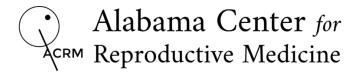
Name:

DOB:	//	/
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Female New Patient Medical History

Name:		Age: SSN:		
Initial Apt Date:	N	Marital Status:		Height:
Religion:	Oc	ccupation:		Weight:
Primary Contact #:		Secondary Contact	#:	
Email:		Race:		
Address:		City, State:		
Preferred Pharmacy Na	ıme:			
Pharmacy City, State: _		Pharmacy Ph	one #:	
Partner name (if applic	able):	Partner o	ccupation:	
Partner phone #:		Partner DOB:		
Emergency contact:		Phone #:		
	Reason for V	isit (Check all that apply)	
Infertility		Repeated I	Miscarriages	
Endometriosis		In Vitro Fe	rtilization	
Pelvic Pain		Irregular Periods		
		Other:		
	Me	nstrual History		
What age did your mer	nstruation begin?	Regularity:		
Average length of cycle	e (from 1 st day of period	d to the 1st day of the ne	ext)	days
Bleeding between perio	ods? Pain be	etween periods?		
Pain during:	None Mild	Moderate	Severe	
Do you have vaginal dis	scharge? Do v	ou bleed after intercour	se?	

Name:					DOB:/	/
Last normal	period/_	_/				
How many t	imes do you h	ave intercourse	per week?			
Do you expe	rience any pa	in during interco	ourse?			
When was y	our most rece	ent: Mammogran	m/ Pap S	Smear	//_	
		F	Past Medical History			
List any injui	ries/illnesses r	equiring hospita	alization:			
Date	Reason					
List any surg	eries you hav	e had:				
Date	Reason					
			have had (such as syp			nital warts,
Alcohol cons	sumption:	Current	beverages/week	Past	beverages/wee	 ek
Cigarette us	e:	Current	packs/day	Past	packs/day	
Recreationa	l/illegal drug u	use (please speci	ify): Current:		Past:	
How many c	affeinated be	verages do you l	have per day?			
Have you ev	er undergone	chemotherapy	or radiation? (If yes, pl	ease expl	ain)	
What allergi	es do you hav	e?				_

Name:						DOB	:
			Me	dications			
Medication			Freq	uency		Indica	ition
Do you curren	tly take a pr	enatal or mult	 ti-vitamir	?		Type:	
			Contrace	eptive Histo	ry		
Please check a	II the types	of birth contro	ol metho	ds you have	used (pa	ast or curre	nt)
Туре	Date	es		Туре		Dates	
Birth Cont	rol Pills ()		Cond	doms	()
IUD	()		Othe	er	()
			Obstet	rical History	,		
Please list all p	regnancies	(including ecto	opic, abo	rtions, misca	arriages,	and delive	ries):
#	Date	Туре	Birth V	VT Sex		Alive (Y/N) Complications
						-	
		•					·
			Fami	ly History			
Are you adopt	ed?	Please check	in the ap	propriate fo	llowing l	ooxes:	
Problem	Mothe	r Father		Sibling	Gra	ndparent	Children
Breast Cancer				<u> </u>			
Ovarian Cance	r						
Other Cancer							
Thyroid diseas	e		T				1

Heart Disease Diabetes

Name:							DOB	::/	_/
Please check in the app	propriate	follow	ing boxe	s:					
Problem	Mother	Fa	ther	Sibling		Grandp	arent	Children	
High blood pressure									
Irregular periods									
Infertility									
Uterine fibroids									
Endometriosis									
Birth defects									
Other									
emale: Please note th	e date an	d resu	Its of the		tests y	ou have			
Test	. 61			Date			Result	.S	
Basal Body Tempera		_							
Hysterosalpingog	•)							
Laparosco Hysterosco									
Hormone T									
Progesterone									
					L				
lease note any infertil	lity medic	ations	you hav	e taken:					
Medication		Date		# Cycles	Dose	5	Did yo	ou Du	
							conce		
Clomiphine Citrate									
(Clomid)									
Letrozole									
hCG (Trigger) Injection	ns								
Fertility Injections	,								
Metformin (Glucopha	ge)								
Other ()								
leases note any fertili	ty treatm	ents y	ou have l	nad:					
Medication	Date	1	# Cycles	Where			Did voi	ı conceive	?
Artificial Insemination				1111676			, 00		
(IUI)									
In Vitro Fertilization									

Other

• •			
Name:			

DOB:	/	/	
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Review of Systems

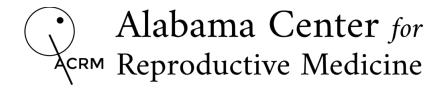
General	Skin	Ears	Eyes
☐ Weight loss or gain	□ Rashes	☐ Decreased Hearing	☐ Glasses or contacts
□ Fatigue	□ Lumps	☐ Ringing in ears	□ Pain
□ Fever or chills	□ Itching	□ Earache	□ Redness
□ Weakness	□ Dryness	□ Drainage	☐ Blurry or double vision
☐ Trouble Sleeping	☐ Hair and nail changes	5	☐ Flashing 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	
Breasts	□ Nosebleeds	□ Dry mouth	
□ Lumps	□ Sinus pain	□ Hoarseness	
□ Pain		□ Thrush	
□ Discharge	Respiratory	□ Non-healing sores	
□ Self-exams	□ Sputum	☐ Last dental exam	
□ Breast-feeding	□ Wheezing		
	□ Painful breathing		
	☐ Coughing up blood		
	☐ Shortness of breath		
	□ Cough		

Name:

DOB:	_/	_/_	
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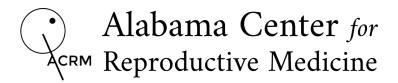
Review of Systems Cont.

Urinary	Genital	Musculoskeletal
□ Increased frequency	□ Pain with sex	☐ Muscle or joint pain
□ Urgency	□ Vaginal dryness	□ Stiffness
□ Burning or pain	□ Hot flashes	□ Back pain
□ Blood in urine	□ Vaginal discharge	□ Redness of joints
□ Incontinent	□ Itching or rash	☐ Swelling of joints
☐ Change in urinary strength	□ STDs	□ Trauma
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		
□ Palpitations		
☐ Swelling (adema)		



Authorization for Treatment:

l,	(DOB:), the
undersigned patient, consent to necessary tr Medicine (ACRM), physicians; physicians taki employees of ACRM. Treatment to include ve other studies, and to perform any operations risks and benefits and consent to undergo ot advisable in the judgment of the attending p associates or assistants in the diagnosis and this treatment should it be necessary to consend consent for this organization to obtain a pertinent information on the undersigned paragencies (including but not limited to healther	eatment by Alabar ng call for ACRM, a enipuncture, medi s and/or procedure her procedures de hysician employee treatment of my co sult with others, I h nd release medica	ma Center for Reproductive and/or any of the qualified cation, ultrasound, X-rays o es after discussion of the emed necessary or of ACRM, or his/her ondition(s). In the course of nereby give my permission I records and other healthcare providers or
Patient Signature	 Dat	e



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.

ACRM Financial Agreement – 5.28.25

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.

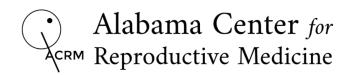
Settling your financial obligations:

- 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

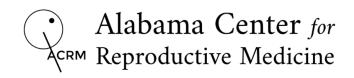
Our Responsibilities

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.

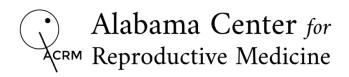
For example: Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve 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.



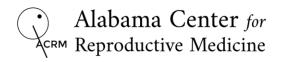
• Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that 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.

<u>Note:</u> 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 m	y protected health informa	ation (PHI) as follow	s:		
1. Entity Authorized to Release Information Provider/Facility Name:		2. Entity Authorized to Receive Information Provider/Facility Name:			
Address:		Address:			
Phone: Fax:		Phone:	Fax:		
3. Information to be Disclose	d (Check all that apply):			
☐ Complete Medical Record	☐ Lab Reports				
☐ Radiology/Imaging Reports	☐ Operative Reports				
☐ Progress Notes	\square Other (specify):				
4. Purpose of Disclosure (Che	ck one or more):				
☐ Personal Use ☐ Continuation of	•	, Determination □	Other (specify)		
	- care = 106ar = 2.0a0	, Determination =	other (speeny)		
5. Patient Rights & Acknowle	dgment				
- I understand that I may revoke th			en notice to the pro	vider named above.	
This authorization will remain in ef	·	_			
- I understand that revocation will i		•			
- I understand that information disc	closed pursuant to this autl	norization may be s	ubject to redisclosu	re and may no	
longer be protected under HIPAA.					
- I understand I may refuse to sign	this authorization, and trea	itment will not be co	onditioned on signir	ig unless permitted	
by lawI understand that the requested in	oformation will be faxed fre	e of charge If requi	ested to he sent via	email I	
acknowledge that email is not cons					
to or intercepted by unauthorized		•	•	•	
apply.	·				
Signature of Patient or Legal	Representative				
Print Name:					
Signature:					
Relationship to Patient (if not self):					
Date:					