



Your Miracle. Our Mission.

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
MPI#

### FEMALE PATIENT: U.S.

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

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Marital status

\_\_\_\_\_  
Home address (street, city, state, zip code)

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

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Fertility Centers  
OF ILLINOIS

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**Employment**

\_\_\_\_\_  
Company name

\_\_\_\_\_  
Company address (street, city, state, zip code)

\_\_\_\_\_  
Occupation

**Primary Insurance**

\_\_\_\_\_  
Insurance company

\_\_\_\_\_  
Address (street, city, state, zip code)

\_\_\_\_\_  
Policy ID number

\_\_\_\_\_  
Group number

\_\_\_\_\_  
Policy holder's name

\_\_\_\_\_  
Policy holder's phone number (if different than above)

**Secondary Insurance (if applicable)**

\_\_\_\_\_  
Insurance company

\_\_\_\_\_  
Address (street, city, state, zip code)

\_\_\_\_\_  
Policy ID number

\_\_\_\_\_  
Group number

\_\_\_\_\_  
Policy holder's name

\_\_\_\_\_  
Policy holder's phone number (if different than above)

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**Referral/Health Care Provider Information**

Specify how you found us.

- Referred by physician   
  Friend/Family   
  Internet   
  Insurance list   
  Education seminar  
 Radio   
  Television   
  Yellow Pages   
  Other: \_\_\_\_\_

\_\_\_\_\_  
Name of physician who referred you

\_\_\_\_\_  
Name of medical group

\_\_\_\_\_  
Address (street, city, state, zip code)

\_\_\_\_\_  
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, zip code)

\_\_\_\_\_  
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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**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.

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**3. Patient Financial Responsibility Notice – Payment & Information Release Consent & HIPAA Acknowledgment: U.S. Patients**

The goal of Fertility Centers of Illinois is to offer you the most sensitive, comprehensive and technologically-advanced care. If you have insurance coverage, we will make our best efforts to coordinate your care in a cost-effective manner within the limits of your insurance benefit and to minimize the expenses for which you are responsible.

Fertility benefits vary widely by state, insurer and specific plan. You are ultimately financially responsible for all charges incurred. Your policy determines the extent to which you will be responsible for all deductibles, co-payments, co-insurance and non-covered services. Fertility Centers of Illinois is not responsible for incorrect information given by your insurance company or failure of your employer to provide accurate information to your insurer about your employment status. Payments to Fertility Centers of Illinois are subject to audit and may require refunds that make you responsible for the charges.

The coverage available to you depends upon your employment status and the choices you make within the plans that are offered to you by your employer. Fertility Centers of Illinois cannot monitor all the requirements of the hundreds of different plans offered in our area. You are responsible for understanding the details of your insurance plan, and we rely on you to keep Fertility Centers of Illinois up to date with correct information about your coverage. This information includes, but is not limited to change of your employment status or status as a beneficiary under family coverage, change of insurance company or plan offered by your employer, or loss of insurance coverage or bankruptcy of your employer.

Fertility Centers of Illinois may find it necessary to decline to treat any patient if the insurer or patient has not made payment.

Managed care plans may require a written referral prior to your receiving service from Fertility Centers of Illinois. If this is the case, you must have the referral with you at the initial appointment, or the appointment may be rescheduled. If you choose to proceed without a valid referral, you will be responsible for all charges.

Some insurance plans require that patients complete a fertility evaluation or other tests before the insurance plan will determine coverage.

Some insurance plans are “diagnostic only,” meaning that they cover certain tests to determine the cause of infertility, but not treatment; in these cases, the patient is financially responsible for all charges not covered by the insurer.

Some insurance plans place a lifetime maximum on what they will pay toward fertility testing and/or treatments; once this maximum is reached, the patient is responsible for all charges.

In regards to drug coverage, please check with your insurance company about:

- How much of the fertility drug costs will they cover?
- Is there a specific pharmacy which must be used for fertility drugs?
- Is prior-authorization required for fertility drugs?

**For Illinois residents:** The Family Building Act requires many, but not all, insurers in Illinois to offer coverage to Illinois residents for infertility treatments. Your FCI financial coordinator or office manager can give you a copy of the Act, or you can view it at <http://insurance.illinois.gov/healthinsurance/infertility.asp>. You may also call the Office of Consumer Health Insurance toll free at 877.527.9431. If you have any questions about coverage, you should seek clarification from your employer and insurance plan in writing before you begin treatment.

\_\_\_\_\_ I have read and understand the policy outlined above and agree to accept full financial responsibility as described. I  
Initial here authorize payment to Fertility Centers of Illinois of insurance benefits for claims submitted on my behalf and I also authorize Fertility Centers of Illinois to release any medical information necessary for claims payments. Patients who are married or in a legal union are jointly responsible for all charges incurred.

\_\_\_\_\_ I acknowledge that I have received a copy of Joint Notice of Privacy Practices.  
Initial here

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**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.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
2.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
3.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
4.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
5.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

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? \_\_\_\_\_

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### 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? \_\_\_\_\_

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## Medical History

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

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

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

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\_\_\_\_\_  
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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:

\_\_\_\_\_  
\_\_\_\_\_

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**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. _____	_____	_____

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**Previous Evaluations**

Have you had (check all that apply):

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

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**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			

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### 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, number of hours per day: \_\_\_\_\_
- Electric blanket use  Yes  No If yes, frequency: \_\_\_\_\_
- Hot tub or sauna use  Yes  No If yes, frequency: \_\_\_\_\_
- 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



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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



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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

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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](http://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.

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### 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.

**877.324.4483 | fcionline.com**



Your Miracle. Our Mission.

## 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.

**877.324.4483 | [fcionline.com](http://fcionline.com)**