Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

Patient name

Date of birth

MPI#

# FEMALE PATIENT: INTERNATIONAL

## THIS FORM MUST BE COMPLETED BY ANY FEMALE PATIENT WHO WILL RECEIVE MEDICAL TREATMENT AND/OR EVALUATION.

## Patient Information

**Demographics**

Name (last, first, middle initial) – please print

Maiden name (if applicable)

Name you prefer to be called (nickname)

Date of birth Age

Marital status

Home address (street, city, state/province, zip code)

Country

Check the box next to your preferred method of contact:

☐ _____ May we leave a detailed message? ☐ Yes ☐ No
Home phone

☐ _____ May we leave a detailed message? ☐ Yes ☐ No
Work phone

☐ _____ May we leave a detailed message? ☐ Yes ☐ No
Cell phone

☐ _____
Email

Emergency contact name Phone number

Fertility Centers OF ILLINOIS®

Your Miracle. Our Mission.®

Patient name

Date of birth

**Employment**

Occupation

## Referral/Health Care Provider Information

Specify how you found us. ☐ Referred by Physician ☐ Friend/Family ☐ Internet ☐ Other: _____

Name of physician who referred you

Name of medical group

Address (street, city, state/province, zip code)

Country

Phone Fax

Were you referred to a specific Fertility Centers of Illinois' physician? ☐ Yes ☐ No

Referred Fertility Centers of Illinois physician

Name of primary health care provider/OB/GYN (if different from above)

Name of medical group

Address (street, city, state/province, zip code)

Country

Phone Fax

Are you pursuing evaluation and/or treatment(s): ☐ Single ☐ With a spouse or partner

Spouse/Partner name (last, first, middle initial)

Spouse/Partner sex: ☐ Female ☐ Male

Reason for your visit today:

Fertility Centers OF ILLINOIS®

Your Miracle. Our Mission.®

Patient name

Date of birth

## Informed Consent Area

**1. Email Consent:**

The physicians and staff of Fertility Centers of Illinois offer patients the opportunity to communicate by email, for general questions or concerns. Because email has certain risks and your privacy and security are of paramount importance to us, patients should carefully consider before giving email consent. Email risks include, but are not limited to:

1) Circulating, forwarding and storing in numerous paper and electronic files

2) Broadcasting to both intended and unintended recipients

3) Misaddressed email

4) Easier falsification than handwritten or signed documents

5) Backup copies existing even after the sender or the recipient has deleted his or her copy

6) Altering, forwarding or use without authorization or detection

7) Introduction of viruses into computer systems

**The physicians and staff of Fertility Centers of Illinois will use reasonable means to protect security and confidentiality of email information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of email communication and therefore you should never include your social security number or date of birth in any email communications to us.**

In addition, email should never be used to communicate acute and/or urgent clinical problems such as pain or abnormal bleeding. Our physicians and staff always try to respond to emails in a timely manner, however for any clinical problems, follow proper guidelines by calling our office or the answering service after hours. In a medical emergency, call 911.

_____ I authorize Fertility Centers of Illinois to communicate with me by email in regards to my medical care and associated financial charges (we will use the email address provided on the first page of this form).

Initial here

**2. Authorization for Use and Disclosure of Health Information to Spouse or Partner (if applicable):**

I hereby authorize Fertility Centers of Illinois to disclose the health information described below to:

_____

Spouse/Partner (please print)

I authorize the following information to be disclosed:

☐ All health information, including (if available) any results and/or information regarding HIV, genetics, psychotherapy/mental health and substance and/or alcohol abuse

☐ Other: _____

Fertility Centers of Illinois will only disclose the health information you have authorized above, except as otherwise required by law.

_____ I authorize Fertility Centers of Illinois to disclose my health (and associated financial) information as designated above.

Initial here

You may revoke this authorization in writing at any time. If you do, it will not affect any previous actions already taken in reliance upon your authorization. Once health information is disclosed pursuant to this authorization, it may be redisclosed and may no longer be protected by privacy laws.

Fertility Centers OF ILLINOIS®

Your Miracle. Our Mission.®

Patient name

Date of birth

**3. Patient Financial Responsibility Notice – Payment & Information Release Consent & HIPAA Acknowledgement: International Patients**

The goal of Fertility Centers of Illinois is to offer you the most sensitive, comprehensive and technologically-advanced fertility care.

**Please be aware of the following:**

You are financially responsible for ALL care provided.

Your Fertility Centers of Illinois financial counselor will review the cost of your planned medical services with you in detail, as well as when payment will be due.

Fertility Centers of Illinois may find it necessary to decline to treat any patient if timely payment is not made. This may result in interruptions to your care.

Drug coverage: In your country, you may be able to order medicine from a local doctor or pharmacy. Alternatively, we will be happy to order your medications for you here in the United States.

_____ I have read and understand the policy outlined above and agree to accept full financial responsibility as described. Patients who are married or in a legal union are jointly responsible for all charges incurred.

Initial here

_____ I acknowledge that I have received a copy of Joint Notice of Privacy Practices.

Initial here

Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

Patient name

Date of birth

## Pregnancy History

Length of marriage (or relationship): _____ Duration of Infertility: (Months having sex without contraception.) _____months

Have you previously been pregnant? ☐ Yes ☐ No Have you previously tried to get pregnant? ☐ Yes ☐ No

Times pregnant: _____ Term births: _____ Premature births: _____

Miscarriages: _____ Elective abortions: _____ Adopted children: _____

Please provide details on each pregnancy below (if applicable).

| | Date | Miscarriage | Elective abortion | Ectopic | No. months to conceive | Infertility treatment | Weight/Sex | C-section | Complications | Is current partner father? |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. | | ☐ | ☐ | ☐ | | ☐ | | ☐ | | ☐ |
| 2. | | ☐ | ☐ | ☐ | | ☐ | | ☐ | | ☐ |
| 3. | | ☐ | ☐ | ☐ | | ☐ | | ☐ | | ☐ |
| 4. | | ☐ | ☐ | ☐ | | ☐ | | ☐ | | ☐ |
| 5. | | ☐ | ☐ | ☐ | | ☐ | | ☐ | | ☐ |

If you had complications with any of the pregnancies listed above, describe:

_____

_____

_____

## Menstrual (Hormonal) History

Date of your last menstrual period: _____ Age at your first period: _____

Are your periods regular? ☐ Yes ☐ No How many days from onset to onset? _____

How many days does your period last? _____ Do you bleed between periods? ☐ Yes ☐ No

Do you have premenstrual symptoms? ☐ Almost always ☐ Rarely ☐ Never

Pelvic pain/cramps: ☐ None ☐ During your period ☐ Before your period ☐ After your period
☐ At mid-cycle ☐ During intercourse ☐ With urination ☐ With bowel movements
☐ Cause you to miss usual activities ☐ Cause you to miss work

Pelvic pain/cramps: ☐ Mild ☐ Moderate ☐ Severe ☐ Getting worse ☐ Improving ☐ Not changing
☐ On the right side ☐ On the left side ☐ In the middle

What medications do you take for pain/cramps? _____

Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

Patient name

Date of birth

## Contraceptive Use

Type: _____ From when to when: _____ Reason discontinued: _____

Type: _____ From when to when: _____ Reason discontinued: _____

Have you ever undergone surgical sterilization or reversal? ☐ Yes ☐ No

If yes, specify which procedure and the approximate date(s): _____

## Sexual History

How many times a week do you have sexual intercourse? _____ How many times do you have intercourse around ovulation? _____

Do you use lubricants for intercourse? ☐ Yes ☐ No If yes, which type? _____

Do you douche before or after intercourse? ☐ Yes ☐ No

Have you ever had unwanted sexual experiences? _____

Do you have any sexual problems at this time? _____

Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

Patient name

Date of birth

## Medical History

Do you have or have you had (check all that apply):

- ☐ Abnormal pap smears
- ☐ Abnormal uterus (shape, etc.)
- ☐ Antichlamydial antibodies
- ☐ Appendicitis
- ☐ Autoimmune disease
- ☐ Breast discharge
- ☐ Cervicitis
- ☐ Chlamydia
- ☐ Chronic headache
- ☐ Colitis or enteritis
- ☐ Cryo (freezing) or surgery of the cervix
- ☐ Cytomegalovirus (CMV)
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Excessive stress
- ☐ Genital herpes
- ☐ Genital warts/condyloma
- ☐ Gonorrhea
- ☐ Head injury
- ☐ High blood pressure
- ☐ Hot flashes
- ☐ Increased acne
- ☐ Increased facial or body hair
- ☐ Mycoplasma
- ☐ Ovarian cysts
- ☐ Pelvic adhesions
- ☐ Pelvic infection
- ☐ Poor sense of smell
- ☐ Psychiatric treatment
- ☐ Recurring vaginitis
- ☐ Seizures
- ☐ Special dietary habits
- ☐ Syphilis
- ☐ Thyroid disorder
- ☐ Toxoplasmosis
- ☐ Trichomonas
- ☐ Tuberculosis
- ☐ Ureaplasma
- ☐ Uterine fibroids or myomas
- ☐ Vision problems
- ☐ Vomiting
- ☐ Weight gain (10 or more lbs)
- ☐ Weight loss (10 or more lbs)

If you answered yes to any question(s), please explain:

Patient name

Date of birth

List all serious or chronic illnesses or injuries not already described:

Do you or your family members have: ☐ Infertility ☐ Hormonal disorder ☐ Other inherited disorders
If yes, explain:

Has anyone in your direct family ever been diagnosed with breast or ovarian cancer? ☐ Yes ☐ No
If yes, explain:

Was anyone in your family born with any birth defects/mental retardation? ☐ Yes ☐ No
If yes, explain:

Do you (or does anyone in your family) have a bleeding/blood clot disorders? ☐ Yes ☐ No
If yes, explain:

Fertility Centers OF ILLINOIS®

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Patient name

Date of birth

## Operations & Hospitalizations

| Date: | Diagnosis: | Operation: | Where performed? | Physician: |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

## Medications

List all prescriptions and over-the-counter drugs and supplements used during the past year.

| Medication name: | Dosage & frequency: | Approximate date(s) taken: | Reason for taking: |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

## Allergies

| To what? (Drug or substance) | When? | What type of reaction? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Fertility Centers OF ILLINOIS®

Your Miracle. Our Mission.®

Patient name

Date of birth

## Previous Evaluations

Have you had (check all that apply):

| | | Approximate Date | Values (if known) |
|---|---|---|---|
| Basal body temperature charting | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Urine LH surge (ovulation predictor kit) | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Endometrial biopsy | ☐ Not done ☐ Abnormal ☐ Normal | | |
| AMH | ☐ Not done ☐ Abnormal ☐ Normal | | |
| FSH | ☐ Not done ☐ Abnormal ☐ Normal | | |
| LH | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Estradiol | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Prolactin | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Thyroid tests (TSH, T4) | ☐ Not done ☐ Abnormal ☐ Normal | | |
| DHEAS | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Testosterone | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Progesterone | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Mycoplasma culture | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Chlamydia culture | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Antichlamydial antibodies | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Hysterosalpingogram (HSG) | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Ultrasound | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Saline sonohystogram | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Laparoscopy | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Hysteroscopy | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Karyotype genetic testing | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Anticardiolipin antibodies | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Lupus anticoagulant | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Antinuclear antibodies (ANA) | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Coagulation screen | ☐ Not done ☐ Abnormal ☐ Normal | | |
| Biochemistry/hematology panel | ☐ Not done ☐ Abnormal ☐ Normal | | |

Patient name

Date of birth

## Previous Treatments

| | How many months? | Dose (if known) | Approximate dates taken |
|---|---|---|---|
| Clomiphene (Clomid, Serophene) | | | |
| Gonadotropins (Follistim, Gonal-F, Bravelle, Menopur) | | | |
| HCG (Novarel, Ovidrel) | | | |
| Progesterone | | | |
| Dexamethasone or other steroid | | | |
| GnRH agonist (Synarel, Lupron) | | | |
| GnRH antagonist (Ganirelix, Cetrotide) | | | |
| Intrauterine insemination | | | |
| Insemination with donor sperm | | | |
| IVF (In Vitro Fertilization) | | | |
| Donor egg | | | |
| Surrogacy | | | |
| Other | | | |

Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

Patient name

Date of birth

## Social History

Current smoker ☐ Yes ☐ No If yes, number of cigarettes per day _____

Past smoker ☐ Yes ☐ No If yes, how long did you smoke? _____ When did you quit? _____

Alcohol ☐ Yes ☐ No If yes, type and number of drinks per week: _____

Marijuana ☐ Yes ☐ No If yes, number of times used per week: _____

Other drugs ☐ Yes ☐ No If yes, type and number of times used per week: _____

Intravenous drug use ☐ Yes ☐ No If yes, type and when? _____

Number of caffeine drinks per day: _____

Radiation exposure ☐ Yes ☐ No If yes, explain: _____

Toxic exposure ☐ Yes ☐ No If yes, explain: _____

Video display terminal use ☐ Yes ☐ No If yes, explain: _____

Electric blanket use ☐ Yes ☐ No If yes, explain: _____

Hot tub or sauna use ☐ Yes ☐ No If yes, explain: _____

Vigorous exercise ☐ Yes ☐ No

Type: _____ Hours/week: _____

Type: _____ Hours/week: _____

## Ethnic Background

The Centers for Disease Control and Prevention (CDC), through the Society for Assisted Reproductive Technology (SART), has statistical reporting requirements which request the race/ethnicity of our patients.

Ethnicity: (Check all that apply)

☐ White

☐ Hispanic or Latino

☐ Black or African American

☐ Asian

☐ Native American or Alaskan Native

☐ Native Hawaiian or other Pacific Islander

☐ Unknown

Fertility Centers OF ILLINOIS®

Your Miracle. Our Mission.®

Patient name

Date of birth

In order to determine which genetic tests may be recommended for you, describe your ethnicity/your family's country (or countries) of origin:

Additionally, for genetic testing reasons, please check this box if you are: ☐ Ashkenazi Jewish, Cajun, and/or French Canadian

Have you ever had any Genetic Testing based on your ethnicity marked above? ☐ Yes ☐ No

If yes, specify the reason(s) for this testing below:

☐ No family history (screening)

☐ Known family history

☐ Known carrier

☐ Egg donor

☐ Infertility

## Additional Information

Please list any additional information that you feel your physician and health care team may need.

## Signature Area

By signing below, I acknowledge that all information provided is complete and accurate to the best of my knowledge and that I authorize all actions as initialed above.

Signature Date

Fertility Centers OF ILLINOIS®

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# NOTICE OF PRIVACY PRACTICES

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

**Introduction**

This Notice of Privacy Practices is being provided to you on behalf of Fertility Centers of Illinois, with respect to medical services provided at Fertility Centers of Illinois' facilities (collectively referred to herein as "We" or "Our). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "Protected Health Information (PHI)." Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received or payment for your health care.

**Your Rights**

Although your health record is the physical property of Fertility Centers of Illinois, you have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by applicable law
- Obtain a paper copy of this Notice of Privacy Practices upon request
- Inspect and copy your health record as provided for by applicable law
- Request an electronic copy of your electronic health record
- Request to amend your health record as provided by applicable law
- Obtain an accounting of disclosures of your health information as provided by applicable law
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- Request a restriction of disclosure of your health information to your health insurer for services for which you pay "out of pocket" in full
- Transmit copies of your health information to third parties when requested by you, in writing

Fertility Centers OF ILLINOIS®

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**Our Responsibilities**

We are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Where required by law, notify you in the event that there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all Protected Health Information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at **fcionline.com**, as well as at our offices, and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which we receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect except where we have already relied upon your authorization.

**Permitted Uses and Disclosures**

*We will use and disclose your health information for **treatment**. For example:* Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. That way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

*We will use your health information for **payment**. For example:* A bill may be sent to you or a third party payer, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment. If you indicate your interest in participating in the Attain IVF Program, we will provide relevant information concerning your medical condition to IntegraMed America's Attain Fertility Division for determination of your qualifications for this financing program.

*We will use and disclose your health information for our **health care operations**. For example:* Members of the clinical staff, the risk or quality improvement manager or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and the reproductive medicine service we provide.

Fertility Centers OF ILLINOIS®

Your Miracle. Our Mission.®

**Other Uses or Disclosures of Protected Health Information**

**Business Associates:** There are some services provided at Fertility Centers of Illinois through contacts with business associates. For example: The management services of IntegraMed America, Inc. and certain laboratories for testing. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do, and bill you or your third party payer for services rendered. So your health information is protected, however, we require the business associate to appropriately safeguard your information.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

**Communication With Spouse/Family:** Health professionals, using their best judgment, may disclose to your spouse, family member or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures and we will not make these disclosures if you object.

**Research:** We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Marketing:** Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.

**Public Health:** As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

**Law Enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTE: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

**For More Information or to Report a Problem/Complaint**

If you believe your privacy rights have been violated, immediately contact Fertility Centers of Illinois' Privacy Officer at **847.729.2188**.

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

If you have any questions or would like further information about this notice, contact Fertility Centers of Illinois' Privacy Officer at **847.729.2188** or visit **fcionline.com**.

This notice is effective as of September 23, 2013.

Fertility Centers OF ILLINOIS®

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# NEW PATIENT INFORMATION – U.S. PATIENTS

Our goal at Fertility Centers of Illinois is to provide you with the most sensitive, comprehensive and technologically-advanced fertility care. In order to make the most of your time at the first appointment, we respectfully request that you prepare ahead of time by following the steps listed below:

1. Review the **Fertility Centers of Illinois Notice of Privacy Practices**.

2. Print and complete the following documents and bring them with you.
   We warmly welcome all types of families, whether pursuing treatment as an individual or as a couple. Complete the following applicable form(s) or portions of forms for your individual circumstances:
   - **Female New Patient Packet (to be completed by any female patient who will receive medical services)**
   - **Male New Patient Packet (to be completed by any male patient who will receive medical services)**

3. If you have Aetna or Humana Insurance, refer to the following requirements from your insurer: **Aetna and Humana Insurance Form**.

4. In order for us to determine which test(s) and treatment(s) may be best for you, **it is important to bring any pertinent medical records with you**. Be sure to contact the health care provider that retains these records and ask for a copy to be provided. To allow time for the authorization, copying and mailing processes, request the records as soon as possible.

5. For questions about our locations, visit **http://www.fcionline.com/locations/**.
   For travel and lodging information, as well as local attractions and activities, visit **http://www.fcionline.com/out-of-town/**.

6. Bring your insurance card(s) and photo identification (i.e. driver's license, state ID) with you; copies will be needed for our files.

7. In order to complete the registration process, please arrive 20 minutes prior to your appointment time.

8. We love children, however, because our staff is dedicated to providing their undivided attention to our patients, we are not able to monitor patients' children during office visits. Please be sure that young children are secured in a stroller for their safety. Whenever possible, have someone come with you to provide care for your child while you spend time with your physician and health care team.

**Fertility Centers of Illinois strives to provide excellent care to every patient in a timely manner. In order for us to best utilize available appointments for patients waiting to be seen, we require a minimum of 48 hours (two business days) notice if you need to cancel or reschedule your appointment. If you miss your appointment or provide less than 48 hours notice to cancel or reschedule, then your credit card will be charged $50 for weekday appointments and $100 for weekend appointments. To cancel or reschedule an appointment, call 877.324.4483.**

We look forward to meeting you. Contact your Fertility Centers of Illinois
Patient Services Team with any questions, concerns or feedback.