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
- ☐ 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	Date	# 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	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
- 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)

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

Alabama Center *for* Reproductive Medicine

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

Alabama Center *for* Reproductive Medicine

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: _____