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 forms mandated by your insurance carrier to obtain coverage and requested laboratory tests. When indicated, we will provide you with written notices for leaves of absence from work. Additional requests for leaves of absence from work, disability or otherwise

not indicated by your treatment will be completed after receipt of form and applicable fee. The staff of Fertility Associates of Memphis will be happy to complete forms upon your request. Please allow 7-10 days for completion of requested forms. The charges for form completion are:

- Family Medical and Leave Act $35.00
- Disability Form $50.00
- Return to Work/Fitness for Duty Form $25.00

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.

Pharmacy Services

Fertility Associates of Memphis, PLLC, uses several pharmacies dedicated to supplying pharmaceutical care exclusively to fertility patients. A few of the pharmacies include but are not limited to: MDR, SMP, Fertility Pharmacy of America and all insurance specific specialty pharmacies. Additional providers can be found on our website www.fertilitymemphis.com. In the interest of full disclosure, Drs. Ke, Kutteh, Brezina and Bailey are investors in Fertility Pharmacy of America.

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
80 Humphreys Center, Suite 307
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(901) 747-2229 Fax (901) 747-4446

Registration Form

Patient Information

Name (last, first, middle initial)		Date of birth M/D/Y	Social security number
Home address	City	State/Zip	Home phone
Email address	You will receive announcements and messages from our practice.		Mobile phone
Employer		Occupation or Department	
Employer address	City	State/Zip	Work phone
Referring physician		Address, city, state	
How did you hear about our practice?			

Spouse Information

Name (last, first, middle initial)		Date of birth M/D/Y	Social security number
Home address	City	State/Zip	Spouse phone
Employer		Occupation or Department	
Employer address	City	State/Zip	Work phone

Insurance Information

Primary insurance company	Effective date	Group number	Relationship: Self____ Spouse____ Child____ Other____
Insured Name		Policy number	
Insurance company address	City	State/Zip	
Secondary insurance company (if applicable)	Effective date	Group number	Relationship: Self____ Spouse____ Child____ Other____
Insured Name		Policy number	
Insurance company address	City	State/Zip	

Please present your medical insurance card to receptionist

PATIENT RESPONSIBILITIES: I understand that as the patient, parent or guardian, I am legally reponsible for payment of all charges relating to the patient's care. In case of default, I agree to pay reasonable attorney's fee for recovery of outstanding charges.

PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me 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 payment claims. In consideration of services rendered, I transfer and assign to 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.

Your privacy is important to us. We will not sell, lease or release your information to anyone. At any point you may opt out of email communication by the unsubscribe link in any email from us.

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, PLLC and Memphis Fertility Laboratory, Inc. 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, PLLC, 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 08/01/2017.

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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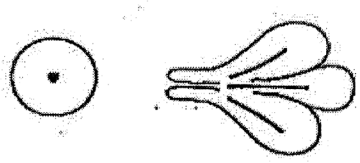
PHYSICIAN USE ONLY: PHYSICAL EXAMINATION

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 _____

FERTILITY ASSOCIATES of MEMPHIS

William H. Kutteh, M.D., PH.D. *Raymond W. Ke, M.D.*
Paul R. Brezina, M.D. *Amelia P. Bailey, M.D.*

Infectious Disease Notice to Patients

Your safety is of our utmost concern. We at Fertility Associates of Memphis (FAM) want to ensure that all of our patients and employees stay healthy. This notice discusses the risks of infectious diseases as they relate to pregnancy. A longer document (Infectious Disease: An Overview) is available on our website with more information; please review that document as well.

The world is home to many forms of bacteria and viruses that can cause significant injury or death to human beings. A recent high profile example of this fact is the impact of COVID-19. It is unknown if COVID-19 is more likely to be contracted or is more severe in pregnant women compared to women who are not pregnant. The risks of pregnancy complications including serious injury or death to the mother and baby are higher in pregnant women who contract any serious infectious disease, including COVID-19. **Pregnant women are considered an at-risk population for COVID-19 and other serious infectious diseases. The safest way for women to proceed when there is a possibility for exposure to any serious infectious disease (including COVID-19, Influenza, or Zika virus) is to avoid pregnancy until this risk of exposure no longer exists and to get vaccinated.**

All women considering pregnancy are strongly encouraged to obtain the following vaccinations prior to attempting pregnancy if not already immune: TDAP, MMR, Varicella, COVID-19.

All women considering pregnancy are encouraged to follow the CDC website to minimize Zika risk at https://wwwnc.cdc.gov/travel/page/zika-information

All women are advised to follow the updated CDC recommendations concerning COVID-19 at https://www.cdc.gov/coronavirus.

All pregnant women and women considering pregnancy are strongly encouraged to obtain a flu shot every year.

I/we understand that elective procedures may be canceled secondary to state or federal restriction or if I harbor an infectious disease. My procedure could be canceled if FAM or the surgical facility is unable to provide staff to perform your procedure or to obtain necessary personal protective equipment (PPE). I/we understand that I/we will be financially responsible for any medical services or procedures, laboratory testing and medication provided up to the point my/our cycle was cancelled. FAM will only refund a pre-payment for services you have not received. I/we understand that I/we have the right to cancel and not move forward with any fertility treatments. In the event that I/we have a scheduled Frozen Embryo Transfer, I/we may still cancel and have my/our embryo(s) refrozen for use in the future.

I/We have read the above and have had the opportunity to discuss the available information about infectious diseases in relation to fertility care and pregnancy with my/our physician. It is my/our desire to continue with fertility treatment.

Patient Name_____

Patient Signature Date _____

_____

FERTILITY ASSOCIATES OF MEMPHIS
80 Humphreys Center, Suite 307
Memphis, TN 38120-2363
Tel: (901) 747-2229 Fax: (901) 474-4446

Genetic Carrier Screening

Patient Name:_____ **DOB:**_____

There exist a class of genetic diseases, know as Autosomal Recessive (AR), in which individuals that do not suffer any symptoms of a disease may have a child with a significant genetic disease. There are hundreds of different AR conditions and it is common for normal individuals to be a carrier for at least one AR condition. In fact, more than 25% of the general population is a carrier for at least one AR condition. To have an AR disease, **BOTH** parents must be carriers for the disease. If both parents are carriers for AR Disease, the chances per birth are 25% for having a child affected with genetic disease, 50% for having a child who is normal but is a carrier for the genetic disease, and 25% for having a normal child that is not a carrier for the genetic disease. 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.

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. Some testing panels evaluate only the most common AR conditions with a relatively small number of tests while other panels are extensive. No panel, however, is capable of detecting all conditions in all people. Furthermore, all tests are associated with the possibility of error which means the chance of having a child with an affected genetic condition cannot be driven to zero even in the presence of a normal testing panel result.

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.** The American College of Obstetrics and Gynecology (ACOG) in March of 2017 released a formal Committee Opinion (#691) recommending all individuals of reproductive age to undergo genetic carrier screening prior to attempting pregnancy. **We strongly recommend that all individuals discuss genetic testing and their family/personal medical history with a licensed genetic counselor; 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.

By signing this form, I verify that I understand the information explained in this form and will notify my physician should I choose to undergo this testing. If I choose to decline this testing, against the recommendations of Fertility Associates of Memphis, I understand that I am accepting the associated risks including having a child that may be handicapped or die from a genetic syndrome that may have been otherwise avoided.

Patient Signature _____ **Date**_____

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.