



## Welcome to ACRM!

Thanks for making an appointment!

We are here because of you. And more importantly, we are here **for** you! We promise to do what we can to help you build the family you seek.

Beyond basic medical care and the full range of Assisted Reproductive Technologies (IVF, Donor Egg, Frozen Egg), we also offer psychological support, in-house acupuncture, and nutrition services should you need them.

To make things easier and more successful for you, we have 4 locations, 7 physicians, 14 nurses, 3 embryologists and whole team of support staff available to you. Our website provides more information about us ([www.acrm.com](http://www.acrm.com)).

We look forward to meeting you!

Lisa Hasty, MD

Andre Denis, MPH, MD

Jim Toner, MD, PhD

Robin Fogle, MD

Sue Ellen Carpenter, MD

David Keenan, MD

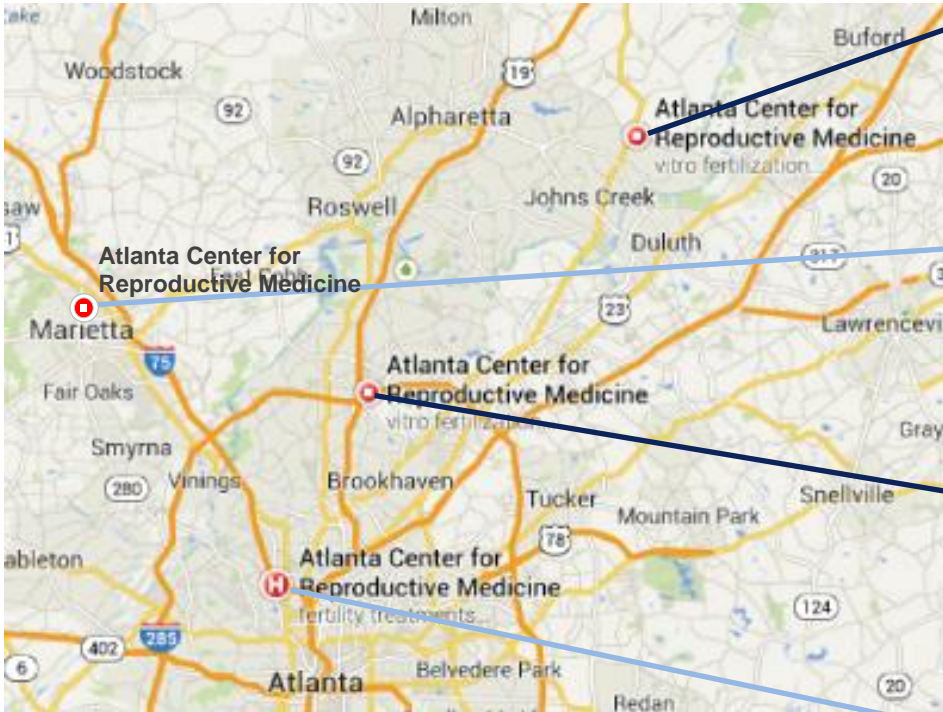
Kathryn C. Calhoun, MD

Steven A. Voelkel, PhD, HCLD

# Office Hours, Locations, & Emergency Contact



A CCRM NETWORK CLINIC



## Johns Creek

6470 East Johns Crossing  
Suite 200  
Johns Creek, GA 30097

OPEN: Mon to Fri, 8 am to 4 pm

## Marietta

711 Canton Road  
Suite 410  
Marietta, GA 30060

OPEN: Mon to Fri, 8 am to 4 pm

## Perimeter (main)

5909 Peachtree Dunwoody Road  
Suite 600  
Atlanta, GA 30328

OPEN: Mon to Fri, 8 am to 4 pm  
Sat, Sun, holidays, 8 am to

## Buckhead

1800 Howell Mill Road  
Suite 675  
Atlanta, GA 30318

OPEN: Mon to Fri, 8 am to 4 pm

**Note: We are open on weekends and most holidays until noon  
(only for certain appointment types)**

Phone: (770) 928-2276 (for all offices)  
Emergencies / After Hours: (770) 928-2276

## For your visit...



Prior to your first visit with us, please:

- Send **Medical Record Release** forms **to each** of your doctors.
- Fill out the **New Patient Questionnaire**, and **fax to (678) 303-0482** or **email to: [medicalrecords@acrm.com](mailto:medicalrecords@acrm.com)**.
- Fill out the **Consents & Authorizations** and **fax to (678) 303-0482** or **email to: [medicalrecords@acrm.com](mailto:medicalrecords@acrm.com)**.

*Note: We will call to confirm your appointment. If we are unable to reach you to confirm, we may cancel it.*



# Medical Records Release

## Authorization for Release and/or Disclosure of Protected Health Information

\_\_\_\_\_  
Patient Name (print) Date of Birth Last 4 digits of SS#

\_\_\_\_\_  
Spouse/Partner Name (print) Date of Birth Last 4 digits of SS#

I authorize:

\_\_\_\_\_  
Name/Organization

\_\_\_\_\_  
Address City, State Zip Code

\_\_\_\_\_  
Phone# Fax# Email Address

**To release the following healthcare information described below (check all that apply).**

*Only this information may be used and/or disclosed pursuant to this authorization. (Note: In accordance with HIPAA's Privacy Rule, psychotherapy notes and infectious diseases cannot be released without being specifically requested.)*

My ENTIRE medical record maintained by the above named practice.

**You must circle "Include" or "Exclude" for EACH of the following:**

*Include or Exclude:* My health information related to infectious diseases (Hepatitis B, Hepatitis C, HIV, etc)

*Include or Exclude:* My health information related to Psychotherapy Notes

My medical record relating to the following treatment or condition: (check all that apply)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Consult Notes       | <input type="checkbox"/> Operative Reports            | <input type="checkbox"/> Ultrasound Reports | <input type="checkbox"/> Genetic Testing |
| <input type="checkbox"/> Blood work Results  | <input type="checkbox"/> Infectious Diseases with HIV | <input type="checkbox"/> Semen Analysis     | <input type="checkbox"/> OB notes        |
| <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> IVF Summary                  | <input type="checkbox"/> Embryo Details     | <input type="checkbox"/> HSG report      |

Other: \_\_\_\_\_

**You may disclose this information via  fax  email  US mail**

**To:** Atlanta Center For Reproductive Medicine  
5909 Peachtree Dunwoody Road, Suite 600  
Atlanta, GA 30328  
Phone: (770) 928-2276 Fax: (770) 592-2092

- I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
- I understand that I have a right to revoke this authorization at any time. My revocation must be in writing, addressed to ACRM, 5909 Peachtree Dunwoody Road Ste 720, Atlanta, GA 30328. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- I understand that my first request for records from ACRM (either for a particular document, set of documents, or entire record) is free, but that ACRM will charge a \$35.00 administrative fee for each additional request filled thereafter, due at the time of release.
- If the patient is a minor (under 18 years old) or incapacitated, authorization must be signed by a parent or legal guardian. If parent is deceased, next of kin or executor of estate must sign authorization.
- This authorization expires upon fulfillment of this request

\_\_\_\_\_  
Patient/Legal Representative's Signature Relation to Patient Date

\_\_\_\_\_  
Spouse/Partner/Legal Representative's Signature Relation to Patient Date

# New Patient Questionnaire



For us to best assist you, it is very important that we understand your health history. Please fill in this questionnaire as best you can. This questionnaire will be held in strictest confidence, but if there are certain responses you would rather provide privately, leave them blank and tell us when we meet. You may find that certain sections of this questionnaire do not pertain to your situation; please complete what seems relevant.

Date: \_\_\_\_\_

**You:** Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_  
 (Please put an \* next to the preferred phone number to call.)  
 Pharmacy Name: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Spouse / Partner** (if applicable)  
 Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_  
 (Please put an \* next to the preferred phone number to call.)  
 Pharmacy Name: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Your Address:**  
 Street: \_\_\_\_\_  
 City, State, and Zip: \_\_\_\_\_

**Referred by:** \_\_\_\_\_  
**Current doctor:** \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone#: \_\_\_\_\_  
 Fax#: \_\_\_\_\_

**How can we help you?**

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**Medical History**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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"/> Other _____                 |
| <input type="checkbox"/> Delayed Puberty         | <input type="checkbox"/> Sickle cell disease           | <input type="checkbox"/> Other _____                 |

Have you ever been treated for substance abuse, depression, or other psychological problem?  
 no     yes, please describe \_\_\_\_\_

Any Allergies? List: \_\_\_\_\_

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 medications, or nutritional supplements on a regular basis? Please chart below.

Medication	Diagnosis	Dosage	Frequency	Duration

## Lifestyle Issues

Are you married or with a partner?

Yes  No

6. If married, which marriage is this for you? \_\_\_\_\_

7. How long have you and your husband/partner known each other? \_\_\_\_\_

8. How long have you and your husband/partner been married/together? \_\_\_\_\_

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

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

Cigarette use:  No  Yes

If yes, the average number smoked daily in the past 3 months (circle answer):

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

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!

Have you experienced a significant weight change (gain or loss) in the past 5 years?

How much? \_\_\_\_\_ lbs gain \_\_\_\_\_ lbs loss

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

Type of Exercise	Hours/wk	Age you began

Are you aware of the possible effect that weight (either under or overweight) may have on fertility?

- Yes  
 Not at all  
 Interested in knowing more

Would you like help adopting healthier lifestyle behaviors, such as:

Weight Management  Yes  No  
 Healthier food choices  Yes  No  
 Healthier eating patterns  Yes  No  
 Stress Management  Yes  No  
 Fitness  Yes  No

Would you like to make an appointment with our nutritionist?

- Yes  
 Not at this time, but I would like some more information

## Menstrual History

Age at your first period: \_\_\_\_\_ Date your LAST period began: \_\_\_\_\_ Are your periods regular?  Yes  No

How many days from one period to the next (e.g. 28 to 30 days)? Minimum: \_\_\_\_\_ Maximum: \_\_\_\_\_

How many days do your periods last (e.g. 4 to 5 days)? Minimum: \_\_\_\_\_ Maximum: \_\_\_\_\_

Do you bleed or spot between periods?  Yes  No

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 (Premenstrual Syndrome)?  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 intercourse without contraception? \_\_\_\_\_

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 see a temperature shift? \_\_\_\_\_

Have you used an ovulation predictor kit (OPK)?  Yes  No If yes, what day did you see a positive result? \_\_\_\_\_

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: \_\_\_\_\_



## 9 | ACRM

Is there a family history of recurring miscarriages?  Yes  No

If yes, describe: \_\_\_\_\_

Is there a family history of cancer on either on the maternal and/or paternal side of your family?  Yes  No

If yes, please note who was diagnosed, age at diagnosis, and type of cancer \_\_\_\_\_

### Pregnancy History

How many total pregnancies have you had? \_\_\_\_\_

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

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

How many biochemical pregnancies have you had?  
(Positive pregnancy test, but nothing on ultrasound) \_\_\_\_\_

How many spontaneous miscarriages have you had?  
(Positive pregnancy test, confirmed with ultrasound,  
but miscarried or delivered before 20 weeks) \_\_\_\_\_

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?	If Biochemical or Miscarriage, how far along were you? (months)	How long to conceive? (months)	Baby born past 37 weeks?	Baby born alive?	Conceived with current partner?
1 <sup>st</sup>		Biochemical Miscarriage Abortion Ectopic 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
2 <sup>nd</sup>		Biochemical Miscarriage Abortion Ectopic 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
3 <sup>rd</sup>		Biochemical Miscarriage Abortion Ectopic 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
4 <sup>th</sup>		Biochemical Miscarriage Abortion Ectopic 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
5 <sup>th</sup>		Biochemical Miscarriage Abortion Ectopic 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

## Hospital / Surgical History

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

Have you ever been surgically sterilized?  No  Yes (indicate when below).

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

Please complete the chart regarding 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: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

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: \_\_\_\_\_

Comments

What do you understand about fertility preservation?

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*...thank you for being thorough...*



## Patient Consents & Authorizations

The following Consents and Authorizations need to be reviewed, completed, and returned by fax, email or in person before or at the first visit.

FAX to (678) 303-0482 or email to: [medicalrecords@acrm.com](mailto:medicalrecords@acrm.com)

- Consent to Treat
- Consent to Communicate
- Consent to Receive Text Messages
- Consent to use Electronic Records
- Consent for Mutual Records
- Obligation to Pay
- Consent to use e-mail
- Authorization to display photos
- Authorization to use Credit Card for billing
- Consent to Verify Insurance benefits

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### Consent to Treat

#### Definitions:

The following defined terms are utilized throughout the following document:

Practice – Atlanta Center for Reproductive Medicine, LLC (ACRM) is referred to herein as the "Practice"

Lab – CCRM – Atlanta, LLC is referred to herein as the "Lab"

When the document refers to either the "Practice" or the "Lab" it is referring to the entities defined above.

I hereby request care by the Practice and the lab, which includes but is not limited to physicians, nurses, counselors, laboratory staff, acupuncturists, and administrative support personnel. I may withdraw my permission at any time without fear of it compromising my decision to return to care at a later time (unless I have been discharged from the practice).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent to Communicate

#### Definitions:

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During the course of treatment at the Practice or the Lab, physicians, nurses, lab personnel, counselors, acupuncturists, nutritionists or administrative staff may have reason to call with information about test results and instructions regarding ongoing care, nutritionists as well as financial aspects of my treatment. I understand that I have the right to modify or rescind my authorization at any time. I certify that each number below is a private and direct number. I hereby grant my permission for ACRM staff to leave a voice mail message, which may include protected health information at the phone numbers I have provided in the event I cannot be reached.

I also grant permission for the Practice or the Lab to discuss information regarding my care and financial matters with my spouse or partner.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse or Partner's Name: \_\_\_\_\_

### Consent to Receive Text Messages

On occasion, Atlanta Center for Reproductive Medicine will send appointment reminders via text messaging. Text messages will not be sent without your permission and your participation is not mandatory. You may revoke your consent and opt out of text messaging at any time. Normal rates and charges will be applied as per your agreement with your cell phone carrier.

I give my permission for text message appointment reminders to be sent to my cell phone.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mobile number capable of receiving text messages: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### Consent to use "Electronic Records"

**Definitions:**

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Lab – CCRM – Atlanta, LLC is referred to herein as the "Lab"

When the document refers to either the "Practice" or the "Lab" it is referring to the entities defined above.

I acknowledge and agree that the Practice or the Lab may convert some or all of my medical records into electronic format and thereafter maintain such medical records only in electronic format. I also acknowledge and agree that Consents (together with my signatures on all such Consents) that are obtained from me may be maintained by the Practice or the Lab in electronic format. For purposes of obtaining my consent (under O.C.G.A. **§10-12-4**), I hereby consent to being required by the Practice or the Lab to receive, recognize, accept, be bound by, and/or otherwise use electronic records and signatures as described herein. I hereby agree that such medical records and Consents and signatures of mine in electronic format are valid and will have the same validity as the hard paper copy thereof. Likewise, facsimiles or scanned images of any signed documents or consents shall have the same validity as the original. I acknowledge that I have carefully reviewed this Consent and understand its content.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent for Mutual Records

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During the course of treatment at the Practice or the Lab there may be portions of my spouse or partner's Protected Health Information (PHI) that will be included in my medical records and portions of my PHI that will be included in my spouse or partner's medical records. I hereby give my express permission and consent for my PHI to be included in my spouse or partner's medical records and for my spouse or partner's PHI to be included in my medical records. I understand and agree that any disclosures that the Practice or the Lab may make of my medical records or my spouse or partner's medical records will include my PHI and my spouse or partner's PHI.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse or Partner's Name: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### Obligation to Pay

#### Definitions:

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When the document refers to either the "Practice" or the "Lab" it is referring to the entities defined above.

I hereby make the assignment of all disability, surgical, medical, and major insurance benefits to the Practice and the Lab 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 or to my partner/spouse's account. I further agree that in the event of nonpayment by my insurer, to bear the cost of collection and/or court cost and reasonable legal fees should this be requested. I understand that I am responsible for services rendered and I agree to pay for services at the time of service. I hereby authorize the Practice or the Lab 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 the Practice or the Lab. I understand that I am financially responsible to the Practice or the Lab for any balance on my account or my partner/spouse's account not covered by my insurance carrier. In the event a patient credit is created on my account, I agree that a refund will not be granted until final adjudication has been determined by all 3rd party payers. 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 Practice or the Lab 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. I also understand that it is my responsibility to notify the Practice or the lab if I become no longer responsible for future balances incurred on my partner/spouse's account due to separation or divorce.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse or Partner's Name: \_\_\_\_\_

### Authorization to display photos

Due to new Federal privacy rules and regulations, we must have permission in writing to display any pictures you may send to us. By signing the authorization below, you are granting ACRM permission to display any pictures you may send. These pictures may be displayed in our nurse's offices or on bulletin boards in our office hallways. The pictures may be seen by all other ACRM patients, all ACRM staff, and ACRM Business Associates. Such photos would be used to provide encouragement to patients currently undergoing treatment for infertility and to celebrate successful outcomes. Your authorization to display such photos could lead to further disclosure and thus the pictures would no longer be protected by federal privacy laws. It is always our intention to protect your privacy. All pictures that are received have all printed identifying information removed before they are displayed.

 Authorized

 Declined

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***This Authorization will expire 5 years after signature date.***

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Consent to use e-mail****Definitions:**

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Lab – CCRM – Atlanta, LLC is referred to herein as the "Lab"

When the document refers to either the "Practice" or the "Lab" it is referring to the entities defined above.

The Practice and the Lab provide you the opportunity to communicate in certain circumstances with certain healthcare providers and administrative services by e-mail. Transmitting confidential patient information by e-mail, however, has a number of risks, both general and specific, that you should consider before using e-mail.

**Risks:**Among the risks:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Recipients can forward e-mail messages to other recipients without the original sender's permission or knowledge.
- Users can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.
- E-mail containing information pertaining to your diagnosis and/or treatment must be included in the your medical records here at the Practice or the Lab. Thus, all individuals who have access to your medical record will have access to the e-mail messages.
- If you send or receive e-mail from your place of employment, you risk having your employer read their e-mail. Your employers or others, such as insurance companies, may read your e-mail and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information.
- You cannot be sure how soon the Practice or the Lab will respond to your e-mail. Although the Practice and the Lab will endeavor to read and respond to e-mail promptly, we cannot guarantee that any particular e-mail message will be read and responded to within any particular period of time. Thus, patients should not use e-mail in a medical emergency.

Our Policy

The Practice and the Lab will make all e-mail messages sent or received that concern your diagnosis or treatment part of your medical record, and will treat such email messages with the same degree of confidentiality as afforded other portions of the medical record. The Practice and the Lab will use reasonable means to protect the security and confidentiality of e-mail information. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by the Practice or the Lab's intentional misconduct. Thus, you must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

- The Practice or the Lab may send (either directly or through a third party e-mail service) unsecured/unencrypted e-mails to you to confirm appointments. These e-mails contain your e-mail address, as well as the date, time, and location of your appointment.
- The Practice or the Lab may send (using a secured/encrypted third party service) e-mail providing normal lab results.



- All e-mails to or from you concerning diagnosis and/or treatment will be made a part of your medical record. As a part of the medical record, other individuals, such as other physicians, nurses, staff counselors, patient accounts personnel, and the like, and other entities, such as other health care providers and insurers, will have access to e-mail messages contained in medical records.
- The Practice or the Lab may forward e-mail messages internally to its staff or externally to its agents for diagnosis, treatment, reimbursement and other handling. The Practice nor the Lab will not, however, forward the e-mail outside to independent third parties without your prior written consent, except as authorized or required by law.
- The Practice or the Lab may send you e-mails to provide updates or other notifications regarding your clinical care as well as financial matters.
- If you send an e-mail to the Practice or the Lab (one of its physicians, another healthcare provider, or an administrative department), we will endeavor to read the e-mail promptly and respond promptly, if warranted. However, the Practice and the Lab can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Because we cannot assure you that we will read e-mail messages promptly, do not use e-mail for situations, questions or conditions where a timely response is needed for diagnostic or treatment purposes or where time is of the essence, including, but not limited to a medical emergency.
- If your e-mail requires or invites a response from us, and you do not respond within a reasonable time, you are responsible for following up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- Do not use e-mail for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.
- Because employees do not have a right of privacy in their employer's e-mail system, do not use your employer's e-mail system to transmit or receive confidential medical information.
- The Practice and the Lab cannot guarantee that electronic communications will be private. The Practice and the Lab are not liable for improper disclosure of confidential information not caused by the Practice or the lab's gross negligence or wanton misconduct.
- You are responsible for protecting your password or other means of access to e-mail sent to or received from the Practice or the Lab to protect confidentiality. The Practice and the Lab are not liable for breaches of confidentiality caused by you or any third party.
- It is your responsibility to follow up and/or schedule an appointment if warranted.
- Any use of e-mail by you that discusses diagnosis or treatment constitutes informed consent to the foregoing.
- Any use of email by you constitutes informed consent regarding this matter. Your signature on this consent acknowledges and accepts these risks and gives the Practice and the Lab permission to communicate via e-mail.
- You may withdraw consent to the use of e-mail at any time by e-mail or written communication to the Practice or the Lab, Attention: Administration Manager.

I hereby grant permission for the Practice and the Lab staff to contact me by email. I have read and fully understand this consent form.

Authorized

Declined

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Consent to Verify Insurance Benefits and Bill Insurance**

I hereby give my permission to ACRM and CCRM Atlanta (or a third party company who it designates) to obtain from my past, present or future 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 also hereby give my permission to ACRM and CCRM Atlanta to forward certain medical information it deems necessary to an outside third party who it designates to determine my eligibility to participate in certain patient financial service programs that are made available through ACRM or CCRM Atlanta. 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 and CCRM Atlanta my prequalification status.

The health insurance and medication benefits verification and the financial services prequalification are offered as a courtesy and without charge. I agree to hold harmless ACRM, CCRM Atlanta, or the third party company performing the verification of insurance benefits and these companies shall have no liability should the information obtained from my insurance company and communicated to me is different from the coverage applied by my insurance company to any claims subsequently filed. I also agree to hold harmless ACRM and CCRM Atlanta and neither shall have any liability if the prequalification for a patient financial program is preliminarily granted but subsequently not granted.

Patients are encouraged to confirm all insurance or reimbursement coverage determinations directly with their insurance carrier or other reimbursement source.

**HEALTH INSURANCE CARD:**

Insurance Company: \_\_\_\_\_  
ID number: \_\_\_\_\_ Group number/name: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Policy number: \_\_\_\_\_  
Phone number for benefits determination: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Your partner's / spouse's name: \_\_\_\_\_

**HEALTH INSURANCE CARD:**

Insurance Company: \_\_\_\_\_  
ID number: \_\_\_\_\_ Group number/name: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Policy number: \_\_\_\_\_  
Phone number for benefits determination: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**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 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.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Consent to use Credit Card for billing

As part of our effort to control the cost of health care for our patients and streamline our administrative processes, we have established an automated credit or debit card system for your convenience. This will simplify payment of your potential co-pays, deductibles, or any 'non-covered' services. This system is similar to what car rental agencies and hotels do worldwide. Our system will securely hold your card information until your health insurance processes your claims and mails you their "Explanation of Benefits" which outlines your financial obligation. Your card will only be charged once your insurance company specifies your exact responsibility. It is the intent of this policy to save you time and simplify the billing process. Your card information will be stored in a confidential and secure setting. Once your card information has been entered, this document will be shredded.

This authorizes ACRM to charge your card (listed below) for any balances due on your account for services provided by either ACRM or CCRM - Atlanta. You will always be advised via a printed ACRM statement of any charge made to your card via this authorization. If the balance is less than \$500, we will charge your card and mail your receipt. For balances above \$500, we will contact you by email or phone regarding the balance due, then charge your card if we have not heard back from you by the close of the next business day.

You: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name imprinted on card: \_\_\_\_\_

Card Type:  VISA  MasterCard [others currently not accepted]

Credit Card number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Billing Address: \_\_\_\_\_ (street)
\_\_\_\_\_ (city, state, zip)

Partner/Spouse: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name imprinted on card: \_\_\_\_\_

Card Type:  VISA  MasterCard [others currently not accepted]

Credit Card number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Billing Address: \_\_\_\_\_ (street)
\_\_\_\_\_ (city, state, zip)