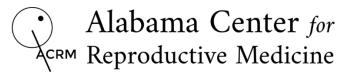
Name:	DOB: /	- /	/
ivailie.	DOD. /	/	



Male New Patient Medical History

Name:	DOB:	Age:
Initial Apt Date:	Marital Status:	
Social Security Number:		_ Height:
Occupation:		Weight:
Primary Contact #:	Secondary Co	ntact #:
Email:	Race:	
Address:	City, Stat	e:
Preferred Pharmacy Name:		
Pharmacy City, State:		
Partner name (if applicable):	Part	ner occupation:
Partner phone #:	Partner DOB:	
Emergency contact:	Phone #: _	
	History	
Have you had a previous vasectomy?	Have you ha	d it reversed?
History of infertility in a prior relationsh	ip?	
Have you seen a urologist for infertility	evaluation? If yes,	who?
When?		
Have you had a semen analysis?	_ When?	
Result:		
Number of pregnancies with current pa	rtner:	
Number of pregnancies with prior relat	ionship(s):	
List any sexually transmitted disease yo		

Name:				DOB:/
Alcohol consumption:	Current	beverages/week	Past	beverages/week
Have you ever smoked a d	igarette?	If yes, when did yo	ou quit?	
Cigarette use: Current	packs/day	Past pa	acks/day	
How many years have you	ı smoked?			
Do you dip or chew tobac	co?	If you vape, how ma	any times (per day?
Recreational/illegal drug (Past:				
How many caffeinated be	verages do you	have per day?		
Have you ever undergone	chemotherapy	or radiation? (If yes, pl	ease expla	ain)
Are you currently taking t	estosterone in a	any form?	Have yo	ou ever?
How long?	-			
Do you have any medicati	on allergies?			
		Current Medications		
Medication		Frequency		Indication
				
				

Name:			DOB:/
		of Systems	
General	Skin	Ears	Eyes
□ Weight loss or gain	□ Rashes	☐ Decreased Hearing	☐ Glasses or contacts
□ Fatigue	□ Lumps	☐ Ringing in ears	□ Pain
□ Fever or chills	□ Itching	□ Earache	□ Redness
□ Weakness	□ Dryness	□ Drainage	☐ Blurry or double vision
□ Trouble Sleeping	☐ Hair and nail change:	s	☐ Flashing lights
			□ Specks
Neck	Nose	Throat	□ Cataracs
□ Lumps	□ Stuffiness	□ Dry mouth	□ Glaucoma
□ Swollen glands	□ Discharge	☐ Bleeding gums	□ Last eye exam
□ Stiffness	□ Itching	□ Dentures	
□ Pain	□ Hay fever	□ Sore throat	
	□ Nosebleeds	□ Dry mouth	

□ Hoarseness

☐ Sinus pain

 $\quad \ \ \, \square \,\, Wheezing$

 $\ \square \ \text{Painful breathing}$

 $\hfill\Box$ Coughing up blood

 $\hfill\Box$ Shortness of breath

 $\quad \square \; Cough$

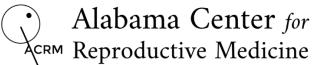
	Review of Systems Cont.	
Urinary	Genital	Musculoskeletal
□ Increased frequency	□ Pain with sex	☐ Muscle or joint pain
□ Urgency	□ Hernia	□ Stiffness
☐ Burning or pain	□ Sores	□ Back pain
☐ Blood in urine	□ Penile discharge	☐ Redness of joints
□ Incontinent	□ Itching or rash	☐ Swelling of joints
☐ Change in urinary strength	□ STDs	□ Trauma
	☐ Erectile dysfunction	
	□ Masses or pain	
Vascular		Endocrine
☐ Calf pain with walking (claudication)		☐ Head or cold intolerance
☐ Leg cramping		□ Sweating
		☐ Excessive thirst (polydipsia)
Neurological	Hematologic	
□ Dizziness	☐ Ease of bruising	Gastrointestinal
□ Fainting	☐ Ease of bleeding	☐ Swallowing difficulties
□ Seizures		☐ Change in appetite
□ Weakness	Psychiatric	□ Nausea
□ Numbness	□ Nervousness	□ Constipation
□ Tingling	□ Depression	□ Rectal bleeding
□ Tremors	□ Memory loss	☐ Change in bowl habits
	□ Stress	□ Heartburn
Cardiovascular		☐ Yellow eyes/skin
☐ Difficulty breathing lying down		□ Diarrhea
☐ Chest pain/discomfort		
□ Tightness		

Name: _____

☐ Swelling (adema)

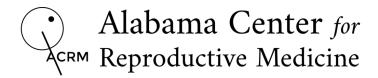
DOB: ____/___

Name:	DOB: / /



Permission to	Rele	ase Perso	nal Healt	h Inform	nation – Ma	ale Partner	
Patient's name:					SS#		
treatments, diagnos	to disc sis, tes ohysici	cuss my accor st results, me	unt and med dications, or	ical condition	ons which may type of protect	roductive Medicine r include symptoms, ted health information coordinate my care,	
Physician		Location		Phone Number		Fax Number	
Name	R	elationship	Phone num	nber	Alternate ph	one number	
and does not affect	my ac ng to <i>A</i> orizati	cess to treat Alabama Cen on will remai	ment. I can r ter for Repro in in effect u	efuse to sig ductive Me ntil I change	n this form. I cedicine or by co	ompleting a new form at I understand that if	
Patient's Signature			Guard	ian Signatu	re (if minor)	// Date	

Name:	DOB: / /



Authorization for Release of Information: Male Partner

Please send my complete medical records to:

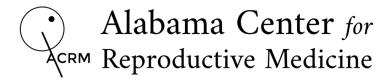
2006 Brookwood Medical Center Drive Suite 302 Birmingham, AL 35209 Phone: 205-307-0484

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 Rele	ease:			
I understand th	nat:			
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 Signatu	re: Date:/			

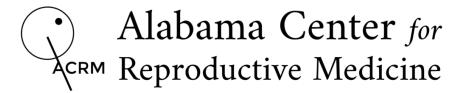
Name:	DOB: / /
	- · · · · · · · · · · · · · · · · · · ·



Insurance Registration Form: Male 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 ins	urance	cards ar	nd driver's license	to the recep	tionist	
Insurance Carrier	Po	licy#	Group #	Effecti	ve date	Policy holder
Medicine (ACRM), and/ be entitled. I allow fax t	or for a ransm s be m rights	assisting ission of nade dire and ber	in any reimburse my medical recor ectly to ACRM, sho nefits under this p	ment or med rds, if necessa ould they ele	lical benefits ary. I furthe ct to receive	such payment. This is a
_	at the ee to	time of	service unless oth	er definite fi	nancial arra	rstand that payment of ngements have been made ts in the event of default of
l authorize treatment by for release of medical ir	'		•		•	nderstand the above consent ity, and treatment.
Patient's Signature			Guardian's Si	gnature		Date

Name:	DOB: / /
Name	ЫОВ/



Notice of Privacy Practices - Male 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, benefit 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:

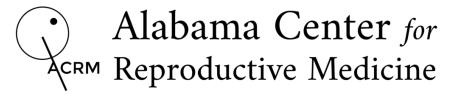
Name:			DOB:	
	inforn whom and si a writ	eceive explicit authorization from you to release individually mation. This authorization must be in writing and give exact in the disclosure applies, the nature of the data to be release signed by the patient (or guardian). You may revoke this autititen statement to the ACRM privacy officer. ral, state or other applicable law requires us to share protect	t details re ed, the app horization	egarding to plicable dates a by providing
disclose any	of your p	abide by the terms of this notice. If, at any time in the future personal information in a way that is materially different fro e change through a mailed announcement or on your visit fo	m this pol	licy, ACRM will
With some e	exception	ns, you have the right to review and obtain a copy of your hed	alth inform	nation.
information. accommoda your informa ACRM is not	. You also ations and ation. You t obligate these righ	e in writing and there may be reasonable charge to provide yoo have the rights to request your records be amended, to red at restricts of your health information and to receive an account have the right to request to receive confidential communiced to agree to a requested restriction. We must receive a wrights. Please speak to the receptionist for further information or rights.	quest spec ounting of a cations of oitten requ	cial the disclosures o your information est from you to
have been v	violated, or	aint about the management of your health information or contact the privacy officer at 205.307.0484. You have the ridepartment of health and human services if you believe the will be no retaliation for filing a complaint.	ght to file	a complaint with

Date

I have read and received a copy of this information.

Patient Signature

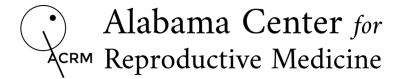
Name:	DOB: / /
	- · - ·



Authorization for Treatment:

I (we),	the undersigned patient(s) and responsible pa	arty/c)								
· //	Alabama Center for Reproductive Medicine (ACRM), phy									
·	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 afte	discussion of the risks and benefits and consent to unde	rgo								
other procedures deemed necessary or advisable in the judgment of the attending physician										
• •	ciates 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									
	this organization to obtain and release medical records									
	undersigned patients, to/from other healthcare provider	rs or								
agencies (including but not limited	agencies (including but not limited to Blue Cross/Blue Shield InfoSolutions).									
Responsible Party	Date									
										
Patient	Date									

Name:	DOB:/	'
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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:

- 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	