

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

☐

Repeated Miscarriages

☐

Endometriosis

☐

In Vitro Fertilization

☐

Pelvic Pain

☐

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

☐

Birth Control Pills (____ - ____)

Type

Dates

☐

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

Please note any fertility treatments you have had:

Medication	Date	# 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
Cataracts

Neck

Lumps
Swollen glands
Stiffness
Pain

Nose

Stuffiness
Discharge
Itching
Hay fever
Nosebleeds

Throat

Dry mouth
Bleeding gums
Dentures
Sore throat
Dry mouth

Breasts

Lumps
Pain
Discharge
Self-exams
Breast-feeding

Respiratory

Sputum
Wheezing
Painful breathing
Coughing up blood
Shortness of breath
Cough

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 bowel habits
Heartburn
Yellow eyes/skin
Diarrhea

Cardiovascular

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



Alabama Center *for* Reproductive Medicine

Authorization for Treatment:

I, _____ (DOB: _____), the undersigned patient, 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 healthcare insurers and pharmacies).

Patient Signature

Date



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 prior to seeking treatment. Please call our billing department at 205-307-0484 option 8 with your questions.

It is important to recognize your insurance policy is a contract between you and your employer.

- Review your insurance policy to understand your infertility benefits and limitations.
- Most infertility coverage is based on treatment cycles and an annual or lifetime benefit maximum.
- Insurance coverage is designed to assist you with your financial obligation with respect to infertility treatments – not eliminate it.

Your financial obligations are to:

- Make payments to ACRM at or before the time of service depending on coverage criteria.
- Pay all applicable deductibles, co-pays, co-insurance.
- Pay for all non-covered services and services non-billable to insurance.

You must inform ACRM of any circumstances that could impact claim submission or processing; otherwise, you will be responsible for all outstanding charges. Examples include:

- You have exhausted your policy benefit or lifetime maximum
- Your insurance policy has changed or has not been updated
- Your insurance company requires you to provide additional information within a specified time

ACRM billing representatives can help guide you through the process of obtaining your benefit information.

- ACRM assumes no responsibility for representations made to us by your insurance company.
- ACRM cannot guarantee that any payment will or will not be made by your insurance carrier until the claim is processed. Patient deposits may be required prior to treatment because of the complexity of fertility coverage.
- If any overpayment is made by you, such overpayment will be refunded after all insurance claims have been processed and all other charges have been paid in full.

Many insurance companies require the patient and/or provider to obtain referrals, pre-authorizations or enroll in plan specific case management programs before they cover infertility services. In these cases:

- Treatment may not begin until you receive confirmation from ACRM that all referrals and authorizations are on file.
- If you choose to start treatment without any required referral, authorization or program enrollment, you will not be allowed to use your insurance coverage and will be considered self-pay for the services. This means full payment will be required before services are rendered.

If ACRM is a non-participating or out of network provider with your insurance carrier:

- We will provide you the courtesy of submitting a claim for your services and require payment in full at the time service.
- In the event you have dual coverage and ACRM does not participate with your primary insurance, ACRM will require payment in full for all treatment.

Utilizing non-ACRM services, such as pharmacy, surgical or laboratory services, requires you to:

- Understand the impact the cost has on your infertility maximum, both yearly and lifetime.
- Determine if your laboratory services are covered under your plan and your financial obligation to that laboratory.
- Understand that medication benefits vary between payors and its impact on your benefit level.
- If required, make payment for these non-ACRM services directly to those providers and work with their staff to determine the financial obligation.

Understanding and managing your financial obligations is extremely important to us. You should receive a monthly statement identifying any outstanding balance.

Settling your financial obligations:

- Your statement will provide a secure link to make payments on-line or you may call our office at (205)-307-0484 to process payments utilizing a credit card (Visa, Amex, MasterCard, Discover).
- You may also pay by check. We charge a service fee of \$25 for all returned checks.
- All outstanding balances that remain unpaid after 120 days may be referred to an outside collection agency or attorney.
- We are unable to offer payment arrangements. Should you need financing we partner with Care Credit and Care Fund. Information on both is available on our website under patient resources.
- Any further treatment may be delayed until your outstanding balance is resolved.
- Fees for medical records include a \$5 search fee, \$1/page for 1-10 pages and \$25 for anything exceeding 10 pages.
- Fees for FMLA paperwork are \$25 per request.

No show policy: If you do not show up for your appointment or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show. No-show appointments may be subject to a \$25 fee. No-show fees are the patient's sole responsibility and must be paid in full before your next appointment.

I/We have read and understand all the terms and conditions presented in this financial policy. I/We agree to be financially responsible for services rendered. For services that have not been paid in full or those requested by me/us to be submitted to insurance, I/we hereby consent to allow ACRM to release information regarding my/our services to the insurance carrier(s) whose information has been provided by me/us.

Patient Name

Date of Birth

Date

Patient Signature

Notice of Privacy Practices

Introduction

This Notice of Privacy Practices is being provided to you on behalf of ACRM with respect to the reproductive medical services provided at ACRM's locations (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 ACRM, 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 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 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

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, www.alabamareproductive.com, as well as 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 recorded 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 that 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're 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 receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used during treatment.

We will use and disclose your health information for our health care 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.

We will collect health information on you and your spouse/significant other.

For example: Although health information in your medical record belongs to you, it will contain some information pertaining to your spouse/significant other. This is because the treatment of infertility may focus on the couple, rather than the individual. We will share information with either partner, unless you indicate in writing otherwise. In cases where a member of a couple refuses to disclose relevant health information to the other partner and there exists a risk of harm to the unaware partner and/or offspring, ACRM may refuse to offer care or treatment if full informed consent is not possible because of the lack of disclosure.

Other Uses or Disclosures of Protected Health 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 judgement, 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 not make these disclosures if you object.
- **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.
- **Electronic Prescribing:** We may use and disclose your health information to Surescripts, an electronic prescribing network, for the purposes of continued treatment.



• **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 contact ACRM's Privacy Officer. We will not act 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 us. This notice is also available on our website at, www.alabamareproductive.com. This notice is effective as of April 1, 2025.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of ACRM's Joint Notice of Privacy Practices. I acknowledge that I have read and understand ACRM's privacy practices and have had the opportunity to ask for a copy if I desire one.

Patient Name: _____

Patient DOB: _____

Partner (if applicable):

- Name: _____

- DOB: _____

PATIENT SIGNATURE

DATE



Authorization for Release of Medical Information

Patient Information

Name: _____ Date of Birth: _____ Phone: _____
Address: _____ City: _____ State: _____ ZIP: _____

I hereby authorize the release of my protected health information (PHI) as follows:

1. Entity Authorized to Release Information

Provider/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

2. Entity Authorized to Receive Information

Provider/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

3. Information to be Disclosed (Check all that apply):

- | | |
|--|---|
| ☐ Complete Medical Record | ☐ Lab Reports |
| ☐ Radiology/Imaging Reports | ☐ Operative Reports |
| ☐ Progress Notes | ☐ Other (specify): _____ |

4. Purpose of Disclosure (Check one or more):

- ☐ Personal Use ☐ Continuation of Care ☐ Legal ☐ Disability Determination ☐ Other (specify) _____

5. Patient Rights & Acknowledgment

- I understand that I may revoke this authorization at any time by providing written notice to the provider named above. This authorization will remain in effect for 1 year or until I revoke it in writing.
- I understand that revocation will not affect actions taken before receipt of the revocation.
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under HIPAA.
- I understand I may refuse to sign this authorization, and treatment will not be conditioned on signing unless permitted by law.
- I understand that the requested information will be faxed free of charge. If requested to be sent via email, I acknowledge that email is not considered secure and there is a risk that my information may be misdirected, disclosed to or intercepted by unauthorized or unintended recipients. If I choose to pick up a paper copy, medical records fees will apply.

Signature of Patient or Legal Representative

Print Name: _____

Signature: _____

Relationship to Patient (if not self): _____

Date: _____