



**THE MIDWEST CENTER FOR
REPRODUCTIVE HEALTH, P.A.**

Arbor Lakes Medical Building, Suite 350
12000 Elm Creek Blvd North
Maple Grove, MN 55369

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Web Site www.mcrh.com

Guide For Satellite Patients The Midwest Center for Reproductive Health, P.A.

Thank you for choosing The Midwest Center for Reproductive Health, P.A. (MCRH). Please accept our warmest welcome to you from the staff at MCRH, as well as our thanks for your interest in the services we provide. We understand the struggles that you face and truly strive to provide the finest care possible in a compassionate and professional environment. It is our hope that we will lay the foundation for success with our individualized treatment based on the unique needs of each patient. We ask that you use this information as a guide in order to familiarize you with MCRH and prepare yourself for what to expect before, during, and beyond your first appointment.

Before Your Appointment:

To ensure your new patient appointment is most beneficial to you, we begin by asking that the following forms be thoughtfully completed and received in our satellite office one week before your appointment. Please feel free to return your completed forms by mail or by faxing it to your appropriate satellite office. If you choose to fax your completed forms, please bring the original copy to your scheduled appointment. If you have a copy of your medical records, you may include a copy with the following forms:

- _____ **Patient Registration Form and Consent for Treatment** – Carefully read and complete both pages of this form. Since this serves as a consent for services, completion of this form is required before your appointment. Be sure to have both patient and spouse or partner (if applicable) initial, sign, and date.
- _____ **History Forms** (both female and spouse/partner) – Each of you should individually complete the appropriate form to the best of your knowledge. Please indicate “not applicable” when this is the case. Completion of these forms allows the staff at MCRH to better understand your individual situation and provide a more individualized discussion during your consultation.
- _____ **Medical Records** – It is most beneficial if medical records from current and/or previous infertility treatment are received at our satellite office before your consultation. In order to expedite the transfer of your previous medical records, enclosed is an “**Authorization for Release of Medical Information**” form for you to return directly to your physician. If you and/or your partner have more than one physician that you have been working with, please feel free to duplicate or to ask MCRH for additional copies of this form. Any medical records released from other facilities will have pertinent information extracted and will be returned to you at the time of your new patient consultation. This will also enable you to have your own copy to reference in the future.
- _____ **Preparing for Pregnancy** – Please read this guide for information to best optimize your chances for successful treatment.

You should also expect a telephone call from one of the MCRH nursing staff before your appointment. The nurse will confirm your appointment, the receipt of your new patient paperwork and your medical records, and will ask any questions regarding your medical history. This phone conversation will help further to clarify your individual situation and any specific topics you wish to discuss during your initial consultation.

What to Expect at Your New Patient Appointment:

Your initial appointment is scheduled as a consultation. In order to give you both the opportunity to meet Dr. Corfman and other members of the MCRH team, we strongly recommend both you and your spouse or partner attend the new patient consultation. During this appointment you will have the opportunity to have a dialogue between you and Dr. Corfman, review any previous treatments, and discuss options for further treatment. Generally, this appointment is approximately 30 minutes in length however, please keep in mind that your appointment may be longer or shorter depending on your unique requirements. **It is with sensitivity to all patients and with regards to the particular nature of our practice, we ask that children do not accompany you to your appointment.**

You will receive a follow up call from our program coordinator regarding the treatment plan that has been outlined for you.

Office Location:

Our main office is located in Maple Grove, MN. Please see the Practice Locations page on our website. If you have any questions regarding directions, please call MCRH at (800) 508-9763.

Cancellation Policy:

A fee will apply for appointments not cancelled at least 72 hours in advance. While we regret the need to do this, this policy allows us to better serve all of our patients who may be waiting for an appointment time.

Billing and Insurance Policies and Questions:

Understanding your medical insurance coverage and your benefits for infertility treatment can be confusing and time consuming. Our Business Office staff is available to answer questions as they arise. However, because plans vary greatly, it is probably best to start by contacting your insurance company directly. Please see the Insurance and Financial Information page on our website.

The fee for a new patient consultation is generally \$370, although this can vary depending on the amount of time spent, the complexity of your medical history, and your options for treatment. This appointment may or may not be covered by insurance and includes chart preparation, extraction of your previous medical records, medical records review with a member of the nursing staff before your appointment, and your physician consultation.

MCRH participates with a number of insurance plans, however, coverage varies. We ask that you contact your insurance company prior to your appointment. If we do not participate directly with your insurance, there may be "out of network" benefits allowing you to see Dr. Corfman.

If you have questions or concerns regarding fees or insurance coverage, please contact the Business Office by calling (763) 494-7736. Many times all it takes is a phone call to ease your insurance concerns and answer your questions.

We look forward to meeting you at your new patient consultation. Please do not hesitate to call with further questions.

Additional Helpful Information about MCRH in Maple Grove

Office Hours:

- Monday through Thursday, 7:00 a.m. - 4:00 p.m.
- Friday, 7:00 a.m. - 12:00 p.m.
- Weekend/holiday hours are available by appointment.

Appointment Scheduling:

Telephone hours are as follows:

- Monday through Thursday, 8:00 a.m. - 12:00 p.m., 1:00 p.m. - 4:00 p.m.
- Friday, 8:00 a.m. - 12:00 p.m.

Please feel free to call for appointments, medication refills, general questions, and other routine clinic communications during these times.

After clinic hours and weekends:

- **Non-emergency calls** should be made to the nurse line at (763) 494-7726. Messages may be left at any time and if necessary, a nurse will return your call by the following day.
- **In case of an emergency**, the answering service may be phoned at (763) 494-7700 or (800) 508-9763. A nurse will be paged to return your call and medical direction will be given.

*Please note that in order to serve all of our patients, we ask that you only page the on-call nurse in an emergency. Non-emergent pages will be billed accordingly.

Laboratory Services:

- Monitoring services and procedures that can be performed at MCRH include: ultrasounds, specific blood testing, intrauterine insemination, post coital testing and sonohysterograms.
- Laboratory services are coordinated between our office and other affiliated laboratories.
- Patients may also choose to coordinate specified laboratory procedures through the services affiliated with their satellite physician.

Andrology Services:

- Andrology services include: semen analysis, semen analysis with strict criteria, antisperm antibody testing, intrauterine insemination preparation, and cryopreservation of back up semen specimen.
- Andrology services are available and conducted through our Reproductive Biology Laboratory by appointment. Testing will be done from 8:30 a.m. - 1:00 p.m. Monday through Thursday and 8:30 am - 10:00 am on Friday.

Support Services/Social Worker:

- Sally Sibbitt, MSW, LICSW, is a clinical social worker specializing in working with infertility and reproductive loss, as well as with other issues. She is a valuable member of our team and we encourage you to utilize her services. She may be contacted directly by calling (952) 925-3533.

Medical Records Policy:

- If you would like to receive a copy of your medical records after becoming a patient of ours, please call (763) 494-7700 or (800) 508-9763. An MCRH Authorization for Release of Medical Information and/or a current Patient Registration Form is required and must be signed by both patient and spouse/partner if applicable. As per MCRH policy, appropriate fees will apply.



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Preparing for Pregnancy

While conception is as easy as "falling off a log" for some people, it is not so easy for many of us. We all know couples who are unhealthy and choose unhealthy lifestyles, yet seem to have no trouble becoming pregnant.

Two of the most important lifestyle factors negatively impacting pregnancy and chances of becoming pregnant are smoking and obesity. The medical literature is full of information which shows smoking (yes, even use of chewing tobacco) and being overweight significantly decreases chances to conceive. Furthermore, both smoking and being overweight have very serious negative effects upon you and your unborn baby, and on your baby's health after birth.

Just as the pilot of an airplane meticulously prepares and performs preflight planning, so, too, should you prepare to become pregnant. When you ask our team at The Midwest Center for Reproductive Health to help you launch and "get this baby off the ground," we recognize that you are also committing to do what is necessary to optimize chances for success. We take your commitment very seriously, just as we take seriously our commitment to help you achieve a pregnancy and a healthy baby.

For those of you who are significantly overweight, we want you to know that we do not wish to begin infertility treatment until you are in a position to be successful. What defines being "significantly overweight"? The National Institutes of Health has adopted a measurement which correlates height and weight with health risks, termed the body mass index (BMI). Studies have shown a body mass index between 19 and 25 to be in a healthy range, whereas a BMI of 30 or greater to be associated with significant health risks. To determine your BMI please go to www.bmi-calculator.net or consult with your local health care provider.

Should your BMI be above 30, it is important for you to know that many studies have shown significant negative impacts upon your chances to conceive, greatly increased chances of complications during your pregnancy and increased chances for health problems in your baby. With this in mind, we discourage initiation of infertility treatment until your BMI is 30 or under.

Having a BMI over 30 is not only a problem for women trying to conceive, but also for men. Sperm function is significantly compromised with elevated BMI.

Should your BMI be 35 or greater, we ask that you seek care with your local health care provider and establish a plan for reducing your BMI **before** you schedule an appointment with Dr. Corfman.

Should you be users of tobacco products, it is important for you to be tobacco and smoke-free before you initiate infertility treatment. When you do your part to prepare for pregnancy, you put yourself in an excellent position to be a parent of a healthy baby. We know that is your goal, and we will be there to help you when you're ready.



**THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.
AND THE SUBSIDIARIES MCRH ALPHA, PA AND
GREAT PLANES REPRODUCTIVE CENTERS, P.A.**

Full completion of this form is mandatory prior to providing any medical services.

PATIENT REGISTRATION RECORD/CONSENT FOR TREATMENT

Date _____ Appt. Date _____ Physician Referred: Yes ___ No ___ If yes, Name _____

FEMALE PATIENT INFORMATION (Print legal name as it appears on driver's license, social security card, etc.)

Patient _____

Last First MI Nickname

Address _____ City _____

State _____ Zip _____ Phone (_____) _____ - _____ *Choose one:*
Home Cell Voicemail Y / N

Birth Date _____ - _____ - _____ Age _____ Social Security Number _____ - _____ - _____

Current Marital Status _____ Married _____ Divorced _____ Single _____ Widowed

*Marital Status is required to provide necessary consenting and patient chart preparation.

Email address: _____

Employer _____ Phone (_____) _____ - _____ *Choose one:*
Work Cell OK to Call Y / N

Employer's Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Patient's Primary Insurance Company/Plan Name _____

Group # _____ Contract/ID# _____ Policy Holder Name _____

Eff Date _____ Insurance Company Address _____

*Please refer to the business office information in your new patient packet for specifics regarding insurance.

SPOUSE/PARTNER INFORMATION Spouse Partner (please check appropriate box)

(Print legal name as it appears on driver's license, social security card, etc.)

Spouse/Partner Name _____

Last First MI Nickname

Birth Date _____ - _____ - _____ Age _____ Social Security Number _____ - _____ - _____

Employer _____ Phone (_____) _____ - _____ *Choose one:*
Work Cell OK to Call Y / N

Employer's Address _____ City _____ State _____ Zip _____

SPOUSE/PARTNER INSURANCE INFORMATION

Insurance Company/Plan Name _____

Group # _____ Contract/ID# _____ Policy Holder Name _____

Eff Date _____ Insurance Company Address _____

*Please refer to the business office information in your new patient packet for specifics regarding insurance.

EMERGENCY CONTACT

Name of Person to Contact (not living with you) _____ Relationship _____

Address _____ Phone (_____) _____ - _____

CONSENT FOR SERVICES

The following information must be **initialed and signed** by **both** patient and spouse/partner below. Please indicate if spouse/partner is not applicable. **Full completion of this form is mandatory prior to The Midwest Center for Reproductive Health, P.A and its subsidiaries (MCRH) providing any medical services.**

Patient Initial Spouse/
 Partner
 Initial

CONSENT FOR TREATMENT. I hereby consent to and authorize the physician(s) and their designees to perform whatever routine diagnostic procedures, treatment, laboratory tests, and to administer such medications in his/her opinion are necessary or advisable.

Patient Initial Spouse/
 Partner
 Initial

TESTING. I understand that while receiving care accidental exposure to my blood or other body fluid may occur. If this rare event occurs, I understand that my blood will be tested for the presence of Bloodborne Pathogens (Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus). These tests are necessary to help protect and counsel the exposed individual. I understand that results of the tests will be a part of my medical record and will not be released except with my prior consent or as required or permitted by law.

Patient Initial Spouse/
 Partner
 Initial

RELEASE OF MEDICAL RECORDS. I hereby authorize MCRH to release to myself, spouse/partner, my referring physician, insurance company, physicians referred by MCRH, or legal guardian, any information, including diagnosis and records of treatment, concerning my past and present medical care. I understand that my medical records will be maintained jointly with my spouse/partner's throughout my care at MCRH. Additionally, I authorize access to MCRH Reference Laboratory results if previously tested. I accept the risks associated with releasing medical records via fax and/or mail.

Patient Initial Spouse/
 Partner
 Initial

NOTICE OF PRIVACY PRACTICES. I acknowledge the receipt the Notice of Privacy Practices Effective June 25, 2003.

Patient Initial Spouse/
 Partner
 Initial

IDENTIFICATION. I understand MCRH requires validation to secure patient's identity via picture ID at the time of new patient appointments to comply with HIPAA privacy Practices.

Patient Initial Spouse/
 Partner
 Initial

RELEASE OF PERSONAL PROPERTY RESPONSIBILITY. I understand that MCRH is not responsible for the loss of valuables and assumes no responsibility for any losses.

Patient Initial Spouse/
 Partner
 Initial

PAYMENT/INSURANCE CONSENT. I acknowledge responsibility for payment for services rendered to me at MCRH. I understand it is my responsibility to obtain a referral from my primary care physician for all care received at MCRH if my insurer requires it. I acknowledge and accept responsibility for all charges denied or identified as non-covered by my insurer. If my account becomes delinquent, I agree to pay all costs the center may incur in collecting its fees including collection agency & attorney fees. If charges on my account are not fully paid within 120 days of the date of service, I also agree to pay interest from that date at a rate of 1.5% per month. Unless full payment is made on the date of service, I authorize my insurer to pay my medical benefits directly to MCRH.

Patient Initial Spouse/
 Partner
 Initial

SATELLITE PATIENTS: I acknowledge that while being seen at a location other than Maple Grove, Dr. Corfman may not be a provider in my insurance network at that facility.

Patient Legal Name Printed _____

Patient Signature _____ Date _____

Spouse/Partner Legal Name Printed _____

Spouse/Partner Signature _____ Date _____

THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.

Female History Form

Each of you should individually complete the appropriate form to the best of your knowledge.

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Duration of Relationship _____ Duration of attempting pregnancy _____

Nature of present employment (title, brief description) _____

II. MEDICAL HISTORY

Height _____ Weight _____

Do you have or have you ever been diagnosed with or treated for (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Breast Discharge |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer Specify: _____ | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hirsutism (excessive hair growth) | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Thyroid Disease/Surgery | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Neurological Problem | | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Poor Sense of Smell | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Ovarian-Cysts |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Colitis | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Visual Disturbance | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pelvic Infection |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall Bladder Disease/Surgery | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Arthritis |
| | | <input type="checkbox"/> Lupus Erythematosus |

Cardiovascular History

Bleeding Disorder	Yes	No
Blood Clots	Yes	No
High Blood Pressure	Yes	No
History of Heart Disease	Yes	No
Heart Murmur	Yes	No
Antibiotics needed for dental/surgical procedure	Yes	No

Allergies

General Allergies	Yes	No	If yes, list: _____
Drug Allergies	Yes	No	If yes, list: _____
Latex Allergy	Yes	No	
Iodine Allergy	Yes	No	
Egg Allergy	Yes	No	

Prescribed Medications:

Past Year	Yes	No	If yes, list: _____
Current	Yes	No	If yes, list: _____

Over-the-Counter Medications:

Current	Yes	No	If yes, list: _____
Homeopathic/Herbal	Yes	No	If yes, list: _____

Current Use of the Following:

Alcohol	Yes	No	If yes, type: _____ amount per week: _____
Smoking	Yes	No	If yes, number of packs per day _____
Recreational Drugs	Yes	No	If yes, type: _____ frequency: _____

III. CONTRACEPTIVE/SEXUAL HISTORY

Have you used in the past (check all that apply):

____ Birth Control Pills Name: _____

____ IUD Name: _____

____ Depo-Provera

If you've ever been on oral contraceptives (pills), were your periods regular after stopping the pills? Yes No

Do you use lubricants for intercourse? Yes No If yes, type: _____

Is intercourse painful or difficult for you? Yes No

How many times per week do you and your partner have intercourse? _____

How many times do you have intercourse at the time of ovulation? _____

Indicate your sexual orientation by circling one of the following: Heterosexual Homosexual Bisexual

IV. MENSTRUAL AND PREGNANCY HISTORY

Age at first period? _____

Are your periods regular? Yes No

If yes, what is the usual length (from onset of period to the onset of your next period) ? _____

If no, how many times per year do you menstruate? _____

Progesterone or Provera needed to initiate bleeding? Yes No

What is the usual duration of your flow? _____

Are cramps: ____mild ____moderate ____severe

Do you bleed or spot between periods? Yes No

How many pregnancies (including elective abortions) have you had? _____

Pregnancy	Year conceived	How long to conceive?	Infertility therapy required to conceive?	(choose one) Elective Abortion? Miscarriage? Ectopic? Pre-term Delivery? Full-term Delivery? Stillborn?	Date baby born	Vaginal delivery or C-section?	Complications?	Male or female	Is current partner the father?
1st				___ wks					Yes No
2nd				___ wks					Yes No
3rd				___ wks					Yes No
4th				___ wks					Yes No
5 th				___ wks					Yes No

V. FAMILY HISTORY

Is there a family history of cancer/malignancy

____ Ovarian Yes No whom: _____

____ Breast Yes No whom: _____

____ Other Yes No whom: _____

Is there a history of hormonal disorders in your family? Yes No

If yes, who and what type _____

Is there a family history of

Cystic Fibrosis? Yes No If yes, whom: _____

Tay Sachs Disease Yes No If yes, whom: _____

Sickle Cell Anemia Yes No If yes, whom: _____

Diabetes Yes No If yes, whom: _____

With which of the following racial/ethnic group do you identify? Check the appropriate racial/ethnic group?

- American Indian/Alaska Native Asian Black/African American
 Hispanic/Latino Native Hawaiian
or Other Pacific Islander White/Caucasian
 Unknown/Not Stated

VI. INFERTILITY HISTORY/TREATMENT

Have you been treated for infertility before? Yes No

If yes, who was your physician? _____
Infertility diagnosis? _____

Which of the following tests have you had performed? Check all that apply and list the results if known:

- | | | |
|--|-------------|----------------|
| <input type="checkbox"/> Postcoital Test | When? _____ | Results: _____ |
| <input type="checkbox"/> Hormonal Testing (FSH, LH, prolactin, estrogen, DHEA-S, testosterone, progesterone) | When? _____ | Results: _____ |
| <input type="checkbox"/> Sonohysterogram | When? _____ | Results: _____ |
| <input type="checkbox"/> Hysterosalpingogram (HSG) | When? _____ | Results: _____ |
| <input type="checkbox"/> Mycoplasma/Chlamydia cultures | When? _____ | Results: _____ |
| <input type="checkbox"/> Thyroid tests | When? _____ | Results: _____ |
| <input type="checkbox"/> Pap Smear (most current) | When? _____ | Results: _____ |
| <input type="checkbox"/> Other - Specify | When? _____ | Results: _____ |

Immunology/Recurrent Pregnancy Loss Testing (if applicable)

- | | | | | |
|--------------------------|-----|----|-------------|----------------|
| Anticardiolipin Antibody | Yes | No | When? _____ | Results: _____ |
| Lupus Anticoagulant | Yes | No | When? _____ | Results: _____ |
| Anti-Chlamydial Antibody | Yes | No | When? _____ | Results: _____ |

Have you ever had any of the following procedures/surgeries:

- | | | | |
|-------------------------------|-----|----|-------------|
| Appendectomy | Yes | No | Date: _____ |
| Cervical Conization or Cautey | Yes | No | Date: _____ |
| C-Section | Yes | No | Date: _____ |
| D & C | Yes | No | Date: _____ |
| Hysteroscopy | Yes | No | Date: _____ |
| Laparoscopy | Yes | No | Date: _____ |
| Laparotomy | Yes | No | Date: _____ |
| Tubal Ligation | Yes | No | Date: _____ |
| Tubal Reversal | Yes | No | Date: _____ |
| Other _____ | Yes | No | Date: _____ |

Indicate the following treatment types you have undergone or are currently undergoing:

- | | |
|--|-------------------------|
| <input type="checkbox"/> Clomid | Number of Cycles: _____ |
| <input type="checkbox"/> Letrozole | Number of Cycles: _____ |
| <input type="checkbox"/> Superovulation | Number of Cycles: _____ |
| <input type="checkbox"/> Intrauterine Insemination (IUI) | |
| <input type="checkbox"/> Husband's Sperm | Number of Cycles: _____ |
| <input type="checkbox"/> Donor Sperm | Number of Cycles: _____ |

In Vitro Fertilization Yes No
Number of Fresh Cycles: _____ Number of Frozen Cycles: _____

Facility/location where treatment occurred _____

THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.

Male History Form

Each of you should individually complete the appropriate form to the best of your knowledge.

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Nature of present employment (title, brief description) _____

II. MEDICAL HISTORY

Height _____ Weight _____

Do you have or have you ever been diagnosed with or treated for (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Neurological Problem | <input type="checkbox"/> Asthma | <input type="checkbox"/> Breast Discharge |
| <input type="checkbox"/> Poor Sense of Smell | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Visual Disturbance | | <input type="checkbox"/> Herpes |
| | | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Anxiety/Depression | | <input type="checkbox"/> Mumps/Testes Involvement |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Cancer Specify: _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Syphilis |
| | <input type="checkbox"/> Gall Bladder Disease/Surgery | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Testes Infection |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Injury |
| <input type="checkbox"/> Thyroid Disease/Surgery | | <input type="checkbox"/> Testes Tumor |
| | | <input type="checkbox"/> Undescended Testes |

Allergies

General Allergies Yes No If yes, list: _____
Drug Allergies Yes No If yes, list: _____

Prescribed Medications:

Past Year Yes No If yes, list: _____
Current Yes No If yes, list: _____

Over-the-Counter Medications:

Current Yes No If yes, list: _____
Homeopathic/Herbal Yes No If yes, list: _____

Current Use of the Following:

Alcohol Yes No If yes, type: _____ amount per week: _____
Smoking Yes No If yes, number of packs per day _____
Recreational Drugs Yes No If yes, type: _____ frequency: _____

Do you frequently use saunas, steam baths, or whirlpools? Yes No

Have you had a high fever (over 102° F) during the past three to four months? Yes No

III. SEXUAL HISTORY

- Have you ever tried to produce a child with another partner? Yes No
- Have you produced a child with another partner? Yes No
If yes, how long did it take to produce the child? _____
When? _____
- Do you have trouble getting an erection? Yes No
- Do you have trouble maintaining an erection? Yes No
- Do you have trouble with ejaculations? Yes No
If yes, ___ premature ejaculations ___ retrograde ejaculations
- Do you feel that your ejaculate is deposited into the vagina? Yes No
- Do you have any abnormal discharge from your penis? Yes No
- How many times per week do you and your partner have intercourse? _____
- How many times do you have intercourse around ovulation? _____
- Have you recently noticed a change in your sexual drive? Yes No
- Have you had an injury or an abnormality of penis, testicles or prostate? Yes No
If yes, when? _____ Outcome/result _____
- Indicate your sexual orientation by circling one of the following: Heterosexual Homosexual Bisexual
- Has your partner ever conceived a child with someone other than yourself? Yes No

IV. FAMILY HISTORY

Is there a history of hormonal disorders in your family? Yes No
If yes, who and what type _____

Is there a family history of

Cystic Fibrosis?	Yes	No	If yes, whom: _____
Tay Sachs Disease	Yes	No	If yes, whom: _____
Sickle Cell Anemia	Yes	No	If yes, whom: _____

With which of the following racial/ethnic group do you identify? Check the appropriate racial/ethnic group:

- American Indian/Alaska Native Asian Black/African American
- Hispanic/Latino Native Hawaiian White/Caucasian
or Other Pacific Islander
- Unknown/Not Stated

The Midwest Center for Reproductive Health, P.A. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Midwest Center for Reproductive Health, P.A., including its subsidiary Great Planes Reproductive Centers, P.A., is required by law to maintain the privacy of protected health information ("PHI") and to provide you with notice of its legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") will tell you about the ways in which we may use and disclose your PHI for treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI. We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("HIPAA").

We are required to follow the terms of this Notice. We will not use or disclose your PHI without your written authorization, except as described or otherwise permitted by this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you, at the time of your appointment, in the mail or you may review the revised Notice, which will be posted in our office.

How We Use and Disclose Protected Health Information About You

The following categories describe different ways that we use and disclose your protected health information. We have provided you with examples in certain categories; however, not every use or disclosure that is in a category and permitted by law will be listed.

Treatment. We may use and disclose your PHI to provide and coordinate the treatment and services you receive. For example, we will disclose your information as necessary to a health care practitioner or agency that provides care to you. We may contact you about treatment recommendations or product recalls.

Payment. We may use and disclose your PHI for various payment-related functions. For example, we may contact your insurer or other health care payor to determine whether it will pay for your treatment and the amount of your co-payment. We will bill you or a third-party payor for the cost of the services you receive. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and the specific services you received.

Health care operations. We may use and disclose your PHI for certain operational, administrative and quality assurance activities. For example, we may use information in your health record to monitor the performance of staff members providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the health care services we provide. We may disclose by calling your name in the clinic area or by asking you to use a sign in sheet at the registration desk. We may disclose health information to business associates if they need to receive this information to provide a service to us and will agree to safeguard protected health information.

Health-related benefits and services. We may also use your PHI to provide you with information about benefits available to you, and, in limited situations, about health-related products or services that may be of interest to you.

Appointment reminders. We may use and disclose PHI to contact you as a reminder that you have an appointment with us for services.

Others involved in your care. We may also disclose to certain family members, personal friends or any other person you identify, PHI directly relevant to that person's involvement in your care or payment related to your care in order to not hinder that person's involvement. We may release information to parents or guardians, if allowed by law.

Potential Impact of Laws Other than HIPAA

HIPAA privacy regulations generally do not "preempt" (or take precedence over) state or federal laws that provide individuals greater privacy protections. For example, state law requires us to obtain your written consent before making some of the disclosures described above. We will follow more stringent state and federal privacy laws where they apply.

Other Uses and Disclosures

We are permitted to use or disclose your PHI for the following purposes, but we may never have reason to make some of these disclosures.

Worker's compensation. We may disclose your PHI as required to comply with laws relating to worker's compensation and similar programs established by law.

Public health. As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury or disability. Public health disclosures include cycle-specific data we report to the Society for Assisted Reproductive Technology.

Law enforcement. We may disclose your PHI for law enforcement purposes as required by law or in response to a subpoena or court order.

As required by law. We will disclose your PHI when required to do so by federal, state or local law.

Health oversight activities. We may disclose your PHI to an oversight agency for activities authorized by law, such as audits, investigations, inspections, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws.

Legal proceedings. If you are involved in a lawsuit or dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested information.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, medical examiners, funeral directors and organ donations. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors to enable them to carry out their duties and to organ organizations that handle organ and tissue donation or transplant.

Correctional institution. If you are or become an inmate of a correctional institution, we may disclose to the institution or its agents PHI necessary for your health and the health and safety of other individuals.

To avert a serious health or safety threat. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military activity and national security, protective services. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities and for the protection of the President, other authorized persons or heads of state.

Victims of abuse, neglect or domestic violence. We may disclose PHI about you to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. We will disclose this type of information if it is required by law or the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy regulations.

Other uses and disclosures of PHI. We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Obtain a paper copy of the Notice on request. You may ask for a copy of our current Notice at any time. Even if you agreed to receive the Notice electronically, you are still entitled to a paper copy.

Inspect and obtain a copy of PHI. You have the right to access and copy most of the PHI that we maintain about you. To inspect or copy your PHI, you must give us a written request. We may deny your request to inspect and copy in certain limited circumstances. If we deny your request, we will notify you of the denial in writing and will explain the basis for our denial. You may ask that the denial be reviewed.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by giving us a written request describing the restriction you seek and to whom it applies. We are not required to agree to those restrictions and cannot agree to restrictions on uses or disclosures that are legally required or which are necessary to administer our business. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Request communications of PHI by alternative means or at alternative locations. You may ask us to contact you at a different residence or post office box. To request confidential communication of your PHI, you must give us a written request telling us how or where you would like to be contacted. We will accommodate all reasonable requests. As permitted by HIPAA, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Request an amendment of PHI. If you believe that PHI we maintain about you is incomplete or incorrect, you may ask us to amend it. To request an amendment, you must give us a written request that includes the reason for your request and any supporting documents, if applicable. We will give all requests careful consideration, but in certain cases, we may deny your request for amendment. If we make the amendment you request, we also may notify those who work with us and have copies of the uncorrected record, if we believe such notification is necessary. If we deny your request, we will notify you of the denial in writing and will explain the basis for our denial. You have the right to file a statement of disagreement with us and we have the right to rebut that statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we make of your PHI after April 14, 2003, for most purposes other than treatment, payment or health care operations or disclosures that you or your personal representative authorized. The right to receive an accounting is subject to certain exceptions, restrictions and limitations. To request an accounting, you must submit a written request specifying the time period. The time period may not be longer than six years and may not include dates before April 14, 2003.

Minors. If you are a minor who has lawfully provided consent for treatment and you wish for us to treat you as an adult for purposes of access to and disclosure of records related to such treatment, please notify one of the staff members or the Privacy Officer.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with us by calling us or by sending your written complaint to our Privacy Officer at the address given below. You may also file a complaint with the U.S. Department of Health and Human Services – Office for Civil Rights. We will not retaliate against you for filing a complaint.

Contacting Us

To obtain forms for submitting written requests, receive additional information about The Midwest Center for Reproductive Health, P.A.'s privacy practices or file a complaint, you may contact our Privacy Officer at The Midwest Center for Reproductive Health, P.A., Attn: Privacy Officer, 12000 Elm Creek Boulevard North, Suite 350, Maple Grove, MN 55369. You may also call us at (763) 494-7700.

Effective Date

This Notice is effective as of June 25, 2003.



**THE MIDWEST CENTER FOR
REPRODUCTIVE HEALTH, P.A.**

Arbor Lakes Medical Building, Suite 350
12000 Elm Creek Blvd North
Maple Grove, MN 55369

Phone 763.494.7700
Toll Free 800.508.9763
Fax 763.494.7706
Web Site www.mcrh.com

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

Patient Name (print) _____ Birth Date _____

Former Name (if any) _____ Telephone _____

Spouse/Partner Name (print) _____

RELEASE INFORMATION FROM (Medical Facility):

Facility: _____

Address: _____

City, State, Zip _____

Phone: _____

Fax: _____

RELEASE INFORMATION TO:

The Midwest Center for Reproductive Health

Attn: Peggy Knoll

1000 East Rosser

Bismarck, ND 58501

Phone: (701) 530-6074 Fax: (701) 530-6028

I hereby authorize the above party to release the following medical information from (date) _____ to _____.
Date last seen in your office _____.

This information should be including but not limited to the following records:

FEMALE

- Operative Reports
- HSG Reports and Films
- Flow sheet from ovulation induction and superovulation cycles
- Biopsy Reports
- Post Coital Results
- Hormonal Studies (LH, FSH, TSH, Prolactin, and DHEAS)
- Current Pap
- Antisperm Antibody Results
- Rubella

MALE

- Semen Analysis Results
- Antisperm Antibody Results
- Urology - Operative Reports

OTHER

- Any other records pertaining to the specific problem you are coming in to see the physician for.

* If applicable: If there is documentation pertaining to alcoholism/drug abuse, mental health/rehabilitation, HIV/AIDS, do you wish for this information to be released? Yes____ No____

I (we) understand that I (we) may revoke this consent at any time with written notification, but that the revocation will not have any affect on the information released prior to notification of cancellation. Further, I (we) realize that the above mentioned facility cannot prevent the re-disclosure of records released as a result of this request; therefore, released from any and all liability resulting from re-disclosure.

PATIENT SIGNATURE

DATE

SPOUSE / PARTNER / GUARDIAN SIGNATURE

(circle appropriate relationship)

DATE

Here is a mailing label to send your New Patient Forms and Release of Information to Mid Dakota Clinic prior to your new patient appointment.

Midwest Center for Reproductive Health
c/o Mid Dakota Clinic
Attn: Peggy Knoll
1000 East Rosser
Bismarck, ND 58507