



THE MIDWEST CENTER FOR
REPRODUCTIVE HEALTH, P.A.

MCRH Alpha Medical, P.A.

Great Planes Reproductive Center, 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

Patient Guide

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 yourself with MCRH and prepare 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 office 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 Services – Carefully read this form and complete the signatures at the end 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) sign, and date this form.

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.

Patient Authorization for Disclosure of Protected Health Information (PHI) – 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 protected health information/medical records, enclosed is a “**Patient Authorization for Disclosure of Protected Health Information**” form for you to return directly to your physician. If you and/or your spouse or 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 PHI/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.

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.



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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 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 Location:

Our office is located in Maple Grove, MN. Please see the map on our website for specific location. There are also many additional satellite locations in other areas as well. Please see the "View Our Locations" tab in the upper right corner of our website for alternate locations. 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:

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 on our website under getting started.

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 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.

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.**



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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 for patients when indicated by MD.

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 weekend phone calls:

- **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** and you feel that you require emergency medical assistance please seek medical care at your nearest ER/Urgent Care facility. Please contact our MCRH on-call nurse by dialing the nurse **pager** (612) 613-2579. You will hear a series of quick beeps, enter your 10 digit call back phone number where you can be reached. If you do not receive a call back within 15 minutes, please call (612) 232-6901 for assistance.

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 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, intrauterine insemination (IUI) preparation, testicular biopsy 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 9:30 a.m. - 1:00 p.m. Monday through Thursday and 9:30 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.

Patient Authorization for Disclosure of Protected Health Information (PHI) Release Policy:

- If you would like to receive a copy of your PHI/medical records after becoming a patient of ours, please call (763) 494-7700 or (800) 508-9763. An MCRH "Patient Authorization for Disclosure of Protected Health Information" is required and must be signed by both patient and spouse/partner if applicable.



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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.



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MCRH Notice of Privacy Practices - Patient

Form 7.20

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule-Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.



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You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the end of this document.

How We May Use or Disclose Protected Health Information-Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office. We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints-You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at: The Midwest Center for Reproductive Health P.A., 12000 Elm Creek Blvd N Suite 350, Maple Grove, MN 55369

Effective Date 6/20/18



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PATIENT REGISTRATION RECORD / CONSENT FOR SERVICES

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

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

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 (____) _____ - _____ 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 _____

Insurance Company Phone Number (on back of card) _____

Do you have secondary insurance? Y / N Policy Information: _____

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

SPOUSE/PARTNER INFORMATION (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 _____ - _____ - _____

Phone (____) _____ - _____ Choose one: Home Cell Voicemail Y / N

Employer _____

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 _____

Do you have secondary insurance? Y / N Policy Information: _____

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

*Please fill in spouse/partner insurance information. Most policies do not have the same ID numbers for policy holder and spouse/partner.

EMERGENCY CONTACT

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

Address _____ Phone (____) _____ - _____



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CONSENT FOR SERVICES

The following information must be **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 (MCRH) and its subsidiaries providing any medical services.**

- **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.
- **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 Blood borne 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.
- **NOTICE OF PRIVACY PRACTICES.** I acknowledge the receipt of the current Notice of Privacy Practices.
- **MEANS OF COMMUNICATING.** I authorize the practice to disclose or provide Protected Health Information (PHI) about my/our treatment directly to me at the address, home phone, work phone and/or cell phone number that I/we have indicated on my Patient Registration and Consent for Services form. I understand that it is my responsibility to notify the practice of any change in this manner of communication. I understand that the practice has no control regarding persons who may have access to the mailing address and listed numbers I have designated to receive my PHI.
- **SECURE COMMUNICATIONS.** By selecting the method(s) of delivery of my PHI by mail, e-mail or fax I understand and accept that my information may be compromised during transmission to, or from MCRH. Therefore, I understand that my disclosed PHI will no longer be the responsibility of the practice.
- **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. I understand MCRH requires my Social Security Number to use as my unique identifier throughout my care.
- **RELEASE OF PERSONAL PROPERTY RESPONSIBILITY.** I understand that MCRH is not responsible for the loss of valuables and assumes no responsibility for any losses.
- **EMERGENCY PLAN.** I understand that in the rare event of an emergency, (fire, flood, power outage, terrorist attack) or natural disaster, (snow storm, tornado, earthquake) MCRH's primary objective is to provide for the safety of the patients and program personnel, fresh and cryopreserved human tissues, and critical equipment and records. If there is compromise or destruction of fresh or cryopreserved tissue (sperm, embryos or oocytes) or if tissue is moved to an alternate location, notification will be made to patients by MCRH staff. MCRH will make efforts to maintain the cryopreserved state of the tissue but will not be held responsible for the loss of tissue viability due to such emergencies or natural disasters. If treatment is interrupted due to these unforeseen events, I may be advised/guided to transfer continued treatment to another facility or discontinue treatment for that cycle. I will keep my individual treatment plans provided by MCRH accessible should it be needed for reference. I am aware that MCRH has established protocols with Emergency Community Services (Police and Fire Departments) to provide additional assistance. Patients may also contact the Society for Reproductive Technology (SART) at <http://www.sart.org> or by phone (205) 978-5000 ext.109 for additional treatment location options.



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CONSENT FOR SERVICES continued

- **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. **Claims will be submitted under the company/facility name and not the physician.** 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.
- **MCRH BILLING ENTITIES/LOCATIONS-** The Midwest Center for Reproductive Health consists of three separate entities:
 - 1. MCRH Alpha Medical, P.A. (Alpha)** - Alpha provides services for consultations, diagnostic and IUI treatment and is currently a participating provider with some of the major insurance companies.
 - 2. The Midwest Center for Reproductive Health, P.A. (MCRH)**-MCRH provides services for all IVF/ART procedures and for out-of-network general infertility patients. MCRH is out-of-network with all insurance companies.
 - 3. Great Planes Reproductive Centers, P.A. (GPRC)**- GPRC provides consultation services for those received at our MCRH satellite clinics and is a participating provider with some of the major insurance companies.

I acknowledge that while being seen at any location other than Maple Grove, Dr. Corfman may not be a provider in my insurance network at that facility. Billing will be through GPRC for visits at a satellite location. Management fees, education and phone appointments will be billed through **MCRH or MCRH Alpha.**

BOTH PATIENT AND SPOUSE/PARTNER SIGNATURES ARE REQUIRED

I acknowledge that signing below indicates that I have read, understand and accept the content and directions in this "Consent for Services Document".

Patient Legal Name Printed _____

Patient Signature _____ Date _____

Spouse/Partner Legal Name Printed _____

Spouse/Partner Signature _____ Date _____



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Patient Authorization for Disclosure of Protected Health Information (PHI)

The Patient Authorization for Disclosure of Protected Health Information (PHI) Form will give our office the authority to provide the person or entity you and your spouse/partner (if applicable) designate on the form with access to your protected health information (PHI). The Patient Authorization is limited to accessing only the information that you and your spouse/partner (if applicable) designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your joint health information to a person or entity that may be involved in your healthcare. Due to the nature of treatment received at MCRH and its subsidiaries, records for patient and spouse/partner will be maintained jointly and this Authorization pertains to all medical records regarding patient and spouse/partner (if applicable).

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Directions for Completion of: Patient Authorization for Disclosure of Protected Health Information (PHI) Form

Patient Information: Please complete the entire section with patient demographic information.

Clinic/Health Provider: This identifies who is to provide the release of your Protected Health Information.

Receiving Party: This information identifies a person or entity you and your spouse/partner (if applicable) have authorized the Provider to release your PHI.

Description of Information to be Disclosed: The type and amount of health information that we disclose is determined by you and your spouse/partner (if applicable). MCRH can disclose or provide access to all of your health information or it can be limited to a specific item.

Release Type: This information tells us how you would like your PHI transmitted to a person or entity. Please see our Authorization for Release of Protected Health Information (PHI) Form for more information. If you wish to view your records, please contact MCRH at 800-508-9763 to schedule a medical record review appointment.

Release Purpose: The purpose of the release of PHI is required to be documented by MCRH.

Termination or Expiration: The Authorization will expire 12 months from your dated signature below, unless you specify an earlier termination. You must renew or submit a new Authorization after the expiration date to continue the Authorization. Please list the date of expiration if earlier than that date. You have the right to terminate the Authorization at any time by submitting a written request to our Privacy Manager. Termination of this Authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. MCRH may require a signed Authorization on disclosures.

Redisclosure Statement: The practice places no condition to sign the Authorization on the delivery of healthcare or treatment. MCRH has no control over the entity/person(s) you have listed to receive your PHI. Therefore, your PHI disclosure under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Secure Communication: By selecting the method(s) of delivery of your PHI, (mail, e-mail or fax) you understand and accept that information may be compromised during transmission to, or from MCRH.

Signature and Date: Because your medical records are kept jointly at MCRH, both patient and spouse/partner (if applicable) will need to sign and date the Authorization. PHI on both parties will be released unless indicated under Information to be released.

Copies: We will provide you with a copy of this signed authorization upon request.

The Midwest Center for Reproductive Health, P.A. and its subsidiaries MCRH Alpha, P.A, and Great Planes Reproductive Centers, P.A.

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
CLINIC/HOSPITAL/ HEALTH CARE PROVIDER <i>(Who has the information you want released?)</i>	<input type="checkbox"/> Midwest Center for Reproductive Health, P.A. and its subsidiaries Name: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
RECEIVING PARTY <i>(Where do you want to information sent or who may have a copy of your PHI per your request?)</i>	<input type="checkbox"/> Midwest Center for Reproductive Health, P.A. <u>OR</u> <input type="checkbox"/> SELF 12000 Elm Creek Blvd N, Suite 350, Maple Grove, MN 55369 Ph.: 800-508-9763 Fax: 763-494-7766 <u>OR</u> Name: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
INFORMATION TO BE RELEASED <i>(What do you want sent or released? Check the applicable box)</i>	___ Records checked below ___ Billing information FEMALE: <input type="checkbox"/> Operative report(s)/Biopsy reports <input type="checkbox"/> Current pap <input type="checkbox"/> Flow sheet from ovulation cycles <input type="checkbox"/> HSG/Sono reports and films <input type="checkbox"/> Post coital results <input type="checkbox"/> Info from IVF cycles clinical / lab <input type="checkbox"/> Blood tests including infectious disease <input type="checkbox"/> Rubella Other _____ MALE: <input type="checkbox"/> Semen analysis results <input type="checkbox"/> Urology-Operative reports Other _____
RELEASE INSTRUCTIONS <i>(How and when do you want the information?)</i>	Date Information is Needed: _____ <i>**please allow 7-10 business days for processing</i> <i>**please review policy for details</i> Release Method/Format Request: (Check ONE) <input type="checkbox"/> Paper <input type="checkbox"/> E-mail (encrypted) <input type="checkbox"/> Fax <input type="checkbox"/> View my records
PURPOSE OF RELEASE <i>(Why this is needed?)</i>	<input type="checkbox"/> Continuing care <input type="checkbox"/> Transfer of care <input type="checkbox"/> Insurance application <input type="checkbox"/> Personal use or review <input type="checkbox"/> Insurance payment/claim <input type="checkbox"/> Litigation/Legal <input type="checkbox"/> Other: _____
<ul style="list-style-type: none"> This Authorization will expire 12 months from your dated signature below, unless you specify an earlier termination. You must renew or submit a new Authorization after the expiration date to continue the Authorization. Please list the date of expiration if earlier than 12 months from the dated signature below. _____ You have the right to terminate this Authorization at any time by submitting a written request to our Privacy Manager. Termination of this Authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. The practice places no condition to sign this Authorization on the delivery of healthcare or treatment. MCRH has no control over the entity/person(s) you have listed to receive your protected health information or the potential of compromised transmission of information. Therefore, your PHI disclosure under this Authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. Your signature indicates your authorization to disclose your PHI as described above. 	

BOTH SIGNATURES ARE REQUIRED

PATIENT NAME _____ PATIENT SIGNATURE _____ Date _____
 (Printed)

SPOUSE/ PARTNER NAME _____ SPOUSE/ PARTNER SIGNATURE _____ Date _____
 (Printed)

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 | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Gall Bladder Disease/Surgery | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> Lupus Erythematosus |

Cardiovascular History

- Bleeding Disorder
- Blood Clots
- High Blood Pressure
- History of Heart Disease
- Heart Murmur
- Antibiotics needed for dental/surgical procedure

Allergies

- General Allergies If yes, list: _____
- Drug Allergies If yes, list: _____
- Latex Allergy
- Iodine Allergy
- Egg Allergy

Prescribed Medications:

- Past Year If yes, list: _____
- Current If yes, list: _____

Over-the-Counter Medications:

- Current If yes, list: _____
- Homeopathic/Herbal If yes, list: _____

Current Use of the Following:

- Alcohol If yes, type: _____ amount per week: _____
- Smoking If yes, number of packs per day _____
- Recreational Drugs 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 Transgender

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)		Date baby born	Vaginal delivery or C-section?	Any physical or cognitive genetic disorders? Any Complications?	Male or female	Is current partner the father?
				Elective Abortion? Miscarriage? Ectopic? Pre-term Delivery? Full-term Delivery? Stillborn?	___ wks					
1st					___ wks					
2nd					___ wks					
3rd					___ wks					
4th					___ wks					
5 th					___ wks					

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?

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

VI. INFERTILITY HISTORY/TREATMENT

Have you been treated for infertility before?

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)

- | | | |
|---|-------------|----------------|
| <input type="checkbox"/> Anticardiolipin Antibody | When? _____ | Results: _____ |
| <input type="checkbox"/> Lupus Anticoagulant | When? _____ | Results: _____ |
| <input type="checkbox"/> Anti-Chlamydial Antibody | When? _____ | Results: _____ |

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

- | | |
|---|-------------|
| <input type="checkbox"/> Appendectomy | Date: _____ |
| <input type="checkbox"/> Cervical Conization or Cautery | Date: _____ |
| <input type="checkbox"/> C-Section | Date: _____ |
| <input type="checkbox"/> D & C | Date: _____ |
| <input type="checkbox"/> Hysteroscopy | Date: _____ |
| <input type="checkbox"/> Laparoscopy | Date: _____ |
| <input type="checkbox"/> Laparotomy | Date: _____ |
| <input type="checkbox"/> Tubal Ligation | Date: _____ |
| <input type="checkbox"/> Tubal Reversal | Date: _____ |
| <input type="checkbox"/> Other _____ | 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
Number of Fresh Cycles: _____ Number of Frozen Cycles: _____

Facility/location where treatment occurred _____

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 |
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| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Gall Bladder Disease/Surgery | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> Lupus Erythematosus |

Cardiovascular History

- Bleeding Disorder
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- Heart Murmur
- Antibiotics needed for dental/surgical procedure

Allergies

- General Allergies
 - Drug Allergies
 - Latex Allergy
 - Iodine Allergy
 - Egg Allergy
- If yes, list: _____
If yes, list: _____

Prescribed Medications:

- Past Year
 - Current
- If yes, list: _____
If yes, list: _____

Over-the-Counter Medications:

- Current
 - Homeopathic/Herbal
- If yes, list: _____
If yes, list: _____

Current Use of the Following:

- Alcohol
 - Smoking
 - Recreational Drugs
- If yes, type: _____ amount per week: _____
If yes, number of packs per day _____
If yes, type: _____ frequency: _____

III. CONTRACEPTIVE/SEXUAL HISTORY

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

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- 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 Transgender

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)		Date baby born	Vaginal delivery or C-section?	Any physical or cognitive genetic disorders? Any Complications?	Male or female	Is current partner the father?
				Elective Abortion? Miscarriage? Ectopic? Pre-term Delivery? Full-term Delivery? Stillborn?						
1st					___ wks					
2nd					___ wks					
3rd					___ wks					
4th					___ wks					
5 th					___ wks					

V. FAMILY HISTORY

Is there a family history of cancer/malignancy

- Ovarian Yes No whom: _____
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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?

- 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?

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)

- | | | |
|---|-------------|----------------|
| <input type="checkbox"/> Anticardiolipin Antibody | When? _____ | Results: _____ |
| <input type="checkbox"/> Lupus Anticoagulant | When? _____ | Results: _____ |
| <input type="checkbox"/> Anti-Chlamydial Antibody | When? _____ | Results: _____ |

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

- | | |
|---|-------------|
| <input type="checkbox"/> Appendectomy | Date: _____ |
| <input type="checkbox"/> Cervical Conization or Cautery | Date: _____ |
| <input type="checkbox"/> C-Section | Date: _____ |
| <input type="checkbox"/> D & C | Date: _____ |
| <input type="checkbox"/> Hysteroscopy | Date: _____ |
| <input type="checkbox"/> Laparoscopy | Date: _____ |
| <input type="checkbox"/> Laparotomy | Date: _____ |
| <input type="checkbox"/> Tubal Ligation | Date: _____ |
| <input type="checkbox"/> Tubal Reversal | Date: _____ |
| <input type="checkbox"/> Other _____ | 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
Number of Fresh Cycles: _____ Number of Frozen Cycles: _____

Facility/location where treatment occurred _____

Please save this file to your computer, then e-mail using the secure e-mail available on our website.

OR

Use this mailing label to send your New Patient Forms and Release of Information to MCRH 1 week prior to your new patient appointment.

**Midwest Center for Reproductive Health
12000 Elm Creek Blvd N, Suite 350
Maple Grove, MN 55369**