-party insurance, employment, etc., will be subject to verification. Patients with insurance policies that cover only a portion of the services must pay the difference between the charges and the anticipated insurance payment at the time the services are incurred. A pre-pay deposit may be required prior to all services beginning.

Insurance claims are subject to eligibility, coverage and plan provisions which are determined by my insurance carrier. In some cases, certain services, supplies or medical care may be denied if found to be considered experimental, investigational or unproven by my carrier. I understand that I will be financially responsible for any denied or non-payable services rendered.

◆ Uninsured Patients/Non-Covered Services

Uninsured patients are required to pay all services in full prior to the services being incurred.

◆ Payment Methods

The following payment methods are accepted: cash, check, money order, credit cards, outside lending institutions, and payment arrangements. Returned checks will be handled in accordance with Patient Financial Services Department NSF check procedures. A \$35 bank fee will be assessed for each returned check.

◆ In-House Collections

All patient balances must be paid within 30 days of time of service. Patients with unpaid delinquent accounts over 90 days old will be referred to outside collection and will be denied any further services. If future services are requested, all services will be considered on a fee-for-service basis and payment in full will be required prior to time of service.

◆ Referral for Outside Collections

Accounts that cannot be collected by the fertility center will be referred to a collection agency, magistrate, or attorney for further collection action in accordance with established guidelines as deemed appropriate by the Fair Debt Collection Practices Act. Any fees assessed will be the responsibility of the debtor.



Reproductive Partners Fertility Center - San Diego

Reproductive Partners Medical Group – La Jolla, Inc.

9850 Genesee Avenue # 800, La Jolla, California 92037

Tel: (858) 552-9177 Fax: (858)-552-9188

◆ Refunds

Overpayments will be refunded to the appropriate party after review of the account. Any patient requesting a refund will not be processed until the account is reviewed and all active or past-due balances are paid in full. Any outstanding accounts receivable balance \$5.00 or under will be adjusted to zero. Any credits (\$5.00) to (\$0.01) will not be refunded.

◆ Assignment of Benefits

I hereby authorize Reproductive Partners Medical Group – La Jolla, Inc. to release the requested and necessary information to my insurance company to complete my claim. I hereby authorize my insurance company to pay all my medical benefits, otherwise payable to myself, directly to Reproductive Partners Medical Group – La Jolla, Inc. If my healthcare insurance is not contracted with Reproductive Partners Medical Group – La Jolla, Inc., I hereby assign Reproductive Partners Medical Group – La Jolla, Inc. any insurance or other third-party benefits available for healthcare services provided to me. I understand the Reproductive Partners Medical Group – La Jolla, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Reproductive Partners Medical Group – La Jolla, Inc., I agree to forward all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I have read, understand, and agree to the above financial policy and assignment of benefits. I understand that charges not covered by my insurance company, as well as applicable copayment, coinsurance, and deductibles, are my responsibility.

Print Name: _____

Signature: _____ Date: _____

LA JOLLA WOMEN'S SURGERY CENTER, INC.
NOTICE OF OUT-OF-NETWORK PROVIDER STATUS

Please be advised that Reproductive Partners Medical Group – La Jolla, Inc. and La Jolla Women’s Surgery Center, Inc. are separate medical providers.

La Jolla Women’s Surgery Center, Inc. is an out-of-network healthcare provider, and as such does not participate with any third party claims administrators or insurance carriers.

Please be advised that services provided by La Jolla Women’s Surgery Center, Inc. are billed separately from Reproductive Partners Medical Group – La Jolla, Inc. and you may be responsible for non-covered charges. If you have questions regarding your financial responsibility, you may contact our consultant who can clarify these issues.

I am aware of the facility’s status and have elected to seek medical care at La Jolla Women’s Surgery Center.

Patient Name (Printed)

Date

Patient Signature

LA JOLLA WOMEN'S SURGERY CENTER, INC.
ANESTHESIA: NETWORK PROVIDER STATUS NOTIFICATION

La Jolla Women's Surgery Center is currently serviced by two anesthesia providers. The surgery center's primary anesthesia provider is an out-of-network provider and, as such, does not participate with any third party claims administrators or insurance carriers. Though schedule availability is limited, the surgery center also has a secondary anesthesia provider who is in-network. Patients seeking to use their insurance benefits for anesthesia-related fees will be accommodated to the best of the surgery center's abilities, but service with the in-network anesthesia provider cannot be guaranteed.

Please be advised that services rendered by either anesthesia provider are billed separately from Reproductive Partners Medical Group – La Jolla, Inc. You will receive a separate bill and you may be responsible for any non-covered charges. If you have questions regarding your financial responsibility, please contact your insurance carrier.

By signing below, I am stating that I fully understand the network provider status of La Jolla Women's Surgery Center's anesthesia providers and have elected to seek medical care at La Jolla Women's Surgery Center.

Patient Name (Printed)

Date

Patient Signature



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Past Medical History Form

Patient Name: _____

Partner Name: _____

OB/GYN Name: _____

How long have the two of you had unprotected intercourse? _____
(No forms of contraception)

Have you ever been pregnant? _____

If yes, please fill out the following in chronological order:

Date (month/year)	Result (e.g., delivery, miscarriage, elective abortion, ectopic, biochemical)	How many weeks (if applicable)	Procedure if applicable (e.g., vaginal delivery, C- section, D&C, D&E)	Any Complications?

MALE FACTOR

Have you fathered pregnancies other than above? If yes, please list dates and outcomes:

Do you smoke? _____

How many a day? _____

Drink alcohol? _____

How many a week? _____

Exposure to fumes/
chemicals/ heat? _____

If yes, please explain

Do you have any significant diseases, if yes please explain.



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Have you completed a semen analysis?

_____ Date: _____

Facility: _____

Results if known:

Volume _____ Count (concentration) _____ Motility Morphology _____

Allergies/Sensitivities to drugs or food	Reaction

Current Medications—Male

Prescription Drugs (e.g. Norvasc)	Strength (e.g. 5 mg)	Direction and Indications (e.g. daily for high blood pressure)	Prescribed By (e.g. John Doe, MD)

Over-the-Counter Drugs	Strength	Directions

Vitamins/ Herbal Supplements	Strength	Directions



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FEMALE FACTOR

Height _____

Weight _____

First day of last menstrual period _____

Days of Bleeding _____

Cycle Length (from first day to first day) _____

Regular or Irregular _____

Heavy or Painful? _____

How do you alleviate pain _____

Are you able to detect an LH surge with an at-home ovulation kit? _____

Blood Levels (if known)

Date: _____ FSH: _____ E2: _____ AMH: _____

Have you had a **Hysterosalpingogram (HSG)** X-ray to evaluate fallopian tubes?

Date _____

Result _____

Have you had any pelvic surgery? _____

Date _____

Type/ findings _____

Do you smoke? _____ # per day? _____

Ever smoked? _____ # per day? _____ # years? _____ When did you quit? _____

Drink caffeine? _____ How many a day? _____

Drink alcohol? _____ How many drinks a week? _____

Exposure to fumes/chemicals/heat? If yes please explain.

Do you have any significant diseases? If yes please explain.

Any past surgical history other than above? If yes please explain.



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Any family history of genetic diseases (single gene inherited, e.g., cystic fibrosis, hemophilia)?

Allergies/Sensitivities to Drugs or Food	Reaction

Current Medications—Female

Prescription Drugs (e.g., Norvasc)	Strength (e.g., 5mg)	Direction and Indications (e.g., daily for high blood pressure)	Prescribed By (e.g., John Doe, M.D.)

Over-the-Counter Drugs	Strength	Directions

Vitamins/ Herbal Supplements	Strength	Directions

