Patient name

Date of birth

MPI#

MALE PATIENT: U.S.

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

Patient Information

Demographics

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

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:

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

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

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

☐ ______ Email

Emergency contact name | Phone number

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Patient name

Date of birth

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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Patient name

Date of birth

Referral/Health Care Provider Information

Specify how you found us.

☐ Refer to Spouse/Partner's Form ☐ 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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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.

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Patient name

Date of birth

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

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

_______________ Initial here — I have read and understand the policy outlined above and agree to accept full financial responsibility as described. I 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.

_______________ Initial here — I acknowledge that I have received a copy of Joint Notice of Privacy Practices.

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Patient name ______________________

Date of birth ______________________

Medical History

Do you have any serious or chronic illnesses or injuries? ☐ Yes ☐ No

If yes, describe:

____

____

Do you take any medications or supplements? ☐ Yes ☐ No

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.				

Do you have any difficulty with erection or ejaculation? ☐ Yes ☐ No

If yes, describe:

____

____

____

Have you ever had a Semen Analysis (SA)? ☐ Yes ☐ No

If yes, were the results ☐ Normal or ☐ Abnormal?

Have you ever fathered a pregnancy? ☐ Yes ☐ No

If yes, when? ____

Past cause(s) of infertility previously diagnosed: ____

Treatment(s): ____

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

- ☐ Abdominal surgery
- ☐ Antichlamydial antibodies
- ☐ Biopsy of testicles
- ☐ Cancer
- ☐ Chlamydia
- ☐ Colitis
- ☐ DES exposure in womb
- ☐ Diabetes
- ☐ Excessive stress
- ☐ Genital herpes
- ☐ Genital warts/Condyloma
- ☐ Gonorrhea
- ☐ Hernia surgery
- ☐ High blood pressure
- ☐ Injury to the testicle(s)
- ☐ Mumps
- ☐ Mycoplasma
- ☐ Penile discharge or pain
- ☐ Physical abnormality
- ☐ Prostatitis
- ☐ Psychiatric treatment
- ☐ Seizures
- ☐ Strenuous exercise
- ☐ Syphilis
- ☐ Undescended testicle
- ☐ Ureaplasma
- ☐ Urethritis/epididymitis
- ☐ Varicocele
- ☐ Varicocele surgery
- ☐ Vasectomy
- ☐ Vasectomy reversal

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: ______________

Do you wear tight underwear? ☐ Yes ☐ No

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Patient name

Date of birth

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

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

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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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