



## Patient Guide

The Midwest Center for Reproductive Health, P.A. (MCRH) and Oakdale Ob/Gyn, P.A. have teamed up to provide you a broader spectrum of personalized care. Please accept our warmest welcome to you from the staff at MCRH and Oakdale Ob/Gyn. We understand the struggles 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 Oakdale Ob/Gyn and 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 by us **one week** before your appointment. Please feel free to return your completed forms by mail or fax to (763) 494-7706. 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 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 our staff 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 in our 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 us 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. If your new patient consultation is done via phone, the records will be mailed back to you.

You should also expect a telephone call from one of the our 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 with Dr. Corfman. In order to give you both the opportunity to meet him and other members of the MCRH and Oakdale Ob/Gyn 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.**

### **Office Locations:**

Oakdale Ob/Gyn REI has two locations to better serve you: one is located in the Arbor Lakes Medical Building in Maple Grove and the other clinic is located in the North Memorial Medical Center in Maple Grove. If you have any questions regarding directions, please call the front desk at: (763) 494-7700 or (800) 508-9763 and select option 1.

### **Cancellation Policy:**

While we regret the need to do this, our policy allows us to better serve all of our patients who may be waiting for an appointment time. If you are unable to keep your scheduled appointment, please call to inform us 72 hours prior to the scheduled appointment. If you fail to cancel your appointment, you may be subject to a \$75.00 failed appointment fee.

### **Billing and Insurance Policies and Questions:**

Along with personalized care, the partnership between MCRH and Oakdale Ob/Gyn offers a wider range of insurance coverage. Your first appointment, regardless of location, will be billed through Oakdale Ob/Gyn. Should Dr. Corfman outline inseminations, surgical procedures, and additional testing for your treatment plan, those appointments will be billed through Oakdale Ob/Gyn. If your treatment option is IVF, donor eggs, donor sperm, or donor embryos, those appointments are billed through MCRH. During your IUI treatment cycle, some laboratory testing may be billed through MCRH as a reference lab if Oakdale Ob/Gyn cannot perform the prepping or testing of specimens.

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

Understanding your medical insurance coverage and your benefits for infertility treatment can be confusing and time consuming. The MCRH and Oakdale Ob/Gyn 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.

**If you have questions or concerns regarding fees or insurance coverage, please contact the Oakdale Ob/Gyn Business Office by calling (763) 587-7000.** 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 MCRH Information

### 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 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 MCRH, 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.

# 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., and Oakdale Ob/Gyn, P.A. are 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 payer to determine whether it will pay for your treatment and the amount of your co-payment. We will bill you or a third-party payer 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 and Oakdale Ob/Gyn, P.A.'s privacy practices or file a complaint, you may contact our Privacy Officer at Oakdale Ob/Gyn, P.A. Attn: Privacy Officer, 9825 Hospital Drive, Suite 205, Maple Grove, MN 55369. You may also call us at (763) 587-7050.

### **Effective Date**

This Notice is effective as of September 23, 2009.



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 providing any medical services.**

\_\_\_\_\_      \_\_\_\_\_  
Patient      Spouse/  
Initial      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      Spouse/  
Initial      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      Spouse/  
Initial      Partner  
                  Initial

**RELEASE OF MEDICAL RECORDS.** I hereby authorize MCRH and Oakdale Ob/Gyn to release to myself, spouse/partner, my referring physician, insurance company, physicians referred by MCRH and/or Oakdale Ob/Gyn, 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 Oakdale Ob/Gyn and 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      Spouse/  
Initial      Partner  
                  Initial

**NOTICE OF PRIVACY PRACTICES.** I acknowledge the receipt of the Notice of Privacy Practices effective September 23, 2009 as it pertains to my medical records in conjunction between MCRH and Oakdale Ob/Gyn

\_\_\_\_\_      \_\_\_\_\_  
Patient      Spouse/  
Initial      Partner  
                  Initial

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

\_\_\_\_\_      \_\_\_\_\_  
Patient      Spouse/  
Initial      Partner  
                  Initial

**PAYMENT/INSURANCE CONSENT.** I acknowledge responsibility for payment for services rendered to me at MCRH **not being billed through Oakdale Ob/Gyn** and/or not covered by my insurance. 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 and/or Oakdale Ob/Gyn.

Patient Legal Name Printed \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse/Partner Legal Name Printed \_\_\_\_\_

Spouse/Partner Signature \_\_\_\_\_ Date \_\_\_\_\_

**OAKDALE OBGYN, P.A. CREDIT POLICY**

In an effort to create understanding, we request that you carefully read and sign the financial terms that are the policy of Oakdale Obstetrics & Gynecology, P.A.

It is the policy of Oakdale Ob/Gyn, P.A. that all monthly statements are to be paid in full upon receipt, unless our business office has authorized prior arrangements.

Oakdale Ob/Gyn, P.A. processes some of our labs through North Memorial Reference Lab. You may receive a bill from North Memorial Reference Lab for some of the lab work you have done during your visit.

Our clinic has participating contracts with several health insurance payers. If you have insurance coverage, your insurance policy will pay for services at the level of benefit you have purchased. Our business office staff will be happy to assist you if you have any questions about Oakdale Ob/Gyn's billing procedures. We do not, however, have answers to your specific insurance policy questions. Therefore, we strongly urge you to contact your insurance company with any questions regarding your medical coverage.

Patients with commercial insurance (any insurance with whom we do **not have** a contract) are required to make payments regardless of any anticipated insurance reimbursement. Because we do not contract with some insurance companies, they are not obligated to make direct payment to our office. If both patient and insurance company make payment to us, we will notify you of any refund credit balance owed to the patient.

**Infertility Patients:** It is the patient responsibility to make sure they have subsequent authorizations prior to initiating treatment. Any services not authorized by the insurance company will be denied and become the patient's financial responsibility. Please note that prior authorization does not guarantee benefit payment. Please contact your insurance company for verification of benefits. All past due accounts must be paid in full prior to starting a new cycle.

**Accounts with a balance over 30 days old will be assessed an 7.92% compounded annual finance charge.** It is important to note that any balance over 60 days old may be placed with a collection agency and/or Credit Bureau. Therefore, if for any reason you are unable to settle your account within 30 days of the statement date, it is imperative that you contact our business office immediately. Do not assume that your insurance company will cover any statement you receive. Call to correct any billing errors promptly. If you ignore our billing statements, we can only assume that you do not intend to pay for the medical services that were provided in good faith.

If it becomes necessary to effect collection with an outside collection agency, you will be charged the total amount of the collection fees, attorney fees, and allowable court fees. This action may also negatively affect your credit rating.

If you are unable to keep your scheduled appointment, please call to inform us prior to the appointment. If you fail to cancel your appointment, you may be subject to a \$75.00 failed appointment fee.

Oakdale Ob/Gyn, P.A. will assess a \$45.00 dollar fee for all checks that are returned with non-sufficient funds.

Please allow us to utilize our knowledge of billing and medical insurance to assist you in getting reimbursed. Please direct all business-related concerns to (763) 587-7035. WE ARE HERE TO HELP YOU!

**All Infertility Patients are required to initial the following:**

\_\_\_\_\_ I am receiving treatment for infertility services. I understand that it is my responsibility to verify coverage and benefits with my insurance company prior to my appointment. I acknowledge and accept responsibility for all charges denied, identified as patient responsibility, or not covered by my insurance company.

**All Other Patients (non-infertility) are required to check one of the following:**

- A. \_\_\_\_\_ I have coverage by a participating insurance plan and will pay all of my co-payments at the time of service and all other charges not covered by my policy when they are billed.
- B. \_\_\_\_\_ I am covered by a commercial insurance plan and will pay for services in full as billed. I understand that I am required to make a \$100 prepayment to be applied to my charges at my first clinic visit each year. For any clinical/surgical procedures performed, I agree to prepay 20% of the estimated charges at least ten business days prior to the procedure/surgery.
- C. \_\_\_\_\_ I WILL PAY AT THE TIME OF SERVICE. This will require a prepayment of \$200 prior to your office visit and the balance will be charged at the end of your office visit. The charges collected on the day of your office visit will only be an estimate of your charges and will be reviewed by our coder for actual charges. A statement with any additional balance due will be sent to you. For any clinic/surgical procedures performed, I agree to pay to Oakdale Ob/Gyn, P.A., 100% of the estimated physician charges at least ten business days prior to the procedure or surgery. Any additional charges will be paid within 30 days of the procedure.

I HAVE READ AND UNDERSTAND THE CREDIT POLICY DESCRIBED ABOVE AND AGREE TO ABIDE BY ITS TERMS.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
ACCT #



**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 <sup>th</sup>					___ 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: \_\_\_\_\_





**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"/> Gonorrhea                |
| <input type="checkbox"/> Visual Disturbance      | <input type="checkbox"/> Kidney Infection             | <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





**Authorization to Communicate Protected Health Information**

I understand that my healthcare information at Oakdale Obstetrics and Gynecology, P.A. (Oakdale) and The Midwest Center for Reproductive Health, P.A. (MCRH), is protected and I was given the opportunity to read and receive a copy of Oakdale's Notice of Privacy Practices.

The name(s) listed below are family members or friends to whom I wish to grant access to healthcare information. I will rely on the professional judgment of my provider and my provider's clinical staff to share such healthcare information, as they deem necessary.

I understand that information is limited to verbal discussion of clinical concerns and/or diagnoses with clinical staff and that no paper copies of my protected healthcare information will be provided without my signature on a Patient Authorization and Request for Use and Disclosure of Protected Health Information form.

I understand that some information is considered sensitive. I understand that I must check the specific boxes in order for my provider's clinical staff to release any sensitive information such as:

- Mental Health/Psychiatric Disorders (including depression)
- Chemical Dependency (drug and or alcohol abuse/treatment)
- HIV/AIDS Virus
- Sexually Transmitted Diseases

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it in writing at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Please Print

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse/Partner Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**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):**

**RELEASE INFORMATION TO:**

Facility: \_\_\_\_\_

Oakdale Ob/Gyn REI/MCRH

Address: \_\_\_\_\_

12000 Elm Creek Blvd N, Suite 350

City, State, Zip \_\_\_\_\_

Maple Grove, MN 55369

Phone: \_\_\_\_\_

Phone: (763) 494-7700 Fax: (763) 494-7706

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 Oakdale Ob/Gyn and MCRH prior to your new patient appointment.**

Oakdale Ob/Gyn REI/MCRH  
12000 Elm Creek Blvd N, Suite 350  
Maple Grove, MN 55369