FERTILITY ASSOCIATES OF MEMPHIS, PLLC

80 Humphreys Center, Suite 307
Memphis, Tennessee 38120-2363
Telephone: (901) 747-2229 Fax: (901) 747-4446
www.fertilitymemphis.com

WELCOME TO OUR PRACTICE!

We appreciate your appointment, and we pledge to provide the highest quality of medical care. Please read the following to ensure the best possible experience for you at our clinic. Do not hesitate to call our Practice Administrator, **Ashley Anderson**, with any questions or concerns.

Our Professional Staff

Our professional staff includes board-certified Reproductive Endocrinologists, registered nurse specialists, embryologists, andrologists, registered sonographers, and medical laboratory technicians.

- **William Kutteh, MD, PhD, HCLD** is the Director of Reproductive Endocrinology and The Recurrent Pregnancy Loss Center
- **Raymond Ke, MD, HCLD** is the Chief of Assisted Reproductive Technology
- **Paul Brezina, MD, MBA** is the Director of Reproductive Genetics
- **Amelia Bailey, MD** is the Director of Minimally Invasive Surgery
- **Jianchi Ding, PhD** is the Embryology and Andrology Laboratory Director

Services provided at Fertility Associates of Memphis include reproductive endocrinology and infertility, advanced reproductive and gynecologic surgery, recurrent pregnancy loss evaluation and management, inseminations, and Assisted Reproductive Technologies (IVF; ICSI; assisted hatching; pre-implantation genetic diagnosis; and use of donor sperm, eggs, or embryos among others). While many of our patients are seeking to build their families, we are happy to see patients for other concerns, especially polycystic ovary syndrome, fibroids, and endometriosis among others.

New Patient and Follow-Up Visits

Initially, you will be scheduled for a comprehensive new patient consultation. During your first visit, a complete history will be taken with review of past treatments. Additional tests may be scheduled. Please bring your completed **Registration Form** and **Infertility Evaluation** form along with all current insurance cards. Also, please bring all old medical records including recent Pap smear, operative notes, laboratory tests, and x-ray films.

Confirmation of Your Appointment

In an effort to keep our clinics efficient, an automated verification service is used to confirm your appointment with us. The service will attempt to contact you starting three evenings before your appointment. When you answer this call, it will ask you to confirm your appointment or give you an opportunity to reschedule or cancel. If the service is unable to reach you in three attempts, then our patient service representative will make two additional attempts. Please insure that we have your accurate telephone number because **if we are unable to confirm your appointment, it will be cancelled**. We will make all efforts to reschedule you at the next available opportunity.

If you must cancel your office visit, please notify us at least 24 hours in advance. Failure to notify our office 24 hours in advance will result in a charge of $150 (new patients) or $50 (return patients) unless the cancellation was because of a valid emergency. Your insurance carrier does not pay for cancelled appointments. After payment of the cancellation fee, you will be rescheduled in your doctor's next available opening.

Insurance/Pre-Authorization

Many of you will have medical insurance coverage. It is your responsibility to be sure that your referral and authorization are up to date prior to your visit. We will be happy to assist you with your referral if you are having difficulty obtaining it from your primary care physician. Please call us at least two business days in advance of your appointment day. You will be responsible for all charges payable at the time of the visit if your referral or authorization is not current. If you prefer to reschedule your appointment for a later date, please do so at least 24 hours before your appointment or the cancellation fee will apply.

Payment Policy

You will not be required to make advance payment for any services that will be **paid in full** by your insurance company. However, to avoid paying these fees in advance, we must have a contract to provide services or an unrestricted promissory note in writing from your insurance company. Payment is expected at the time of your visit. Payment for all ovulation induction/intrauterine insemination cycles and all assisted reproductive technologies (IVF, ICSI, donor oocytes, FET) must be made in advance of cycle initiation, which is the first day of medication. We accept cash, checks, and Visa/Mastercard/Discover. Questions may be addressed to our practice administrator.

Letter for Predetermination of Benefits

If your treatment includes any of the assisted reproductive techniques, we can assist you by filing a letter for predetermination of benefits. Please be advised that it may take four (4) weeks to get a response from your insurance company. If a non-restricted letter is received prior to the start of treatment, you will only be expected to pay the difference of those services that are not fully covered by your insurance. If services are not covered, you will be required to make full payment in advance for these procedures. If a credit balance remains, we will process your refund as quickly as possible.

Diagnosis

We currently utilize the ICD-10 International Classification of Diseases and the latest Current Procedural Terminology (CPT) codes to classify your diagnosis and treatment and will use all appropriate medical diagnoses (irregular menses, fibroids, endometriosis, polycystic ovary syndrome, etc.). Most couples we see are referred because they desire to become pregnant. In many cases, this includes a diagnosis of infertility (exceptions would be recurrent pregnancy loss). We are required to code your visit with all appropriate diagnoses. Failure to do so would constitute fraud.

Surgery

Our staff will schedule your surgery and preauthorize the procedure with your insurance company. Please be advised that pre-authorization **does not ensure payment**. Please contact your insurance company to determine if your insurance pays for your planned surgery. Procedures that are pre-authorized but not covered will be the patient's responsibility.

After your surgery is scheduled, we will inform you about the portion of the surgery fee for which you will be responsible to pay as determined by the terms of your insurance policy. This payment is due two (2) weeks prior to the date of surgery.

Post-Op Visits / Return Visits / Annual Exams

Your post-operative visit will be scheduled at the time of your surgery. This visit is designed to ensure that you are healing normally after your surgery and will be performed by one of our specialty-trained registered nurses. Return visits to discuss plans for additional treatment for fertility concerns should be scheduled as an office visit. In general, your Ob/Gyn or referring physician should perform your annual exam and Pap smear, which we do require within the previous three years.

Phone Calls/Messages/Privacy

Our office phone 901-747-BABY (2229) is answered Monday through Friday from 8:00 a.m. to 4:30 p.m. If you have a true emergency at any time, please call 911 or go to the nearest emergency room for care; if your issue is urgent but not emergent, call (901) 747-2229. During business hours, a member of our professional staff will be brought to the phone. After hours, follow the instructions to page the staff member on call.

We realize that infertility treatment will generate many routine questions. To allow our staff time to take care of patients in the office at that moment, we ask that you leave a message on our voice mail system for routine queries. When you call, please leave us your name, phone number, date of birth, and the reason you are calling. If it concerns medications, we will also need your pharmacy name, phone number, and the medication you need with dose. If you leave a message before 2:00 PM, our nurses will return your call the same day. After 2:00 PM, the nurse will return your call the next day. For a discussion of test results or treatment plans, you should schedule a return office visit. If this is not convenient, we can schedule a telephone consultation with your physician. These calls are generally not covered by your insurance, and you may make payment in advance by credit card.

Non-emergency phone calls should be made during regular business hours; those that occur after 4:30 p.m. on weekdays and on weekends will be billed at $25 for each call (to patient, pharmacy, etc.) and are not covered by insurance companies. Extended phone calls to our professional staff (physicians, nurses, andrologists, embryologists) will be billed at $25 minimum. These charges are not covered by and will not be filed with insurance. In most cases, additional questions are best addressed at a brief office visit with your physician.

Medical Records

We ask that you (and your partner if applicable) obtain all prior medical records and any other medical documents from your referring physician before your consultation date. These include (but are not limited to) pap smears, blood tests, ultrasound reports, operative notes, and office notes. Without these records, your evaluation and management may be delayed or duplicated.

You have a right to your medical records that are generated from Fertility Associates of Memphis, PLLC. A completed and signed Medical Record Release as well as a paid copy/mailing fee as allowed by Tennessee law is required.

Form Completion

We routinely must complete multiple forms mandated by your insurance carrier to obtain coverage and request laboratory tests. When indicated, we will provide you with written notices for leaves of absence from work. We will request your assistance in completing these multiple

forms. Additional requests for leave of absence from work or disability not indicated by your treatment will be completed after receipt of a payment of $25. Similarly, requests for forms to be completed for non-formulary drugs and "letters of medical necessity" will be performed after receipt of a $25 fee for each.

Laboratory Services

Fertility Associates of Memphis, PLLC does not provide routine laboratory services. Memphis Fertility Laboratory, Inc., provides exclusive andrology, endocrinology, and embryology services related to assisted reproductive techniques. In the interest of full disclosure, Drs. Ke, Kutteh, Brezina and Bailey are investors in Memphis Fertility Laboratory, Inc.

Laboratory Corporation of American (LabCorp) provides routine phlebotomy and laboratory services for Fertility Associates of Memphis, PLLC. Patients are able to view, download, and print all LabCorp test results anytime, anywhere by registering at http://patient.labcorp.com.

Smoking Policy

Tobacco use is known to decrease the pregnancy rates in women undergoing treatment for infertility. It is also associated with increased complications during pregnancy (such as miscarriage) and childbirth. Tobacco use has also been shown to decrease sperm function. Moreover, it is simply harmful to your overall health. Smoking is not allowed in our office at any time. We cannot allow any patient undergoing an assisted reproductive technology cycle to smoke, as it not only adversely affects the smoker's chance of success but all other patients that will be treated that day. **We reserve the right to cancel your treatment if we determine that you have been smoking during a treatment cycle.**

Weekend Schedule

Many medical treatments must be carried out seven days of the week. Certain treatments such as in vitro fertilization cannot be postponed for one or two days; therefore, we have physicians, nurses, laboratory personnel, and office staff in the office every weekend to perform these necessary procedures. Our office is open at 8:00 AM on the weekends and will close as soon as all scheduled testing and procedures are complete. There are no regular office appointments on the weekends. If you have a procedure that must be performed on Saturday or Sunday, you can reach the nurse on call before 4 p.m. by calling 901-747-2229 and paging the professional staff on call. Inseminations are performed Monday through Saturday. If it is anticipated that your insemination will fall on a Sunday, several strategies may be used that will allow you to have an insemination on a Monday through Saturday without sacrificing your success rates.

Thank you for choosing Fertility Associates of Memphis. We look forward to working with you on an individualized plan of care.

Kutteh Ke Fertility Associates of Memphis, PLLC
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Registration Form

PATIENT INFORMATION

NAME (Last, First, Middle Initial)		Date of Birth / /	Social Security Number - -
Address	City	State/Zip	Home Phone ( )
Employer	Occupation/Department		Cell Phone ( )
Employment Address	City	State/Zip	Work Phone ( )
Referring Physician	Address	City	State/Zip
Your email to notify you of announcements about our practice			
How did you hear about our practice?			

SPOUSE INFORMATION

NAME (Last, First, Middle Initial)		Date of Birth / /	Social Security Number - -
Address	City	State/Zip	Spouse Phone ( )
Spouse Employer	Occupation/Department		Work Phone ( )
Employer Address	City	State/Zip	

INSURANCE INFORMATION

Provider Name			Expiration Date	Relationship
Insurance Company	Address	City	State/Zip	____ Self ____ Spouse ____ Child ____ Other
Insured Name	Group No., Policy No., I.D. No., Effective Date			
Secondary Insurance Co.				Relationship
Address	City	State/Zip		____ Self ____ Spouse ____ Child ____ Other
Insured Name	Group No., Policy No., I.D. No., Effective Date			

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING

PATIENT'S RESPONSIBILITIES: I understand that as the patient, parent, or guardian, I am legally responsible for payment of all charges relating to my care. Patient and/or guarantor(s) agree to pay reasonable attorney's fees and cost of same.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to the insurance company or its representatives, any information needed for this or other insurance claim. In consideration of services rendered, I transfer and assign to Kutteh Ke Fertility Associates of Memphis, PLLC, any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.

Patient Signature _____ Date _____

Authorization to Release
Medical Information – Treatment Instructions - Prescriptions

Your Name: _____ DOB: _____

Partner name: _____ Partner DOB: _____

Insurance Co: _____ Pharmacy name & phone: _____

In order for us to contact you, please indicate all contact telephone numbers and circle your order of preference. We recommend allowing us to leave a message with one of your contact numbers. Please do not list a pager number.

Your home phone: _____ 1 2 3 4 May we leave a message? Yes No

Your work phone: _____ 1 2 3 4 May we leave a message? Yes No

Your cell phone: _____ 1 2 3 4 May we leave a message? Yes No

Alternate phone: _____ 1 2 3 4 May we leave a message? Yes No

May we release information to your Partner? Yes No Partner work phone: _____

Partner cell phone: _____

I give my permission to Drs. Raymond Ke, William Kutteh, Paul Brezina,Amelia Bailey and the staff of Fertility Associates of Memphis and Memphis Fertility Laboratory to render medical care and treatment. I authorize the physicians or their staff to release information pertaining to my care to the above phone numbers, pharmacy, reference laboratories and consulting physicians. I understand that I have the right to withdraw this consent for the release of information at any time. Such withdrawal must be in writing. NO INFORMATION CAN BE RELEASED AFTER CONSENT HAS BEEN WITHDRAWN.

Signature of Patient/Guardian and Date: _____

Acknowledgement of New Patient Packet and of Financial Responsibility

I am aware that every effort has been made to verify my insurance coverage for services provided by Fertility Associates of Memphis. I understand that services rendered may not be covered by my health insurance or other health benefit program. I understand that I must notify this practice if I have, or have applied for, any benefits from TennCare, State Medicaid, Medicare or Tricare. I agree to be financially responsible for any and all services rendered by Fertility Associates of Memphis including those denied as non-covered and any and all services rendered by Memphis Fertility Laboratory, prior to initiating treatment. I understand and accept responsibility for the terms and conditions outlined in the New Patient Packet. Furthermore, I acknowledge receipt and understanding of the New Patient Packet and all information included therein.

Signature and Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Fertility Associates of Memphis's Notice of Privacy Practices as required by HIPAA Privacy Regulations effective 09/23/2013.

Signature and Date: _____

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FEMALE PARTNER'S EVALUATION

Today's Date: _____

Name: _____ Age: _____ Date of birth: _____

Occupation: _____ Partner's Name: _____

Who referred you to our care? _____ Who is your OB/Gyn? _____ FAX _____

THE MAIN PURPOSE OF TODAY'S VISIT IS: *(Please circle as many as apply)*

1. Infertility (_____ years)
2. Blocked or damaged tube(s) / Tubes tied
3. Amenorrhea (no periods)
4. Polycystic ovaries (PCOS)
5. Irregular menstrual cycles (irregular periods)
6. Hirsutism (excess facial/body hair)
7. Endometriosis
8. Leiomyomata (fibroids)
9. Male infertility/ Low sperm count
10. Pelvic pain / Pelvic adhesions (scar tissue)
11. In vitro fertilization (IVF)
12. Recurrent pregnancy loss (miscarriages)
13. Pregnancy complication / Stillbirth
14. Menorrhagia (heavy periods)
15. Premature menopause
16. Other (Specify) _____

PHYSICIAN USE ONLY

Total number of pregnancies _____
Full term (>37 weeks) _____
Pre term(20 to 37 wks) _____
Miscarriage (<20 wks) _____
Termination _____
Ectopic (tubal) _____
Living children _____

Have you been treated with these medications? *(Please circle as many as apply)*

Provera, Medroxyprogesterone acetate	Progesterone, Prometrium, Crinone
Clomiphene, Serophene, Clomid	hCG, Profasi, Pregnyl, Ovidrel, Novaryl
Letrozole, Femara	Bromocriptine, Cabergoline, Dostinex
Gonal F, Follistim	Lupron, Ganirelix, Cetrotide, Antagon
Bravelle, Repronex, Menopur	Synthroid, Levothyroxine
Glucophage, Metformin, Avandamet	Heparin, Lovenox, Aspirin 81mg, IVIG

Other _____

Have you ever had any of these treatments? *(Please circle, and indicate number of treatments)*

Intrauterine insemination (IUI) _____	Tubal / uterine surgery _____
In vitro fertilization (IVF) _____	Donor sperm _____
Embryo adoption _____	Donor egg _____
Frozen embryo transfer (FET) _____	Other _____

YOUR PREGNANCY HISTORY *(Please include ALL pregnancies)* Blood Type? _____

	Year of delivery or loss	How many months to get pregnant?	How long did the pregnancy last?	Who is the father?	Any complications?
1.					
2.					
3.					
4.					
5.					
6.					

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FERTILITY WORK-UP

Have you had a hysterosalpingogram (HSG; x-ray "dye test" of the tubes)? **Yes** **No**

When? _____ Where? _____

Results: _____

Have you had a sonogram (Ultrasound of the pelvis / uterus / ovaries)? **Yes** **No**

When? _____ Where? _____

Results: _____

Have you had surgery in your abdomen or pelvis? **Yes** **No**

When? _____ Where? _____

Procedure: _____

Procedure: _____

Have you had surgery (Biopsy / cone / LEEP / cryo / freezing) on your cervix? **Yes** **No**

Have you ever had an abnormal Pap smear? **Yes** **No**

Date of your last pap smear: _____ Was it normal? **Yes** **No**

Have you ever had: *(Circle as many as apply)*

Ovarian cysts or tumors	Endometriosis	Ectopic (tubal) pregnancies
Scar tissue in your pelvis	Uterine septum	Scar tissue inside your uterus
Uterine fibroids	Uterine polyps	Uterine birth defects
Chlamydia	Gonorrhea	Pelvic inflammatory disease

Other sexually transmitted infection (e.g., Herpes, genital warts, HPV, etc.)

OVULATION ASSESSMENT

Do you have regular, predictable, spontaneous menstrual periods? **Yes** **No**

Age of your first period: _____ How many days does your period last? _____

How many days from the first day of one period to the first day of the next? _____

Do you ever have spotting in between periods? _____

If you do not have periods, when did they stop? _____

Are your periods heavy, either now or in the past? _____

Do you have premenstrual symptoms? **Yes** (____Cramps ____Breast pain ____Bloating ____Mood changes) **No**

Do you have pain or cramps with your periods? **Yes** (_____Mild _____Moderate _____Severe) **No**

Do you have pelvic pain between your periods? **Yes** (With ovulation?_____) **No**

What medicine or action helps decrease the pain? _____

What have you used for birth control?_____ When did you stop? _____

Have you ever taken medicine to start your periods? **Yes** (When? _____ What?_____) **No**

Do you have or have you ever had: *(Please circle as many as apply)*

Blood test for: Progesterone FSH TSH (thyroid) Glucose Insulin Hemoglogin A1c

Nipple discharge Hot flashes Night sweats Hair loss Acne Diabetes Thyroid disease

Unwanted hair on _____Chin_____Sideburns _____Mustache _____Chest _____Abdomen

What is your weekly exercise? _____

What is your weight? Currently_____ Ideally_____ One year ago_____ Five years ago_____

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PAST MEDICAL HISTORY / SYSTEMS REVIEW *(Please circle any conditions that you have or have had)*

High blood pressure	Heart disease	Stroke	Mitral valve prolapse
Lung disease / Asthma	Cystic fibrosis	Hepatitis	Gallbladder disease
Bowel disease	Liver disease	Blood in stool	Skin disease
Psychiatric disease	Headaches	Depression / Anxiety	Neurological disease / seizures
Urinary tract infections	Kidney disease	Blood in urine	Cancer
Bleeding disorder	HIV infection	Breast disease	Vision or hearing defects
Sickle cell anemia / trait	Blood disease (Anemia)	Diabetes	Thyroid disease

Other _____

Surgeries or hospitalizations *(Please give dates)*: _____

_____

_____

Date of your last mammogram: _____ Was it normal? **Yes** **No** (Explain_____)

Current Medications: *(Please include dosage, frequency, and any over-the counter drugs, herbs, and vitamins)*

_____

_____

_____

Food / Medication / Latex Allergies: _____

_____

Habits: Do you use tobacco? **Yes** (_____cig/day; _____total # of years) **No**

Are you a former smoker? **Yes** (Congratulations! When did you quit?_____) **No**

Do you drink alcohol? **Yes** (# of drinks/week: _____) **No**

Illicit drug use? **Yes** (Type?_____ How often?_____) **No**

# of caffeinated drinks per day: _____

FAMILY HISTORY

	Age	Age at Death	Medical or Pregnancy-Related Problems	
Mother:	____	_____	_____	**None**
Is she menopausal? **Yes** (What age? ____ Did she have a hysterectomy?_____)				**No**
Father:	____	_____	_____	**None**
Brother/Sister:	____	_____	_____	**None**
Brother/Sister:	____	_____	_____	**None**
Brother/Sister:	____	_____	_____	**None**

Any cancer? **Yes** (____Breast ____Ovarian ____Colon ____Other_____) **No**

Any blood clots? **Yes** (Who, and where?_____) **No**

Any autoimmune diseases? **Yes** (Who, and what type?_____) **No**

Anyone with: _____Genetic or inherited diseases? _____Birth defects? _____Mental retardation? **No**

Any medical diseases not listed? **Yes** (Who, and what type? _____) **No**

What is your ethnic background?_____

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COUPLE'S SEXUAL HISTORY

How often do you and your partner have sexual intercourse? _____

Do you time intercourse to ovulation? **Yes** (___Calendar ___Phone App ___Urine predictor kits ___Other) **No**

Do you use any lubricants during intercourse? **Yes** (What kind? _____) **No**

Do you have any pain with intercourse? **Yes** (Where? _____) **No**

Do you have any other sexual difficulties as a couple? **Yes** (Please explain _____) **No**

HAVE YOU HAD ≥2 MISCARRIAGES? Yes____*(Please answer below)* **No** ____*(Please skip to next section)*

Genetic Factors:

Have you had a karyotype (chromosome) test? **Yes** (When?_____Result?_____) **No**

Has your partner had a karyotype test? **Yes** (When?_____Result?_____) **No**

Have you had a karyotype test on a miscarriage? **Yes** (When?_____Result?_____) **No**

Have you/your partner had any other genetic tests? **Yes** (When?_____Result?_____) **No**

Immunologic Factors: Do you have an autoimmune disease (e.g. lupus, rheumatoid arthritis, etc) **Yes** **No**

Have you had any abnormal immune tests? (*Please circle as many as apply*) **No**

Positive syphilis test	Lupus anticoagulant	Anticardiolipin antibodies
Antithyroid antibody	PTT dRVVT	Antiphospholipid antibodies
Rheumatoid factor	Immunologic therapy	Antinuclear antibodies

Other immune tests (Describe_____)

Thrombophilic Factors:

Do you have a history of blood clots? **Yes** (When? ____ Where?_____) **No**

Have you been tested for:	Factor V Leiden	Factor II (prothrombin)	MTHFR
(*Please circle as many as apply*)	Protein S	Antithrombin	Protein C

Have you ever been on a blood thinner? **Yes** (____Heparin ____Lovenox ____Coumadin ____Baby aspirin) **No**

Reason:_____

MALE PARTNER'S EVALUATION **Not Applicable**

P NP

Name: _____ Date of Birth:_____

Occupation: _____Name of urologist (if applicable): _____

Any previous pregnancies? **Yes** (Year and Outcome _____) **No**

Has your sperm been tested? **Yes** (When?_____ Result?_____) **No**

Have you had a varicocele of the scrotum? **Yes** (Reason:_____) **No**

Have you seen a urologist for any reason? **Yes** (Reason:_____) **No**

Have you had: _____Genital surgery? _____Genital trauma? _____ Genital infections? _____Hernias? **No**

What health problems do you have?_____ **None**

What medications / vitamins do you take?_____ **None**

Do you : Smoke or use tobacco? **Yes** (_____cig/day; _____total # of years) **No**

Use alcohol? **Yes** (# of drinks/week: _____) **No**

Use illicit drugs? **Yes** (Type?_____ How often? _____) **No**

Do you have allergies to any food, drugs, or latex? **Yes** (_____) **No**

What diseases run in your family?_____ **None**

Does infertility run in your family? **Yes** (Whom?_____) **No**

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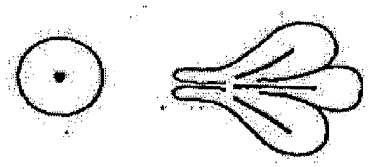
PHYSICIAN USE ONLY: PHYSICAL EXAMINATION

Height: _____ Weight: _____ BMI: _____ kg/m^2 BP: _____ RR: _____ Temp: _____

HEENT, incl. thyroid	N	AbN
Skin, incl. hirsutism	N	AbN
Neurological	N	AbN
Heart / CV	N	AbN
Respiratory	N	AbN
Ext. Genitalia / Vagina / Cervix	N	AbN
Adnexae	N	AbN



Uterine size: _____ Position: _____

FEMALE DIAGNOSES:

1) CPT _____ CPT _____
2) CPT _____ CPT _____
3) CPT _____ CPT _____
4) CPT _____ CPT _____
5) CPT _____ CPT _____
6) CPT _____ CPT _____

MALE DIAGNOSES:

1)_____ CPT _____
2)_____ CPT _____
3)_____ CPT _____
4)_____ CPT _____

LMP: _____ Today is cycle day: _____ Urine hCG Result:_____

MICRO: Chlamydia Mycoplasma Aero/Anaerob Culture Urine Analysis Urine C&S

GENERAL: PNS CBC CMP Platelet Iron Profile Sickle cell Screen LDH 25OH-Vitamin D3

REI: CD3 FSH/LH/E2 Random FSH/LH/E2 CD _____ P4 AMH Quant hCG

ENDO: TSH PRL HgBA1C Fasting Insulin Free Testos Total Testos Lipid Profile
8am Cortisol 17-OHP SHBG DHEAS

GENETIC: Karyotype- female FMR1 PCR CF mutation analysis Carrier Screening

ANATOMIC: HSG GYN USG DAY 3 USG Sonohysterogram Trial Transfer

IMMUNE: LAC APA anti-β2GP1 Anti-adrenal Anti-thyroid ANA anti-DS-DNA

THROMB: Factor V Leiden Factor II MTHFR Prot C Act Prot S Act Antithrombin

MALE: Semen analysis Sperm culture Retrograde analysis AS Ab Refer to Urology

MALE ENDO: FSH LH PRL TSH Total T Free T

MALE STD: HIV I/II RPR Hepatitis B sAg Hepatitis C Ab

MALE GENETIC: Karyotype- male Y-chromosome microdeletions CF mutation analysis CryoBank

Need HSG films/Records from: _____Book OR:_____F/U Appt:_____

INFO/ADVICE

Start PNV / DHA
PCOS / Metformin
Clomid / Letrozole
Gonadotropins
DOR
CoQ10 / DHEA
RPL
LSC/HSC
APA/Heparin
Lovenox
IUI
IVF ICSI PGT
Stop Smoking
Weight Loss
Male Fertility
Genetic Testing
Donor Egg/Embryo
Donor Sperm
Meds' Preg Categ
Endometriosis
Fibroids
Decrease Caffeine

Date _____ Nurse/Resident_____ MD _____ Dictated _____

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Patient Name:_____ **DOB:**_____

Consent for Genetic Carrier Screening

Universal genetic carrier screening allows couples to screen for a variety of genetic disorders prior to becoming pregnant. Genetic carrier screening is a simple blood or saliva test that evaluates an individual's DNA to determine if s/he is a carrier of any genetic abnormalities. Most individuals who are carriers of these genetic mutations do not have any symptoms. If both partners are carriers of the same genetic mutation, however, the couple is at risk of passing on the disease to their offspring.

The most common genetic disorders that are tested for include: Cystic Fibrosis, Fragile X Syndrome, Spinal Muscular Atrophy, Tay-Sachs, and Sickle Cell Anemia. In addition to those conditions, genetic carrier screening can also identify other more rare diseases. A full list of diseases can be provided upon request.

If both genetic parents of the child are genetic carriers, the risk of their child having the genetic condition is 25%. If one parent is a carrier, the child has a 50% chance of being a carrier as well and a much lower risk of actually having the condition or disease. Therefore, while we recommend the screening of at least one partner, we offer both partners genetic carrier screening. It is also recommended that you have genetic counseling to assess other genetic risks based on these tests and your family history and personal medical history.

Although universal genetic carrier screening is incredibly accurate, receiving a negative result cannot completely eliminate the chance that you will not have a child with a genetic disorder. More importantly, if a positive finding is reported in both you and your partner, we can offer specific treatment options to help reduce the chance of the disease being passed on to your offspring. **We recommend genetic carrier screening to all individuals of reproductive age. We strongly recommend that all individuals discuss genetic testing with a licensed genetic counselor and by signing this form I verify that I have been given this contact information:**

Natera Horizon Carrier Screening: Phone (650-249-9090) and www.natera.com

There is a chance that your insurance company may not pay for some or all of the cost of the test. If this is the case, you will be responsible for payment. If you do not have insurance, the out-of-pocket cash price depends on the lab utilized and is available upon request.

Prior to beginning any fertility treatment we request that you review universal genetic carrier screening with your physician and as a couple you decide to decline or accept this testing.

☐ I consent to genetic carrier screening ☐ I decline genetic carrier screening

Patient Signature _____ Date: _____

Physician Signature _____

1/2016 PRB

What do I need to know about Zika virus and pregnancy?

(April 2018 Update)

FERTILITY ASSOCIATES of MEMPHIS

Dr. William H. Kutteh, MD, PhD Dr. Raymond W. Ke, MD
Dr. Paul R. Brezina, MD, MBA Dr. Amelia P. Bailey, MD

Zika virus is carried by certain types of mosquitoes (*Aedes* species) and causes Zika virus disease, which can also be spread through sexual contact and blood transfusions. Only 20% of people who get Zika virus have symptoms such as joint pain, red eyes, fever, rash, muscle pain, or headache. The illness is usually mild and goes away on its own; however, serious consequences can occur in pregnancy. When a woman who is pregnant catches Zika virus, severe birth defects and a very small head can result in the baby as well as miscarriage and stillbirth. The Centers for Disease Control and Prevention (CDC) frequently update their website with new information on Zika virus; this is your best resource, and we recommend that you check the website frequently: **www.cdc.gov/zika**, especially if you are considering travel.

How do I prevent becoming infected with Zika virus?

1. **Do not travel to an area with Zika virus!** The CDC website is the best place to check for the most updated list of countries with active Zika virus infections. Many of these countries are located in the Caribbean, Central (including Mexico) and South America, and Pacific Islands; there have also been cases of local transmission in Brownsville, Texas, and Miami, Florida.
2. Prevent mosquito bites.
   a. Stay indoors, especially places with air conditioning, and utilize window and door screens and mosquito netting if needed, especially for babies less than two months old.
   b. Wear long-sleeved shirts and long pants so less skin is exposed.
   c. Use insect repellents with ingredients that are registered with the Environmental Protection Agency (EPA) such as DEET, IR-3535, para-menthane-diol, 2-undecanone, oil of lemon eucalyptus, and picaridin, all of which are in most over-the-counter repellents and are recommended by the CDC and EPA as safe in pregnancy and breastfeeding. If you prefer more natural ingredients, you can use the Terminix All Clear Sidekick and/or the Invisaband (both of which are available on Amazon), which are effective. You can also have someone else spray your clothes with permethrin while you are not wearing them; once they have dried, you can safely touch and wear them. The permethrin will last through several washes. Do NOT use insect repellents on babies younger than 2 months old; do NOT use oil of lemon eucalyptus- or para-menthane-diol-containing products on children younger than 3 years old.
   d. Current recommendations state that you should not have sex with a male partner who has possibly been exposed to Zika virus or should use a condom, making sure you are using it correctly and with every intercourse, **for 6 months**.
   e. See a healthcare provider or go to your local Health Department if you are concerned that you have been exposed to Zika virus.

How is Zika virus treated?

There are blood and urine tests that can be performed to confirm whether or not you have been infected; diagnosis is based on the results of these tests combined with travel or exposure history and symptoms. At this time there is no vaccine to prevent Zika virus or medicine to treat it. Your best defense is to prevent mosquito bites and sexual contact with someone who may have Zika virus since there is no treatment.

If I become infected with Zika virus, how will this affect my fertility treatment?

If you may have been exposed to Zika virus by any means, even if you do not have symptoms, you should wait at least **8 weeks** to have unprotected sex and to conceive after the possible exposure. If a man has been exposed, even if he does not develop symptoms, he should wait **6 months** after possible exposure before having unprotected sex and before conceiving. **We recommend following these CDC guidelines, which decrease but do not eliminate risk; and we may delay your fertility treatment to keep you and your baby safe.** We may be able to freeze sperm, eggs, or embryos prior to a possible Zika exposure in order to pursue inseminations or in vitro fertilization more safely with the shortest possible delay in fertility treatment. **It is your responsibility to tell your doctor if you or your partner falls into any of these high-risk categories.**

If I become infected with Zika virus, how does this affect my future pregnancies?

The CDC is still trying to find out more about Zika virus disease, and there are many yet unanswered questions. Based on what we know so far, even having Zika virus disease should not affect future pregnancies after the above recommended delays (8 weeks- 6 months). It is likely that having the disease prevents you from having it during a future pregnancy, similar to chickenpox.

Please discuss all concerns with your doctor, who will work with you to minimize risk to you and your baby.

Patient Acknowledgment: _____ **Date:** _____

Updated on 6-14-18 by AMA

NOTICE OF PRIVACY PRACTICES

Fertility Associates of Memphis, PLLC
80 Humphreys Center, Suite 307
Memphis, TN 38120-2363
Phone: (901) 747-2229 Fax: (901) 747-4446

Privacy Officer: Practice Administrator (901) 747-2229 ext. 103

Effective Date: August 1, 2017

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a paper chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign-In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

24. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

a. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

b. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

c. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

d. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

e. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

f. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner, in which, this office handles a complaint, you may submit a formal complaint to:

Southeast Region – Atlanta (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)
Timothy Noonan, Regional Manager
Office for Civil Rights
U.S. Department of Health
and Human Services Sam
Nunn Atlanta Federal Center,
Suite 16T70 61 Forsyth
Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: OCRMail@hhs.gov

The complaint form may be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.