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

Reproductive Health and Fertility Center
Essentia Health – Duluth
Patient Guide for Consultative Services

Thank you for choosing The Reproductive Health Fertility Center at Essentia Health – Duluth Clinic. Our goal is to provide you with an individualized treatment plan based on your unique needs. We recognize that pursuing treatment for fertility can be physically and emotionally challenging. It is our sincere desire to ease your way in all aspects of this process. The information provided here is a guide to help familiarize you with our Center and prepare you for what to expect before, during and beyond your consultative visit(s).

We are pleased to have Dr. Randle Corfman available onsite at the **Essentia Health – Duluth for consultation regarding reproductive care**. Dr. Corfman is a Reproductive Endocrinologist. He is board certified in Obstetrics and Gynecology and completed a two-year fellowship in Reproductive Endocrinology and Infertility at Yale University. Dr. Corfman is the founder and Medical Director of The Midwest Center for Reproductive Health, P.A. (MCRH) in Maple Grove, Minnesota.

Your consultation meeting with Dr. Corfman is scheduled:

Date:_____ **Time:** _____ The Obstetrics and Gynecology Departments is located on the third floor of Essentia Health – Duluth Clinic First Street Building. **Please check in** with registration on the third floor 15 minutes prior to your scheduled appointment time.

Before Your Appointment:
To ensure your consultative appointment is most beneficial to you (and your partner), we begin by asking that the following forms be thoroughly completed and received at the Maple Grove location a minimum of 10 days before your appointment. Please feel free to return your completed forms by mail, using the enclosed address label or you may 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 coy 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 prior to sending to MCRH in Maple Grove. As a consultant to Essential Health, Dr. Corfman asks that you carefully read and complete this form so that you are registered as a patient in his office as well as Essentia Health. **Essentia Health – Duluth will handle all scheduling, care coordination and billing for all your reproductive care while you are being seen here.**

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 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

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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.

Remember that we ask for these forms to be sent to MCRH in Maple Grove at least 10 days prior to your appointment. If not received by this time, we may need to cancel and reschedule your appointment.

What to expect at your consultation visit:
In order to give you and your spouse/partner the opportunity to meet the physician and other members of the Reproductive Health and Fertility Center team, we strongly recommend you both attend the consultation visit. During this appointment you will have the opportunity to have a dialogue with your consulting physician, review previous tests and treatment, and discuss option for further treatment. Generally, this appointment is 30-40 minutes in length. However, your appointment may be longer depending on your unique requirements.

If you decide that you would like to proceed with a treatment plan that is outlines for you, Dr. Corfman will work with our Reproductive Health and Fertility Center team to coordinate and manage your treatment. Some treatment, specifically, In Vitro Fertilization is not available at Essentia Health – Duluth. We will continually keep you informed of your options. Specialists from the billing office are also available to outline financial options and to answer any billing and/or insurance questions you may have.

Office Location:
Our office is located in the Essentia Health - Duluth First Street Building at 420 East First Street. Parking is most convenient in the Second Street Essentia Health – Miller Dawn ramp. If you need to cancel or reschedule your appointment please call (218)786-3282 as soon as possible.

Thank you for choosing the Essentia Health – Duluth Reproductive Health and Fertility Center. We look forward to seeing you at your appointment. Please don't hesitate to call with questions or concerns, or how to find our location.

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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 *(**Who** has the information you want released?)*	☐ Midwest Center for Reproductive Health, P.A. and its subsidiaries **Name:**_____ **Address:**_____ **Day Phone:** _____ **City:**_____ **State:**_____ **Zip:** _____
RECEIVING PARTY *(**Where** do you want to information sent or who may have a copy of your PHI per your request?)*	☐ Midwest Center for Reproductive Health, P.A. *OR* ☐ SELF 12000 Elm Creek Blvd N, Suite 350, Maple Grove, MN 55369 Ph.: 800-508-9763 Fax: 763-494-7766 *OR* **Name:**_____ **Address:**_____ **Day Phone:** _ **City:**_____ **State:**_____ **Zip:** _____
INFORMATION TO BE RELEASED (***What** do you want sent or released? Check the applicable box)*	___Records checked below ____ Billing information **FEMALE:** ☐ Operative report(s)/Biopsy reports ☐ Current pap ☐Flow sheet from ovulation cycles ☐ HSG/Sono reports and films ☐ Post coital results ☐ Info from IVF cycles clinical / lab ☐ Blood tests including infectious disease ☐Rubella Other_____ **MALE:** ☐ Semen analysis results ☐ Urology-Operative reports Other _____
RELEASE INSTRUCTIONS (**How** and **when** do you want the information?)	Date Information is Needed:_____ ***please allow 7-10 business days for processing* ***please review policy for details* Release Method/Format Request: (Check **ONE**) ☐ Paper ☐ E-mail (encrypted) ☐ Fax ☐ View my records
PURPOSE OF RELEASE *(**Why** this is needed?)*	☐ Continuing care ☐ Transfer of care ☐ Insurance application ☐ Personal use or review ☐ Insurance payment/claim ☐ Litigation/Legal ☐ Other:_____

- 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 _____ **(Printed)** **SPOUSE/ PARTNER SIGNATURE** _____ **Date**_____

THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.

Female History Form

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

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Duration of Relationship _____ Duration of attempting pregnancy_____

Nature of present employment (title, brief description) _____

II. MEDICAL HISTORY

Height _____ Weight _____

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

- ☐ Chronic Headaches
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Loss of Balance
- ☐ Neurological Problem
- ☐ Poor Sense of Smell
- ☐ Seizures
- ☐ Visual Disturbance
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Cancer Specify: _____
- ☐ Hirsutism (excessive hair growth)
- ☐ Thyroid Disease/Surgery
- ☐ Appendicitis
- ☐ Colitis
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Gall Bladder Disease/Surgery
- ☐ Hepatitis
- ☐ Liver Problems
- ☐ Breast Discharge
- ☐ Chlamydia
- ☐ Endometriosis
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Ovarian-Cysts
- ☐ PCOS
- ☐ Pelvic Infection
- ☐ Syphilis
- ☐ HIV/AIDS
- ☐ Kidney Infection
- ☐ Arthritis
- ☐ 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) Elective Abortion? Miscarriage? Ectopic? Pre-term Delivery? Full-term Delivery? Stillborn?		Date baby born	Vaginal delivery or C-section?	Any physical or cognitive genetic disorders? Any Complications?	Male or female	Is current partner the father?
1st					__ wks					
2nd					__ wks					
3rd					__ wks					
4th					__ wks					
5th					__ 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 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:

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

<u>Immunology/Recurrent Pregnancy Loss Testing (if applicable)</u>

- ☐ Anticardiolipin Antibody When?_____ Results:_____
- ☐ Lupus Anticoagulant When?_____ Results:_____
- ☐ Anti-Chlamydial Antibody When?_____ Results:_____

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

- ☐ Appendectomy Date: _____
- ☐ Cervical Conization or Cautery Date: _____
- ☐ C-Section Date: _____
- ☐ D & C Date: _____
- ☐ Hysteroscopy Date: _____
- ☐ Laparoscopy Date: _____
- ☐ Laparotomy Date: _____
- ☐ Tubal Ligation Date: _____
- ☐ Tubal Reversal Date: _____
- ☐ Other _____ Date: _____

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

- ☐ Clomid Number of Cycles: _____
- ☐ Letrozole Number of Cycles: _____
- ☐ Superovulation Number of Cycles: _____
- ☐ Intrauterine Insemination (IUI)
  - ☐ Husband's Sperm Number of Cycles: _____
  - ☐ 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.

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):

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

Allergies

- ☐ General Allergies — If yes, list: _____
- ☐ Drug Allergies — If yes, list: _____

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:_____

Do you frequently use saunas, steam baths, or whirpools?

Have you had a high fever (over 102° F) during the past three to four months?

III. SEXUAL HISTORY

Have you ever tried to produce a child with another partner?

Have you produced a child with another partner?
If yes, how long did it take to produce the child? _____
When? _____

Do you have trouble getting an erection?

Do you have trouble maintaining an erection?

Do you have trouble with ejaculations?
If yes, ___ premature ejaculations ____ retrograde ejaculations

Do you feel that your ejaculate is deposited into the vagina?

Do you have any abnormal discharge from your penis?

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?

Have you had an injury or an abnormality of penis, testicles or prostate?
If yes, when? _____ Outcome/result _____

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

Has your partner ever conceived a child with someone other than yourself?

IV. FAMILY HISTORY

Is there a history of hormonal disorders in your family?
If yes, who and what type _____

Is there a family history of

- ☐ Cystic Fibrosis? If yes, whom: _____
- ☐ Tay Sachs Disease If yes, whom: _____
- ☐ Sickle Cell Anemia 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

V. INFERTILITY HISTORY/TREATMENT

Have you been treated for infertility before?
If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

Is your partner currently seeing a doctor for evaluation of infertility?
If yes, specify physician name and location _____

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

☐ Semen Analysis	When? _____	Results: _____
	When? _____	Results: _____
	When? _____	Results: _____
☐ Chlamydia Test	When? _____	Results: _____
☐ Mycoplasma Test	When? _____	Results: _____
☐ Antisperm Antibody Test	When? _____	Results: _____
☐ Hamster Egg Penetration Assay	When? _____	Results: _____
☐ Chromosome Test	When? _____	Results: _____
☐ Testicular Biopsy	When? _____	Results: _____
☐ X-ray or ultrasound of Testes	When? _____	Results: _____
☐ Hormonal Assays (FSH, LH, prolactin, Testosterone)	When? _____	Results: _____
☐ Thyroid Tests	When? _____	Results: _____
☐ Other - Specify _____	When? _____	Results: _____

Have you every had any of the following procedures or surgeries:

☐ Hernia Repair	Date: _____
☐ Varicocele Repair	Date: _____
☐ Vasectomy	Date: _____
☐ Vasectomy Reversal	Date: _____
☐ Other _____	Date: _____

What drugs have you taken for infertility? Check all that apply:

- ☐ Clomiphene Citrate (Serophene®, Clomid®)
- ☐ hMG (Pergonal®)
- ☐ Bromocriptine (Parlodel®)
- ☐ Testosterone or Male Hormone
- ☐ hCG (Profasi®, A.P.L.®)
- ☐ Urofollitropin or FSH (Metrodin®)
- ☐ Other - specify _____

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.

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