



(770) 928-2276

email: info@acrm.com

fax (770) 592-2092

www.acrm.com

Lisa A. Hasty, MD, FACOG
André L. Denis, MD, MPH, FACOG
Jim Toner, MD, PhD, FACOG
Sue Ellen Carpenter, MD, FACOG
Robin H. Fogle, MD, FACOG
David L. Keenan, MD, FACOG
Reproductive Endocrinology and Infertility

Chad A. Johnson, PhD, HCLD
Reproductive Studies Laboratory Director
Steven A. Voelkel, PhD, HCLD
Director of Research

Steven C. Gerson, CPA, MPAcc
Chief Financial Officer

Dear Patient:

Welcome to the Atlanta Center for Reproductive Medicine. It is our pleasure to serve you in the area of Reproductive Medicine and Infertility. We are dedicated to providing the highest quality of total patient care.

Together, our medical, reproductive studies laboratory staff and nursing staff bring over 100 combined years of professional experience to treat reproductive and infertility disorders. Our Center's staff focuses on using knowledge and skill in bringing patients a broader array of options for treatment plans which meet their clinical, psychological, and financial needs. Our primary concern is bringing together a treatment strategy that reflects a proper match of solution to patient problem.

We take great care in ensuring that patients are treated at all times with unparalleled clinical excellence, as well as with tremendous sensitivity. The endeavor of the physicians and the staff is to assist the patient in making decisions that are right for their circumstances.

In preparation for your first visit, we ask that you read and complete the attachments regarding medical records, financial and insurance information, and general practice information.

We look forward to caring for you and in making your visits as comfortable as possible. Should you ever have any questions or concerns, please feel free to call us.

Thank you for the opportunity to serve you.

Sincerely,

Atlanta Center for Reproductive Medicine

Atlanta Center for Reproductive Medicine

5909 Peachtree Dunwoody Road, Suite 720 Atlanta, GA 30328
1800 Howell Mill Road, Suite 675, Atlanta, GA 30318
6470 East Johns Crossing, Suite 200, Johns Creek, GA 30097-2511

General Information



OFFICE HOURS:

Office Visits: 8:00AM - 4:00 PM Monday through Friday
Telephone Availability: 8:00AM - 4:00 PM Monday through Friday
Calls after 4 PM will be returned the next business day.

WEEKEND OFFICE VISITS: Some infertility treatment approaches require daily ultrasound and hormone level monitoring. All weekend monitoring is performed at our Atlanta Perimeter location during AM hours.

MAIN OFFICE TELEPHONE NUMBER:

770-928-2276

MAIN OFFICE FAX NUMBER:

770-592-2092 (Atlanta - Perimeter Office)

HOLIDAYS AND HOLIDAY WEEKENDS

Occasionally the office will close early on the day before a holiday or holiday weekend. To make sure that you reach us and have your questions answered, please call before noon on these days.

EMERGENCIES

In the event you have an after-hours emergency, telephone calls will be answered by our answering service. They will refer emergency calls to the physician on call. Messages will be taken for non-emergency calls, such as appointment scheduling, test results, etc. These messages will be promptly returned the next business day.

CHILDREN IN OUR OFFICE

For the comfort of the patients around you, and for the safety of your children, we ask that you please arrange for childcare during visits to our office. Our staff cannot be responsible for supervision of children in the waiting area and OSHA safety regulations do not allow us to have children in the clinical areas or exam rooms.

Thank you,
The Staff of Atlanta Center for Reproductive Medicine

Your Initial Appointment



We are committed to providing quality and excellence in our care for our patients. In that regard, we set aside over an hour with our physicians and primary nurses for our new patient appointments. We thus have plenty of time to discuss fully your history, your current situation and develop an individualized treatment approach with you.

Out of consideration for the many other families who are waiting for appointments and because of the significant quantity of the time allotted for you, we ask that if you find that you are unable to keep your scheduled appointment you cancel within 24 hours of the actual appointment. Same-day cancellations and/or no shows for appointments will be subject to a \$100.00 fee.

We confirm our new patient appointments four (4) business days in advance. Should we be unable to confirm your appointment by the third day prior to the appointment, we will assume you will not be keeping the appointment. We will thus remove your appointment from our schedule.

MEDICAL RECORDS INFORMATION

In preparation for your first visit, we are enclosing general medical, patient, and insurance information forms. The completed forms should be faxed to 770-592-2092 immediately upon receipt. Even though you have faxed your completed forms to us in advance, please bring the completed original forms with you to your first visit.

You should complete the enclosed Medical Records Release Authorization form and fax it to your physician(s). The form instructs them to fax the requested information to our main office at 770-592-2092. Our knowledge of your prior history and treatment is essential in properly assessing your current circumstances.

PRE-CONCEPTUAL SCREENING LABS

For those preparing for pregnancy, we obtain pre-conceptual screening lab information on each new patient. These lab tests are listed below:

Female Screening Labs

HIV	GC & Chlamydia Cultures
Hepatitis B, C	Blood Type & RH
Rubella Titre	RPR
CBC with Diff	PT, PTT
Pap	

Male Screening labs

HIV
RPR
Hepatitis B,C
Blood Type & Rh

If you have had any of these tests performed in the last 12 months, please obtain a copy of the results from the physician/facility where the tests were performed, and provide it to our office for your records here.

If you have not had these tests performed in the last 12 months, the physician will order them during or subsequent to your first visit with us *if you attempt pregnancy*.

New Patient Questionnaire



It is very important that we understand your health history in order to best help you. Please take time to answer these questions honestly. Seemingly unimportant facts may prove helpful. If for any reason you have a personal objection to answering any specific portion of this questionnaire, leave it blank and talk to us in private. This questionnaire will be held in strictest confidence. You may find that certain sections of this questionnaire do not pertain to your situation. Please complete all relevant portions.

Date: _____

Your name: _____ Nickname: _____

Your Age: _____ Occupation: _____

Phones: Home: _____ Work: _____

Cell: _____ Pharmacy: _____

E-Mail: _____

Husband/Partner's name: _____ Nickname: _____

Age: _____ Occupation: _____

Phones: Work: _____ Cell: _____

E-Mail: _____

Your Address: _____

Referred by: _____

Current Ob/Gyn doctor: _____

Practice name: _____

Address: _____

Phone: _____

REASON FOR VISIT

What problem(s) do you want help with?

MEDICAL HISTORY

Weight: _____ Height: _____

Do you follow a particular food diet or have any special dietary habits? Yes No

If yes, specify: _____

When was your last annual gyn exam? _____

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

- | | | |
|--------------------------------------------------|--------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Excess hair (hirsutism) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Breast Discharge | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Seizures / Epilepsy |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Diabetes / Insulin Resistance | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Hepatitis ___A ___B ___C |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid problems | |
| <input type="checkbox"/> Delayed Puberty | <input type="checkbox"/> Sickle cell disease | |

Any Allergies? List: _____

List any regular vigorous exercise you get below (swimming, cycling, running, etc.)

Type of Exercise	Hours/wk	Age you began

Within the last year, have you taken any prescription medications? Please chart below.

Medication	Diagnosis / Reason	Dosage	Frequency	Duration

Are you taking any vitamins, over-the-counter meds, or nutritional supplements on a regular basis? Please chart below.

Medication	Diagnosis	Dosage	Frequency	Duration

Do you or have you ever used (check **all** that apply):

Alcohol: How many drinks per week usually? Wine _____ Beer _____ Cocktails _____

Cigarette use:

o Average number of cigarettes smoked daily in the past 3 months (circle answer):

▪ < 1, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10-20, >20

o Number of years of smoking: _____

Recreational Drugs (Marijuana, Cocaine, etc.)

[If you would feel more comfortable not writing anything down, please discuss this directly with your physician]

Specify: _____

If married:

- Which marriage is this for you? _____
- How long have you and your husband known each other? _____
- How long have you been married? _____

MENSTRUAL HISTORY

Age at first period: _____ Date of LAST period: _____ Are your periods regular? Yes No

What is the usual # of days from the start of one period and the next? _____ Minimum
_____ Maximum _____

What is the usual # of days your periods last? _____ Minimum _____ Maximum _____

Do you bleed or spot between periods? Yes N.

Have you ever used an intrauterine device (IUD)? Yes No What type: _____ For how long? _____

Have you ever had pelvic inflammatory disease (PID)? Yes No Describe: _____

Do you have PMS? Yes No If yes, is it: MILD MODERATE SEVERE

Do you have painful menses? Yes No If yes, is it: MILD MODERATE SEVERE

Is intercourse painful? Yes No If yes, is it: MILD MODERATE SEVERE

Do you use lubricants for intercourse? Yes No Which brand? _____

Do you douche before or after intercourse? Yes No

How many times per week do you and your partner have intercourse? _____

How many months have you been trying to get pregnant? _____

How many months have you had unprotected intercourse? _____

Did your mother have any difficulty with conception or pregnancy? Yes No Don't know

Did your mother take diethylstilbestrol (DES) when she was pregnant with you? Yes No Don't know

At what age did your mother begin menopause? _____

Have you used Basal Body temperature (BBT)? Yes No. If yes, what day did you ovulate? _____

Have you used an ovulation predictor kit (OPK)? Yes No If yes, what day did you ovulate? _____

Have you been exposed to any toxins? Yes No If yes, which: _____

How many cups of coffee or caffeinated beverages do you drink each day? _____

What is your ethnic origin?

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- White
- Unknown
- Native Hawaiian or other Pacific Islander

Do you have any ancestors from the following ethnic groups?

- Ashkenazi Jewish
- Mediterranean
- African
- Cajun
- French Canadian
- Asian

Is there a family history of infertility? Yes No.

If yes, describe: _____

Is there a family history of birth defects? Yes No.

If yes, describe: _____

Is there a family history of recurring miscarriages? Yes No.

If yes, describe: _____

PREGNANCY HISTORY

How many pregnancies have you had altogether? _____

How many full-term (>37 weeks) births have you had? _____

How many pre-term (< 37 weeks) births have you had? _____

How many miscarriages have you had? _____

How many ectopic ("tubal") pregnancies have you had? _____

How many abortions have you had? _____

How many adopted children do you have? _____

Please fill in the chart below:

#	Year	Outcome?	Type of therapy required to conceive:	How long to conceive? (months)	Baby born past 37 weeks?	Baby born alive?	Is current partner the father?
		<input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Ectopic <input type="checkbox"/> Delivery			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Ectopic <input type="checkbox"/> Delivery			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Ectopic <input type="checkbox"/> Delivery			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Ectopic <input type="checkbox"/> Delivery			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Ectopic <input type="checkbox"/> Delivery			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

HOSPITALIZATIONS / SURGICAL HISTORY

Have you had any surgeries / operation? No Yes (describe below).

Have you ever been surgically sterilized? No Yes

Have you been hospitalized for other than surgery? No Yes (describe below).

Please complete the chart about any prior surgeries or hospitalizations:

Year	Reason for surgery or hospitalization	Procedure or Treatment	Outcome

PRIOR FERTILITY TESTING

Have you been evaluated for infertility before? Yes No.

If yes, who was your physician? _____

Address: _____

What cause of infertility was diagnosed? _____

Which of the following tests have you had performed? *Check all that apply and results if known.*

- 'Day 3' FSH, LH, Estradiol Date: ___/___/___ Results: _____
- AMH (anti-Mullerian hormone) Date: ___/___/___ Results: _____
- Hysterosalpingogram Date: ___/___/___ Results: _____
- Saline sonogram Date: ___/___/___ Results: _____
- Laparoscopy Date: ___/___/___ Results: _____
- Hysteroscopy Date: ___/___/___ Results: _____
- Postcoital Test Date: ___/___/___ Results: _____

INFERTILITY TREATMENT HISTORY

- ◆ Number of prior clomiphene (Clomid, Serophene) cycles: _____
- ◆ Number of prior Letrozole (Femara) cycles: _____

details:

	Drug	Dose	# follicles	Intrauterine Insemination (IUI)?	Pregnancy?
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

◆ Number of prior Gonadotropin Cycles: _____

(Gonadotropins are FSH and LH, and include: Follistim, Gonal-F, Bravelle, Repronex, and Menopur)

details:

	Dose	peak Estradiol	# follicles	Intrauterine Inseminations?	Pregnancy?
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

◆ Number of prior Fresh In Vitro Fertilization (IVF) Cycles: _____

◆ Number of prior Frozen IVF Cycles: _____

details:

	1	2	3	4
Date				
IVF Center				
Fresh or Frozen Cycle?				
Max. Starting Dose				
# Eggs Retrieved				
# Eggs Fertilized				
ICSI?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
# Embryos Transferred				
Embryo Age (day 2, 3, 5, or 6)?				
Pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

MALE HISTORY

Marriage #: _____

Weight: _____ Height: _____ Blood type (if known): _____

Urologist: _____

Address: _____

Number of pregnancies conceived with current partner: _____

Number of pregnancies conceived with previous partners: _____

Please give dates and outcomes of pregnancies with prior partners:

Date of pregnancy	Delivered?	Aborted?	Miscarried?

Have you ever had a semen analysis (sperm count) performed? Yes No.

Volume	Count (million/ml)	Motility (%)	Morphology (%)

Do you have any medical problems unrelated to your fertility?

Nature of problem	Treatment	Physician

Have you had any surgeries / operation? No Yes (describe below).

Have you ever been surgically sterilized? No Yes

Have you been hospitalized for other than surgery? No Yes (describe below).

Please complete the chart about any prior surgeries or hospitalizations:

Year	Reason for surgery or hospitalization	Procedure or Treatment	Outcome

Within the last year, have you taken any prescription medications? Please chart below.

Medication	Diagnosis / Reason	Dosage	Frequency	Duration

In particular, have you ever taken these medications:

- Sulfasalazine
- Cimetadine (Tagamet)
- Chemotherapy
- Calcium channel blockers (e.g., Norvasc, Procardia; any generic drug name ending in "-dipine")
- Allopurinol
- Anabolic steroids
- Interferon
- Colchicine
- Androgen hormones
- Antidepressants

Do you or have you ever used (check all that apply):

- Alcohol: How many drinks per week usually? Wine _____ Beer _____ Cocktails _____
- Cigarette use:
 - o Average number of cigarettes smoked daily in the past 3 months (circle answer):
 - < 1, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10-20, >20
 - o Number of years of smoking: _____
- Recreational Drugs (Marijuana, Cocaine, etc.)
 [If you would feel more comfortable not writing anything down, please discuss this directly with your physician]
 Specify: _____

Do you or have you ever had any difficulties with (check all that apply):

- Erection: If yes, please explain: _____
- Ejaculation: If yes, please explain: _____

- Have your genitals ever been exposed to excessive heat? Yes No.
 - Have you had any serious injuries to your genitals? Yes No.
 - Have you had any infections of your penis, testicles or prostate gland? Yes No.
 - Is there any history of birth defects in your family? Yes No.
 - Is there any history of recurrent miscarriage in your family? Yes No.
 - Do you have any allergies to medications? Yes No.
- If yes, please note: _____

What is your ethnic origin?

- American Indian or Alaska Native
- Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- Asian
- White
- Black or African American
- Unknown

Do you have any ancestors from the following ethnic groups?

- Ashkenazi Jewish
- Cajun
- Mediterranean
- French Canadian
- African
- Asian

**ATLANTA CENTER FOR REPRODUCTIVE MEDICINE
AUTHORIZATION FOR VERIFICATION OF INSURANCE BENEFITS
AND PREQUALIFICATION FOR OTHER PATIENT FINANCIAL SERVICES**

Note: A separate form must be completed for husband and wife, if applicable.

* Social Security Number is requested in that most insurance companies identify covered persons by social security number.

Patient's Name _____ Date of Birth _____ Patient's Social Security No.* _____

Insured's Name _____ Date of Birth _____ Insured's Social Security No.* _____

Insured's Address _____ Home Phone Number _____

Patient's relationship to Insured: ___ Self ___ Spouse ___ Other

Complete the following, using your health insurance card.

Primary Insurance Company _____

Insurance Company Phone number listed on card for Benefits determination _____

ID No. _____ Group No. _____

Insured's Employer _____ Policy No. _____

Secondary Insurance Company _____

Insurance Company Phone number listed on card for Benefits determination _____

ID No. _____ Group No. _____

Insured's Employer _____ Policy No. _____

Complete the following, using your prescription benefits card, if you have one.

Primary Insurance Company _____

Insurance Company Phone number listed on card for Benefits determination _____

ID No. _____ Group No. _____ Policy No. _____ Other No. (Specify Type) _____

Insured's Employer _____

Secondary Insurance Company _____

Insurance Company Phone number listed on card for Benefits determination _____

ID No. _____ Group No. _____ Policy No. _____ Other No. (Specify Type) _____

Insured's Employer _____

I hereby give my permission for Atlanta Center for Reproductive Medicine (ACRM), OR third party company who it designates to obtain from my health insurance and prescription benefits companies full and complete health insurance and medication coverage information, including, but not limited to coverage related to infertility (**if applicable**). I give my permission to ACRM to forward the information provided above to the third party company for benefit verification purposes. I give my permission to the third party company to forward health insurance benefit and prescription benefit information obtained from my insurance companies to ACRM. A facsimile of this signed document shall stand as an original.

I also hereby give my permission to ACRM, to forward certain medical information it deems necessary to an outside third party who is designates to determine my eligibility to participate in certain patient financial service programs that are made available through ACRM. These include, but are not limited to the Shared Risk Program and Family Fee Financing Program. Patients are in no way required to participate in these programs. I likewise give my permission to the third party company to forward to ACRM my prequalification status.

The health insurance and medication benefits verification program and the financial services prequalification program is offered as a courtesy and without charge. Neither ACRM or the third party company performing the insurance verification of benefits and prequalification for patient financial service programs shall have any liability to any person with respect to assistance provided under the program, including if insurance or the reimbursement coverage is verified under the program, but coverage is later denied; or if the prequalification is preliminarily granted but subsequently not granted. Patients are encouraged to confirm all insurance or reimbursement coverage determinations made under the program directly with their insurance carrier or other reimbursement source.

Signature _____

Date _____

ATLANTA CENTER FOR REPRODUCTIVE MEDICINE
Infertility, Gynecology & Reproductive Endocrinology

PATIENT REGISTRATION FORM (please print)

PATIENT

Name _____
Last First Middle Name Called

Home Address _____

City/State/Zip _____

Telephone Home () _____ Work () _____
Cell () _____ Pager() _____

Date of Birth _____ Race _____ Social Security # _____ Marital Status _____

Employer's Name _____ Occupation _____

City/State/Zip _____

***Please provide a Physical Address as well as Mailing Address**

PARTNER/SPOUSE

Name _____
Last First Middle Name Called

Telephone Home () _____ Work () _____
Cell () _____ Pager () _____

Date of Birth _____ Race _____ Social Security # _____ Marital Status _____

Employer's Name _____ Occupation _____

City/State/Zip _____

***Please provide a Physical Address as well as Mailing Address**

Person to inform, other than spouse, in case of emergency _____

Telephone _____ Relationship _____

Name of Referral Source _____

Business Address _____

City/State/Zip _____ Telephone () _____

I hereby make the assignment of all disability, surgical, medical, and major insurance benefits to Atlanta Center for Reproductive Medicine, LLC and to release any medical information necessary to execute an assignment of benefits. I understand that regardless of any insurance coverage I might have, I am personally responsible for all charges to this account. I further agree in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fees should this be requested.

Attention All Aetna Patients - You may be required to register with Aetna's Infertility Hotline. If a patient is required by Aetna to register with the Aetna Infertility Hotline but fails to do so, Aetna will not consider paying for any services, and all services rendered will be your responsibility. Call 1.800.575.5999, Option 2 to obtain your registration number, and complete the below:

My Aetna Registration No. is: _____ OR ___ I called Aetna and was informed that I am not required to register.

PATIENT AUTHORIZATION

I understand that I am responsible for services rendered and I agree to pay for services at the time of service. I hereby authorize Atlanta Center for Reproductive Medicine, LLC to release any information acquired in the course of my examination and treatment to my insurance company or to another physician. I direct my insurance carrier to issue payment directly to Atlanta Center for Reproductive Medicine, LLC. I understand that I am financially responsible to Atlanta Center for Reproductive Medicine, LLC for any balance not covered by my insurance carrier. The cost of collection (35%) will be added to all delinquent accounts at the time they are placed with a collection agency.

I/We understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the Atlanta Center for Reproductive Medicine may add one and one half percent (1 ½%) per month to any balance owed, and in the event of default to pay collection charges and/or attorney fees.

Signature of Patient Date

Signature of Spouse/Partner Date

To help you understand and anticipate any difficulties in insurance benefits you may encounter, please review this document.

Insurance coverage in this area of medicine is not as straightforward as in most other areas. For example,

- many times there is coverage for testing to determine *why* you are infertile, but no coverage for its treatment
- many times payment depends on *why* the service was performed. For instance, if we do an ultrasound of your ovaries to ensure that an ovarian cyst is shrinking, it will be paid, but if we do the ultrasound to track your response to fertility medications, it will often not be paid.
- many times the information we get from your insurer over the phone is incorrect or incomplete.

To best serve you, we have developed this approach:

Determination of Insurance Benefits

When you become a patient at ACRM, we contact your insurance company to obtain information regarding the coverage you have for infertility care. We have developed a list of the questions that we ask so as to get a picture of the nature and extent of your coverage. We will provide you a copy of this summary. Please review this information. If you think you have different coverage, or a different level of benefits, please notify us, so we may clarify the information. We suggest that you also call your insurance company directly for clarification.

Unfortunately, this 'verification' of benefits does not oblige insurers to pay. Insurance companies protect themselves by stating that verification of your insurance coverage by them is:

- not a guarantee of payment, and is
- not a guarantee of what is actually covered and not covered.

Because of this disclaimer, even when they have told you or us that a service is covered, there is no obligation for them to pay. The true determination as to whether a service is covered is made at the time the claim is received by the insurance company. Whether insurance will pay is dependent on whether:

- the service you received is covered by your plan
- the reason for the service (the diagnosis) is covered by your plan
- the appropriate deductibles and copays have been met
- "pre-existing condition" exclusions apply

Further complicating payment is that some plans require that:

- you have experienced infertility for a specified amount of time before services will be covered, or
- the infertility is not due to prior elective sterilization, or
- certain treatment steps be taken before other treatment steps will be covered. This may not always be consistent with the course of treatment that we think is best for you. For instance, some companies will pay for IVF treatment, but only after 3 tries of gonadotropin cycles have failed.

There may be occurrences where your insurance company denies payment and deems that a service "is not consistent with the diagnosis" assigned to you.

Claims Filing

- ***For Insurance Companies/Networks With Which We Are Contracted***

We will be happy to file a claim for coverage of rendered services with your insurance company if you have insurance with a network with which we participate, if your plan provides benefits for the service provided for the reason it was provided, and if there are no other restrictions on covered services of which we are aware. We will collect any required co-payment at the time of your visit.

If you have insurance with an insurer with which we participate, but your plan does not provide benefits for your diagnosis or for the procedures/services rendered, then full payment is required at each visit. We expect all balances to be settled on the day it occurs.

Currently, we participate in these networks:

<ul style="list-style-type: none">• AETNA - PPO, POS, HMO and Indemnity• Beechstreet PPO• Blue Cross Blue Shield of GA-PPO• Choice Care PPO• Choice Care - WellStar Employee Plan (WEP)• CIGNA - PPO, POS and HMO• Coventry PPO, POS and HMO• First Health (Affordable) PPO• Great West Healthcare PPO, POS and HMO	<ul style="list-style-type: none">• Multiplan PPO• PPO Next/HealthStar PPO• Private Healthcare Systems PPO• Southcare PPO• State Health Plan - UHC - Definity with HRA, HDHP, PPO, HMO and Indemnity• SuperMed PPO (formerly 1st Medical Network)• Unicare PPO• United Health Care PPO, POS, HMO, EPO and Indemnity
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

- ***For Insurance Companies/Networks With Which We are Not Contracted***

If you have health insurance with an insurer with which we do not participate, then full payment for all services rendered is required at the time of your visit. As noted above, we require that each patient's balance be settled on the day it occurs. We will provide you with a statement that can be submitted to your insurance company for reimbursement directly to you.

Other Items

Infertility treatment can be expensive, and we do not want to let you get 'in over your head.' Thus, we collect in full for each service as it is rendered, except in the case of IVF Services, which is discussed further below. We strive to anticipate how much each service will cost you for each and every visit (by calculating your portion of charges after insurance is applied), and expect that costs be paid at that visit. On occasion, however, this is not possible. In some cases the actual charge can only be estimated (as in surgery). In other cases, we discover monies owed after a visit has occurred. These situations are described below, and also the way we handle them.

- *All IVF Cycles*

Fees for all IVF Cycles (IVF, Frozen Embryo Transfers, Egg Recipient/Donor Cycles, etc.) are collected in advance of the start of the Cycle.

- *Surgery*

If you are having surgery, we will calculate an estimate of the charges you would be responsible to pay based on your "in" or "out" of network status and based on the information the insurance company provides to us. This payment is required prior to the surgery. We will also file the claim with your insurance company. If you are "in" network, you are responsible for any patient balance after insurance adjustments have been taken. If you are "out" of network, you are responsible for the difference between what we charge and what insurance pays.

- *Additional Services Rendered*

Occasionally, when the doctors review lab results, they determine that another test is needed to make a complete evaluation. When this occurs, the charges for the additional test will be posted to your account at the time test is ordered.

Occasionally, our audits detect that services were incorrectly posted to your account, resulting in overcharges or undercharges. When we identify such errors, we will correct your account, resulting in a credit or a balance.

- *Settling of Balances*

As discussed above, there are times when insurance companies process a claim in a manner different than expected. In these cases, Initial each box.

- a claim may be completely denied as not covered, with no payment being made, thereby making you entirely responsible for the charge, or
- a claim may pay differently than was anticipated, also thereby making you responsible for a larger portion of the charge than expected.
- even though your insurance company communicated to us and we in turn communicated to you that a given service or set of services is covered, this IS NOT A GUARANTEE BY US of your insurance company's coverage for that service or set of services. If your insurance company denies coverage for any reason, you are responsible for full payment of the services billed. Because the insurance company states that the verbal information they provide is not a guarantee of payment nor can it be relied on as a guarantee of coverage, we are not responsible for any statement made by your insurance company, nor any statement made by us to you based on information given to us by your insurance company. It is very important for you to understand that the only TRUE representation of whether a given service is covered is when your insurance company actually processes the claim.

When this occurs, we will first try to understand why: Was the claim processed correctly? Were the appropriate diagnoses used? Were benefits incorrectly stated to us at verification? Typically an insurance company will send an EOB ("Explanation of Benefits") that outlines what they paid and didn't pay and why. If we believe there are errors in the claim, we will resubmit it. If you receive an EOB that processed your claim differently than you expected, please call your insurance company to clarify. If the insurance company states that they processed the claim incorrectly, please obtain the name of the person you spoke with, and call us with that information so we can note this in your account. If your insurance company reprocesses the claim, when you receive the corrected EOB showing payment was made to us, please call us to issue a refund to you.

If however there are no errors, we will make the corresponding adjustments to your account, determine the portion of the charge you are responsible for, and post this portion to your account.

As stated previously, there are times when an insurance company states that the test or procedure performed is not consistent with the diagnosis assigned to you. The physicians at ACRM perform or order services to be performed when they determine that they are important in the diagnosis and treatment of the patient for the particular circumstances of the patient. When your insurance company denies payment and renders the decision that the services are "not consistent with the diagnosis," it has decided otherwise.

When services have been performed by/ordered by an ACRM physician, and your insurance deems the services to be "inconsistent with the diagnosis," your physician has deemed them to be important in your diagnosis and treatment and for your particular circumstances. Your signature below acknowledges your agreement that you will be responsible for the payment for these services, should your insurance company deny payment and state that these services are "inconsistent with the diagnosis" assigned to you.

Initial each box.

- ***Credit Card Authorizations***

As you may now understand, there are instances of charges being generated or recognized on days when there is no office visit scheduled. With the very busy lives of our patients, it is difficult to reach patients to come in and settle balances as they arise. Therefore, it is our office's policy to require a credit card authorization be maintained on file so that your balances can be settled as they occur. Our patients like this strategy for convenience.

When these cases arise:

- We will call you before making any charge in excess of \$500.
- We will call you before making any charges to a Debit Card, regardless of the amount.
- We will call you before making any charge for a service provided more than 6 months ago.
- We will mail to you a copy of your credit card receipt and your statement on the day the charge is made.

An authorization form will be supplied to you and your spouse for your signatures.

- ***Insurance Company Look Back Periods***

Insurance companies often perform audits of paid claims. These audits can be performed for up to two years from the latter of the following (a) the date of service, (b) the receipt of the claim, (c) the payment of the claim, or (d) the receipt of an appeal. When an insurance company performs an audit of and determines that claims were paid in error and should not have been, the insurance company contacts us for a refund of the monies they paid. They then direct us to collect for these services from the patient. Unfortunately this may mean that for a period of up to two years after any one of the above listed events your insurance company may reverse their decision. If this should occur we will then contact you for payment of these services.

- ***Interest on Unpaid Balances***

Should you have an outstanding balance on your account that is your responsibility and that is greater than 30 days old, we will assess simple interest on the unpaid balance at the rate of 1.5% per month. This represents an annual interest rate of 18%.

- *Administrative Billing Fee When Your Co-Pay, Co-Insurance or Patient Responsibility Balance Is Not Paid at the Time of Service*

When your co-pay, co-insurance or patient responsibility balance for that day's visit is not paid at the time of service delivery, we will assess a \$25.00 administrative billing fee and subsequently bill you for the unpaid amount.

- *Account Representatives*

We understand that infertility is a challenging problem. Unfortunately, managing insurance benefits is often troublesome in this area. We have Patient Account Representatives who are well trained to help you navigate these often troubled waters. Feel free to work with them.

Thank you.

Patient's Attestation:

I fully understand Atlanta Center for Reproductive Medicine's Patient Accounts and Insurance Policy described above. I understand that I am responsible for any balance not covered by or paid by insurance for any reason.

Signature

Date

ATTENTION: Documents To Return ASAP



The following forms are to be completed in their entirety and returned to us via fax at 770-592-2092 as soon as you receive them.

These forms help us assist you in a more efficient and timely manner and allow us to verify benefits *in advance* so we can appropriately serve you on the day of your visit. The information requested on these forms may seem redundant, but each form has a separate purpose and destination.

We have an outside source that verifies medical and prescription drug insurance benefits for us. It is a courtesy service we offer to our patients, and there is no cost to you for this service. We have provided two copies of the form entitled *Atlanta Center for Reproductive Medicine - Authorization for Verification of Insurance Benefits*. One copy is for you to complete and the other copy is for your spouse/partner to complete.

In addition, there is a form requesting your demographic and insurance information for your chart. Be aware that we will ask you to update this form periodically.

Lastly, you will find a patient questionnaire asking for your infertility information. Even if you are not initially an infertility patient, please take a minute to complete this form, as it is valuable information to the medical staff regarding your medical history.

Please remember to sign and date each form where requested. Your signature gives us permission to verify your benefits and file any claims where appropriate.

If you have any questions regarding these forms, please feel free to call us at 770-928-2276, and we will be happy to answer them.

DOCUMENTS TO RETURN VIA FAX to 770-592-2092

1. Authorization For Verification of Insurance Benefits
2. Patient Registration Form
3. Patient Questionnaire or Health History Questionnaire

Do not discard your originals once you fax them to us. We will get those originals from you when you come for your first visit.

Medical Records Release



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL AND PRIVILEGED INFORMATION

PLEASE SEND THIS FORM TO YOUR OB/GYN, UROLOGIST OR OTHER REFERRING PHYSICIAN

I have scheduled an appointment with the Atlanta Center For Reproductive Medicine. I am currently scheduled for _____.

Please forward a copy of my medical records to ;

Atlanta Center For Reproductive Medicine
5909 Peachtree Dunwoody Road Suite 720
Atlanta, GA 30328
Fax (770) 592 -2092

including any records that pertain to my infertility. They should include most or all of the following:

Semen Analysis	Hysterosalpingogram
Ultrasound Reports	Endometrial Biopsy Reports
Screening Blood work	Pap Smear and/or Cervical Cultures

Hormonal assays such as testosterone, prolactin, progesterone, LH, FSH and/or thyroid profiles

Operative reports, especially hysteroscopy, laparotomy and/or laparoscopy

Any treatment cycle notes (IUI, IVF, GIFT, ZIFT)

I understand this consent may be revoked at any time except due to the extent any action has already been taken in reliance on this consent.

This facility, its employees and officers are released from legal responsibility or liability for the release of the above information.

If the patient is a minor (under 18 years old) or incapacitated, authorization must be signed by a parent or legal guardian.

Patient/Legal Guardian Signature

Relation to Patient

Social Security Number

Date of Birth