Name: _____ DOB: ____/____/____

Alabama Center *for* Reproductive Medicine

Female New Patient Medical History

Name: _____ Age: _____ SSN: _____

Initial Apt Date: _____ Marital Status: _____ Height: _____

Religion: _____ Occupation: _____ Weight: _____

Primary Contact #: _____ Secondary Contact #: _____

Email: _____ Race: _____

Address: _____ City, State: _____

Preferred Pharmacy Name: _____

Pharmacy City, State: _____ Pharmacy Phone #:_____

Partner name (if applicable): _____ Partner occupation: _____

Partner phone #: _____ Partner DOB: _____

Emergency contact: _____ Phone #: _____

Reason for Visit (Check all that apply)

- ☐ Infertility
- ☐ Endometriosis
- ☐ Pelvic Pain
- ☐ Reversal of Sterilization
- ☐ Repeated Miscarriages
- ☐ In Vitro Fertilization
- ☐ Irregular Periods
- ☐ Other: _____

Menstrual History

What age did your menstruation begin? _____ Regularity: _____

Average length of cycle (from 1st day of period to the 1st day of the next) _____ days

Bleeding between periods? _____ Pain between periods? _____

Pain during: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Do you have vaginal discharge? _____ Do you bleed after intercourse? _____

Name: _____ DOB: ____/____/____

Last normal period ___/___/____

How many times do you have intercourse per week? _____

Do you experience any pain during intercourse? _____

When was your most recent: Mammogram ___/___/___ Pap Smear ___/___/___

Past Medical History

List any injuries/illnesses requiring hospitalization:

Date Reason

_____ _____

_____ _____

_____ _____

List any surgeries you have had:

Date Reason

_____ _____

_____ _____

_____ _____

List any sexually transmitted diseases you have had (such as syphilis, gonorrhea, herpes, genital warts, PID, tubal infections, ect.)

_____

Alcohol consumption: Current _____ beverages/week Past____ beverages/week

Cigarette use: Current _____ packs/day Past ____ packs/day

Recreational/illegal drug use (please specify): Current: _____ Past: _____

How many caffeinated beverages do you have per day? _____

Have you ever undergone chemotherapy or radiation? (If yes, please explain)

_____

What allergies do you have? _____

Name: _____ DOB: ____/____/____

Medications

Medication	Frequency	Indication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently take a prenatal or multi-vitamin? _____ Type: _____

Contraceptive History

Please check all the types of birth control methods you have used (past or current)

Type	Dates	Type	Dates
☐ Birth Control Pills	(_____-_____)	☐ Condoms	(_____-_____)
☐ IUD	(_____-_____)	☐ Other _____	(_____-_____)

Obstetrical History

Please list all pregnancies (including ectopic, abortions, miscarriages, and deliveries):

#	Date	Type	Birth WT	Sex	Alive (Y/N)	Complications

Family History

Are you adopted? _____ Please check in the appropriate following boxes:

Problem	Mother	Father	Sibling	Grandparent	Children
Breast Cancer					
Ovarian Cancer					
Other Cancer					
Thyroid disease					
Heart Disease					
Diabetes					

Name: _____ DOB: ____/____/____

Please check in the appropriate following boxes:

Problem	Mother	Father	Sibling	Grandparent	Children
High blood pressure					
Irregular periods					
Infertility					
Uterine fibroids					
Endometriosis					
Birth defects					
Other					

Previous Infertility Evaluation and Treatment

Female: Please note the date and results of the following tests you have had:

Test	Date	Results
Basal Body Temperature Charting		
Hysterosalpingogram (HSG)		
Laparoscopy		
Hysteroscopy		
Hormone Tests		
Progesterone Level		

Please note any infertility medications you have taken:

Medication	When	# Cycles	Dose	Did you conceive?
Clomiphine Citrate (Clomid)				
Letrozole				
hCG (Trigger) Injections				
Fertility Injections				
Metformin (Glucophage)				
Other (_____)				

Pleases note any fertility treatments you have had:

Medication	When	# Cycles	Where	Did you conceive?
Artificial Insemination (IUI)				
In Vitro Fertilization				
Other (_____)				

Name: _____ DOB: ____/____/____

Review of Systems

General

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble Sleeping

Skin

- Rashes
- Lumps
- Itching
- Dryness
- Hair and nail changes

Ears

- Decreased Hearing
- Ringing in ears
- Earache
- Drainage

Eyes

- Glasses or contacts
- Pain
- Redness
- Blurry or double vision
- Flashing lights
- Specks
- Cataracs
- Glaucoma
- Last eye exam _____

Neck

- Lumps
- Swollen glands
- Stiffness
- Pain

Breasts

- Lumps
- Pain
- Discharge
- Self-exams
- Breast-feeding

Nose

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain

Respiratory

- Sputum
- Wheezing
- Painful breathing
- Coughing up blood
- Shortness of breath
- Cough

Throat

- Dry mouth
- Bleeding gums
- Dentures
- Sore throat
- Dry mouth
- Hoarseness
- Thrush
- Non-healing sores
- Last dental exam _____

Name: _____ DOB: ____/____/____

Review of Systems Cont.

Urinary

- Increased frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinent
- Change in urinary strength

Genital

- Pain with sex
- Vaginal dryness
- Hot flashes
- Vaginal discharge
- Itching or rash
- STDs

Musculoskeletal

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

Vascular

- Calf pain with walking (claudication)
- Leg cramping

Endocrine

- Head or cold intolerance
- Sweating
- Excessive thirst (polydipsia)

Neurological

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremors

Hematologic

- Ease of bruising
- Ease of bleeding

Psychiatric

- Nervousness
- Depression
- Memory loss
- Stress

Gastrointestinal

- Swallowing difficulties
- Change in appetite
- Nausea
- Constipation
- Rectal bleeding
- Change in bowl habits
- Heartburn
- Yellow eyes/skin
- Diarrhea

Cardiovascular

- Difficulty breathing lying down
- Chest pain/discomfort
- Tightness
- Palpitations
- Swelling (adema)

Name: _____ DOB: ____/____/_____

Alabama Center *for* Reproductive Medicine

Permission to Release Personal Health Information – Female Partner

Patient's name:_____SS# _____-___-_____

Any physician, staff, employee or representative of Alabama Center for Reproductive Medicine has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following physicians and or other persons in order to facilitate and coordinate my care, treatment and payment:

Physician	Location	Phone Number	Fax Number

Name	Relationship	Phone number	Alternate phone number

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke this permission by writing to Alabama Center for Reproductive Medicine or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

_____ _____ ___ /___ /___

Patient's Signature Guardian Signature (if minor) Date

Name: _____ DOB: ____/____/_____

Alabama Center *for* Reproductive Medicine

Authorization for Release of Information: Female Partner

Please send my complete medical records to:

☐ **2006 Brookwood Medical Center Drive**
Suite 302
Birmingham, AL 35209
Phone: 205-307-0484
Fax: 866-829-2082

☐ **7209 Copperfield Drive**
Montgomery, AL 36117
Phone: 205-307-0484
Fax: 866-829-2082

Items Needed: Complete Medical Record

Purpose of Release: _____

I understand that:

1) This authorization is voluntary. I may refuse to sign this authorization, and my treatment and/or payment obligations will not be affected.
2) This authorization will remain in effect for one year, or until I revoke it in writing, which I may do at any time.
3) My records may contain hepatitis and HIV screening results that may be included in the record release.
4) The sender of this health information cannot guarantee that the recipient of the information will not re-disclose this information.
5) I have the right to receive a copy of this authorization form after I sign it.

Patient Name:_____ Date of Birth: _____/___/____

Social Security #: _____-_____-_____ Telephone #: (_____) _____-_____

Patient Signature:_____ Date:____/___/____

Name: _____ DOB: ____/____/_____

Alabama Center *for* Reproductive Medicine

Insurance Registration Form: Female Partner

Responsible Party: ☐ Self or ☐ Other

Relationship to Patient: _____

Last Name: _____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____- _____- _____ Date of Birth: ____/____/_____

Primary Phone #: (____) -____-_____ Secondary Phone #: (____)-____-_____

Occupation: _____ Employer: _____

Please present your insurance cards and driver's license to the receptionist

Insurance Carrier	Policy #	Group #	Effective date	Policy holder

I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other health care provider who may be of assistance, in the opinion of Alabama Center for Reproductive Medicine (ACRM), and/or for assisting in any reimbursement or medical benefits to which the patient may be entitled. I allow fax transmission of my medical records, if necessary. I further authorize and request that insurance payments be made directly to ACRM, should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of the assignment shall be considered as the effective and valid as the original.

I acknowledge full financial responsibility for services rendered by ACRM. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by ACRM physicians and personnel. I have read and fully understand the above consent for release of medical information, insurance authorization, financial responsibility, and treatment.

_____ _____ _____

Patient's Signature Guardian's Signature Date

Name: _____ DOB: ____/____/_____

Alabama Center *for* Reproductive Medicine

Notice of Privacy Practices – Female Partner

This notice describes how medical information about you may be used and disclosed and about how you can get access to this information. Please review it carefully.

The policy of Alabama Center for Reproductive Medicine (ACRM) is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of ACRM.

Individually identifiable health and personal information are any information obtained by ACRM in connection with providing healthcare treatment, obtaining payment and related healthcare operations. This relates to past, present, or future information that ACRM receives from you as our patient.

ACRM collects personal information in order to learn about your medical history, medical conditions render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time to time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow-up and appointment reminders, as well as treatment alternatives or other health-related benefits. We may leave a message on your answering machine or voicemail to contact you about appointments or to have you call our office. As a part of our standard treatment and healthcare operations, we may share our treatment plan with a facility such as a hospital, laboratory, diagnostic services or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. As required by your insurance contractor, we will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefjt and coverage determinations, pre-certification, utilization review and related activities for worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our practice management computer system. We also maintain information about you in our medical chart. ACRM limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting disclosure of your medical & billing record. Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies.

We do not disclose personal information to third parties unless one of the following expectations applies:

1) *We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to the ACRM privacy officer.*
2) *Federal, state or other applicable law requires us to share protected information or records.*

We are obligated to abide by the terms of this notice. If, at any time in the future it is necessary to disclose any of your personal information in a way that is materially different from this policy, ACRM will give you notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have the right to review and obtain a copy of your health information.

This request must be in writing and there may be reasonable charge to provide you with a copy of your information. You also have the rights to request your records be amended, to request special accommodations and restricts of your health information and to receive an accounting of the disclosures of your information. You have the right to request to receive confidential communications of your information. ACRM is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact the privacy officer at 205.307.0484. You have the right to file a complaint with the secretary of the department of health and human services if you believe that your privacy rights have been violated. There will be no retaliation for filing a complaint.

I have read and received a copy of this information.

_____ ___/___/___ _____

Patient Signature Date

Name: _____ DOB: ____/____/_____

Alabama Center *for* Reproductive Medicine

Authorization for Treatment:

I (we),_____the undersigned patient(s) and responsible party(s), consent to necessary treatment by Alabama Center for Reproductive Medicine (ACRM), physicians; physicians taking call for ACRM, and/or any of the qualified employees of ACRM. Treatment to include venipuncture, medication, ultrasound, X-rays or other studies, and to perform any operations and/or procedures after discussion of the risks and benefits and consent to undergo other procedures deemed necessary or advisable in the judgment of the attending physician employee of ACRM, or his/her associates or assistants in the diagnosis and treatment of my condition(s). In the course of this treatment should it be necessary to consult with others, I hereby give my permission and consent for this organization to obtain and release medical records and other pertinent information on the undersigned patients, to/from other healthcare providers or agencies (including but not limited to Blue Cross/Blue Shield InfoSolutions).

_____ _____

Responsible Party Date

_____ _____

Patient Date

Name: _____ DOB: ____/____/_____

Alabama Center *for* Reproductive Medicine

Financial Responsibility Agreement

ACRM is committed to providing you with the best possible care and will help you receive the maximum allowable insurance benefits possible. We are here to assist you and are available to answer any questions you may have about your insurance coverage, but it is ultimately the patient's responsibility to inform themselves of their benefits and coverage. Please call our billing department at 205-307-0484 option 8 with your questions.

With your signature below, you hereby acknowledge and authorize the following:

1. Should my insurance carrier refuse payment (e.g., non-covered services, lapse in coverage, my failure to secure a referral from my primary care physician, provider is out of network, etc.) or if I am uninsured, I will pay for all services rendered upon receiving a written and/or verbal notice of the denial of my claim. I agree to pay all bills upon receipt of statement, unless other arrangements are made. I understand that payment is due and payable to The Alabama Center for Reproductive Medicine.
2. I understand that in order to be seen, any current balances must be paid down at 50% of the total at the time of check in with the remaining half being due prior to my next appointment.
3. I further agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my medical record. Thus, to ask the office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.
4. In the event I do not pay for these or any other services provided to me when due, I agree to pay all costs associated with collection, including reasonable attorney fees (whether or not a law suit is commenced) as part of the collection process. I understand that any unpaid bills will be sent to collections at 120 days past due.

ACRM will submit your claim to your insurance plan. It is the responsibility of the patient to provide us with updated demographic and insurance information for accurate billing. All co-payments, deductibles, or non-covered services must be paid at the time of service, unless a payment agreement has been established. Fees for medical records include a $5 search fee, $1/page for 1-10 pages and $25 for anything exceeding 10 pages. For patients who are uninsured, payment in full is required at the time of the visit for all services. A $25 fee will be charged for all returned checks.

By my signature below, I certify to having read the above statements and fully understanding my financial responsibility for all care rendered to me so long as I am a patient of this practice regardless of any changes in my insurance coverage.

_____ _____

Signature of patient OR representative and relationship to patient Date