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

Last Name First Name MI	Date of Birth (dd/mm/yy)	Age	Pt Acct # (New)_____ (Old) _____ By GG BF AD IS HCA MD This section interoffice use only

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 ☐	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 Fertility Center – 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 Fertility Center – 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 Fertility Center – La Jolla, Inc.

PHONE CONSULTATIONS:

*I understand that Reproductive Partners Fertility Center – La Jolla, Inc. physicians are licensed only in the State of California. I expressly agree that exclusive jurisdiction for any dispute with Reproductive Partners Fertility Center – 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 Fertility Center – 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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NOTICE OF PRIVACY PRACTICES

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

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 healthcare you have received, or payment for your healthcare.

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 healthy 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 request by you, in writing

Our Responsibilities

We are required to:

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

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at **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) 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.

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/her 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 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.

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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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 **fertilityclinicsandiego.com**.

This notice is effective as of January 1, 2014

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ACKNOWLEDGEMENT FORM OF REPRODUCTIVE PARTNERS FERTILITY CENTER – LA JOLLA, INC. JOINT NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Reproductive Partners Fertility Center – 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 Fertility Center – 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.

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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 Fertility Center – 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 Fertility Center – La Jolla, Inc. If my healthcare insurance is not contracted with Reproductive Partners Fertility Center – La Jolla, Inc., I hereby assign Reproductive Partners Fertility Center – La Jolla, Inc. any insurance or other third-party benefits available for healthcare services provided to me. I understand the Reproductive Partners Fertility Center – La Jolla, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Reproductive Partners Fertility Center – 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**

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Have you had any fertility treatment? _____

If yes, which practice(s) were they completed at? _____

If yes, please complete in chronological order:

Date (month & year)	**Cycle Type** -In vitro fertilization, fresh (IVF) -Frozen embryo transfer (FET) -Intrauterine Insemination (IUI) -Intercourse with medications	**Stimulation Medications and Dose** if known (e.g., Clomid, Follistim, Menopur, Gonal-F, Bravelle)	**Outcome** (e.g., negative or positive pregnancy, miscarriage, live birth)

Do you have a specific procedure you are interested in or anything else you would like us to know? (Include additional pages if needed.)

_____

_____

_____