IVF PHOENIX™
Advanced Technologies: Making Conception Affordable

JOHN L. COUVARAS, MD, FACOG

NEW PATIENT INFORMATION

Date _____ Referral Source _____

Name _____ _____ _____
(Last) (First) (MI)

Date of Birth _____ Social Security Number _____ _____ _____

Street Address _____

_____ _____ _____
(City) (State) (Zip)

Home Telephone (_____) _____ Work Telephone (_____) _____

E-mail _____

Employer _____

Street Address _____

_____ _____ _____
(City) (State) (Zip)

Telephone Number (if different from above) (_____) _____

Emergency Contact _____ Telephone (_____) _____

Partner's Name _____ _____ _____
(Last) (First) (MI)

Date of Birth _____ Social Security Number _____ _____ _____

Employer _____ Telephone (_____) _____

Street Address _____

_____ _____ _____
(City) (State) (Zip)

Primary Insurance Carrier _____

Insured _____ Relationship _____

ID # _____ Group # _____

Secondary Insurance Carrier _____

Insured _____ Relationship _____

ID # _____ Group # _____

I authorize the release of any medical records or other information necessary to process my medical claims.

_____ _____ _____ _____
Patient's Signature Date Spouse's/Partner's Signature Date

I authorize payment of medical benefits to IVF Phoenix™ for any or all medical services performed. I understand that I am financially responsible for the charges not covered by my insurance.

_____ _____ _____ _____
Patient's Signature Date Spouse's/Partner's Signature Date

I authorize release of any and all information pertaining to me in this office to my spouse/partner.

_____ _____ _____ _____
Patient's Signature Date Spouse's/Partner's Signature Date

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INITIAL VISIT

Please fill out the following information and return it to our office prior to your initial consultation.

Date:_____

Patient's Name: _____

Partner's Name: _____

Address: _____ APT.#: _____

City: _____ State: _____ Zip: _____

Telephone (day): _____ Telephone (evening):_____

Referring Doctor: _____ Primary Care Dr. (If applicable): _____

Referred By (if other than the above doctor): _____

Patient's Age:_____ Date of birth: _____ Ethnic origin: _____

Partner's Age: _____ Date of birth: _____ Ethnic origin: _____

Occupation (patient): _____

Occupation (partner):_____

Marital Status: _____ Length of marriage: _____

Children (ages/sex): _____

MENSTRUAL HISTORY

Last Menstrual Period:_____ Previous Menstrual Period: _____

Age at time of first menstrual period:_____

	Yes	No
Are your periods regular or irregular?	❒	❒
How many days do you bleed? _____		
How many long is your menstrual cycle? (from the start of one cycle to the start of the next):_____		
Do you have cramps?	❒	❒
If yes, are they: ❒ Mild ❒ Moderate ❒ Severe		
Do you take pain medication for cramps?	❒	❒
If yes, specify: _____		
Do you bleed or spot in between periods?	❒	❒
If yes, specify: _____		
If you have ever been on oral contraceptives (birth control pills), were your periods regular after you stopped taking them?	❒	❒
If yes, date/length of use: _____		
How many times per week do you and your partner have sexual intercourse? _____		
How many times do you have intercourse around ovulation?_____		
Is sexual intercourse painful or difficult for you? ❒ Painful ❒ Difficult ❒ Neither		
How long have you been trying to get pregnant? _____		

PAST OBSTETRICAL HISTORY

	Year	Live Birth	Miscarriage	Elective Abortion	Infertility Treatment	Time to Conception	Current partner is the father
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							
6th Pregnancy							
7th Pregnancy							
8th Pregnancy							

OBSTETRICAL HISTORY CONTINUED

	Yes	No
Were there any complications during or after any of your pregnancies?	❒	❒
If yes, explain: _____		
Did your mother or father have any difficulty with conception or pregnancy?	❒	❒
If yes, explain: _____		
Did your mother take Diethylstilbestrol (DES) when she was pregnant with you?	❒	❒

PAST MEDICAL HISTORY

_____ Weight _____ Height _____ Blood Type (if known)

	Yes	No
Have you ever been treated for cancer?	❒	❒
If yes, explain therapy: _____		
Have you ever received X-rays to the pelvic area for therapy or treatment of the diagnosis?	❒	❒

Do you have or have you ever had any of the following?(check all that apply):

❒ Anemia
❒ Appendicitis
❒ Arthritis
❒ Blood Transfusions
❒ Breast Discharge (milky)
❒ Breast Soreness
❒ Breast Tenderness
❒ Cancer, Specify:_____
_____
❒ Chlamydia
❒ Chronic Bronchitis
❒ Chronic Headaches
❒ Colitis
❒ Color Blindness
❒ Diabetes
❒ Dizziness
❒ Endometriosis
❒ Epilepsy
❒ FACTOR V
❒ Gallbladder Disease
❒ Gonorrhea
❒ Hashimoto's Disease
❒ Heart Disease
❒ Heart Murmur
❒ Hepatitis
❒ Herpes
❒ Hirsutism (Excessive hair growth)
❒ High Blood Pressure
❒ Immunization: German Measles
❒ Kidney Infection
❒ Liver Problems
❒ Loss of Balance
❒ Measles: German
❒ Measles: Regular
❒ Migraines
❒ Mononucleosis
❒ MTHFR A1298
❒ MTHFR C677
❒ Neurological Problems
❒ Nongonococcal Urethritis
❒ Ovarian Cysts
❒ Parasitic Infection
❒ Pelvic Infection
❒ Pneumonia
❒ Poor Sense of Smell
❒ Rheumatic Fever
❒ Scarlet Fever
❒ Seizures
❒ Syphilis
❒ Thyroid Problems
❒ Tuberculosis
❒ Ulcers
❒ Vaginitis (Trichomoniasis, Yeast)
# of episodes: _____
❒ Visual Disturbances
❒ Any Allergies? List: _____
_____

PAST SURGICAL HISTORY

Please give chronological order starting with the most recent surgery.

If any of the following categories do not allow enough space, please list any further procedures and information on the back of this page.

	Procedure	Month and Year of surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

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MEDICATIONS

(List all medications you are currently taking)

	Name of Medication	Dosage	Frequency of Use	Reason for Use
1.				
2.				
3.				
4.				
5.				

ALLERGIES

(list all medications, iodine, and/or shellfish)

_____

_____

_____

SOCIAL HISTORY

(Occupation - Hobbies - Habits)

_____

_____

Smoking History: ❒ Never smoked ❒ Used to smoke ❒ Still smoke Packs per day:_____ How many years?_____

Recreational drugs: _____ Alcohol intake: _____

PAST CONTRACEPTION

What form of contraception method do you use now or have used in the past? Check all that apply:

❒ Pills (name):_____ ❒ IUI (name):_____ Other: _____

❒ Diaphragm ❒ Withdrawl ❒ Foams/Jellies ❒ Condoms ❒ Rhythm ❒ None

For each method of contraceptive used, specify length of use and reason for discontinuation:

	Method	Length of Use	Reason for Discontinuation
1.			
2.			
3.			

PSYCHIATRIC HISTORY/EMOTIONAL PROBLEMS

_____

_____

_____

DIET AND EXERCISE

Do you follow any particular food diet or have any special dietary habits? If yes, explain: _____

_____

List the forms and frequency of regular, vigorous exercise (swimming, cycling, running, etc.) and age you began: _____

_____

_____

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PREVIOUS EVALUATION FOR INFERTILITY OR GYNECOLOGICAL PROBLEMS

	Yes	No
Have you ever been treated for infertility before?	❒	❒

If yes, who was your physician? _____

What diagnosis was determined as the cause of your infertility? _____

What drugs have you taken for infertility? Check all that apply:

- ❒ Clomiphene citrate (Serophene, Clomid)
- ❒ hMG (Pergonal, Humegon, Repronex)
- ❒ estrogen
- ❒ progesterone
- ❒ prednisone (or cortisone-like drugs)
- ❒ antibiotics
- ❒ GnRh or LHRH (Factrel)
- ❒ hCG (Profasi, A.P.L.)
- ❒ Bromocriptine (Parlodel)
- ❒ danazol (Danocrine)
- ❒ urofollitropin (Follistim, Metrodin)
- ❒ none
- ❒ Any others? Specify: _____

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

BBT	Date: _____	Results: _____
Postcoital Test	Date: _____	Results: _____
Hormonal Assays (FSH, LH, prolactin, estrogen, DHEA-S, progesterone, testosterone)	Date: _____	Results: _____
Endometrial Biopsy	Date: _____	Results: _____
Hysterosalpingogram	Date: _____	Results: _____
Ultrasound	Date: _____	Results: _____
Antibodies	Date: _____	Results: _____
Laparoscopy, Hysteroscopy	Date: _____	Results: _____
Mycoplasma/Chlamydia Cultures	Date: _____	Results: _____
Thyroid tests	Date: _____	Results: _____
Other? Specify: _____	Date: _____	Results: _____

Have you ever had surgery for Tubal Reversal?	❒	❒

If yes, specify dates: _____

Have you ever had surgery for removal of adhesions?	❒	❒
Have you ever had a cervical conization, cryo, or cautery?	❒	❒
Have you ever had any other surgery? (D&C, Ovarian, Appendectomy, Thyroid)	❒	❒

If yes, please specify: _____

Have you ever undergone Artificial Insemination or In Vitro Fertilization?	❒	❒

If yes, using partner or donor sperm? _____

Is your partner seeing a doctor for evaluation of infertility?	❒	❒

If yes, specify physician's name and location: _____

Does the doctor feel that your partner has an infertility problem?	❒	❒

If yes, what is the diagnosis and how is he being treated? _____

Has he ever fathered a child with another woman?	❒	❒

If yes, when: _____

If there is any other information you feel would help us in your diagnosis or treatment, please enter below:

_____

_____

_____

_____

_____

_____

_____

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Please email completed forms to info@ivfphoenix.com

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MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Address _____

Phone Number (Day) _____ Phone Number (Evening) _____

Date of Birth _____ Partner's Date of Birth _____ Length of Relationship _____ Duration of Infertility _____

Insurance Company _____ Insurance I.D. # _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment- title(s), location, brief description, number of years employed:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you now or have you ever been exposed to any of the following:

❒ Heat ❒ Toxic Fumes ❒ Other Specify: _____

❒ Chemicals ❒ Nuclear Radiation _____

III. MEDICAL HISTORY

Weight _____ Height _____ Blood Type (if known) _____

	Yes	No
Have you lost more than 20 pounds in the last year?	❒	❒
Do you follow a particular food diet or have any special dietary habits?	❒	❒

If yes, specify: _____

List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:

Exercise	Hrs/Week	Age	Exercise	Hrs/Week	Age

Do you frequently take saunas or steam baths?	❒	❒
Have you ever had surgery in the pelvic area?	❒	❒
Have you ever received X-rays in the pelvic area for therapy or diagnosis?	❒	❒

If yes, specify date and type of surgery: _____

If yes, explain: _____

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

❒ Anemia
❒ Appendicitis
❒ Arthritis
❒ Blood Transfusion
❒ Breast Milky Discharge
❒ Breast Soreness
❒ Breast Tenderness
❒ Cancer? Specify _____
❒ Chlamydia
❒ Chronic Bronchitis
❒ Chronic Headaches
❒ Colitis
❒ Cystic Fibrosis
❒ Diabetes
❒ Dizziness
❒ Epilepsy
❒ FACTOR V
❒ Gallbladder Problems
❒ Gonorrhea
❒ Hashimoto's Disease
❒ Heart Disease
❒ Hepatitis
❒ Herpes
❒ High Blood Pressure
❒ Kidney Infection
❒ Liver Problems
❒ Loss of Balance
❒ Measles: German
❒ Measles: Regular
❒ Migraines
❒ Mononucleosis
❒ MTHFR A 1298
❒ MTHFR C677
❒ Mumps
❒ Mumps with Testes Involved
❒ Neurological Problems
❒ Nongonococcal Urethritis
❒ Parasitic Infection
❒ Pneumonia
❒ Prostatitis
❒ Rheumatic Fever
❒ Scarlet Fever
❒ Seizures
❒ Syphilis
❒ Testes Infection
❒ Testes Injury
❒ Testes Tumor
❒ Thyroid Problems
❒ Tuberculosis
❒ Ulcers
❒ Visual Disturbances
❒ Any Allergies? List _____

	Yes	No
Have you ever been treated for cancer?	❒	❒
If yes, explain therapy: _____		
Within the last year, have you taken any prescription medications?	❒	❒
If yes, list all prescriptions and problems for which you were taking them: _____		
Are you taking any over-the-counter medications on a regular basis?	❒	❒
If yes, list all medications and diagnoses: _____		
Have you had a high fever (over 102°F) during the past 3-4 months?	❒	❒

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

❒ Alcohol - How many glasses per week do you usually drink? Wine_____ Beer_____ Cocktails_____

❒ Cigarettes - Number of packs per day_____

❒ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____

IV. SEXUAL HISTORY

Are you circumcised?	❒	❒
When you were a child, were both testes descended into the scrotum?	❒	❒
At what age did you begin shaving regularly or start to grow a beard?	❒	❒
How many times have you been married?	❒	❒
Have you ever produced a child with another partner?	❒	❒
If yes, how long did it take to produce a child? _____ When was this (dates)? _____		
Have you ever tried to produce a child with another partner?	❒	❒
Do you have trouble getting an erection?	❒	❒
Maintaining an erection?	❒	❒
Do you have trouble with ejaculations?	❒	❒
If yes, ❒ Premature ejaculations ❒ Retrograde ejaculations?		
Do you feel that some of your ejaculate is deposited in the vagina?	❒	❒
Do you ever have orgasms without ejaculation during masturbation?	❒	❒
Do you have any discharge from the penis?	❒	❒
How many times per week do you and your partner now have intercourse?	❒	❒
How many times do you have intercourse around ovulation?	❒	❒
Have you noticed a change in your sexual drive recently?	❒	❒

V. FAMILY HISTORY

Is there a family history of infertility?	❒	❒
If yes, who (list all members and relationship to you) _____		
Is there a history of hormonal disorders in your family?	❒	❒
If yes, list who (relationship to you) and what type: _____		

VI. HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?	❒	❒
If yes, who was your physician? _____		
What cause of infertility was diagnosed? _____		

What drugs have you taken for infertility? Check all that apply:

❒ Clomiphene citrate (Serophene®, Clomid®)
❒ hMG (Pergonal®)
❒ Tamoxifen
❒ Testolactone
❒ Bromocriptine (Parlodel®)
❒ Testosterone or male hormone
❒ hCG (Profasi®, A.P.L.®)
❒ Fluoxymesterone (Halotestin®)
❒ GnRH or LHRH (Factrel®)
❒ Urofollitropin or FSH (Metrodin®)
❒ Other- Specify _____
❒ None

	Yes	No
Have you ever had varicocele repair?	❒	❒
If yes, when? _____		
Have you ever had vasectomy reversal or repair?	❒	❒
If yes, when? _____		
Have you and your partner ever tried artificial insemination?	❒	❒
If yes: using ❒ your sperm? ❒ donor sperm?		
Have you and your partner ever tried in vitro fertilization?	❒	❒
If yes, when and explain: _____		

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

Semen Analysis	When? _____	Results: _____
Chlamydia Test	When? _____	Results: _____
Mycoplasma Test	When? _____	Results: _____
Antibody Test	When? _____	Results: _____
Hamster Egg Test	When? _____	Results: _____
Chromosome Test	When? _____	Results: _____
Testicular Biopsy	When? _____	Results: _____
X-ray or Ultrasound of Testes	When? _____	Results: _____
Hormonal Tests (FSH, LH. Prolactin, testosterone)	When? _____	Results: _____
Thyroid Tests	When? _____	Results: _____
Other - Specify _____	When? _____	Results: _____

Is your partner currently seeing a doctor for evaluation of infertility?	❒	❒
If yes, specify physician name and location: _____		
Does the doctor feel that your partner has an infertility problem?	❒	❒
If yes, what is the diagnosis and how is she being treated? _____		
Has she ever had children with another man?	❒	❒
If yes, when? _____		

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone (home): _____

_____ Phone (work): _____

I hereby authorize the release of photocopies of the following medical records in the possession or control of **IVF Phoenix™**, its employees and/or agents. FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S 36-661), CONFIDENTIAL COMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. 36-681), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

_____ I consent to the release of HIV/AIDS related information as part of this authorization.
Initial

Please check one:

❒ All medical records
or

❒ The following described records only (specify types and dates):

_____

_____

Transfer records to (Name/Practice): _____

Address: _____ Phone:_____

_____ Fax:_____

TRANSFER / RELEASE:
I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time provided I notify **IVF Phoenix™** in writing to that effect. I understand that any release, which was made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/fax of this authorization is considered acceptable in lieu of the original. This consent will expire sixty (60) days after the signed date below.

_____ _____
Patient's Signature Date

_____ _____
Spouse/Partner's Signature Date

_____ _____
Records Prepared By Date

Mailed:_____ Faxed: _____ Received by: _____
Name Date

9817 N 95th St, Building I-107 • **Scottsdale**, AZ 85258 6859 E Rembrandt Ave, Suite 111A • **Mesa**, AZ 85212
T: 602.765.2229 W: ivfphoenix.com F: 480.621.7780 Please email completed forms to info@ivfphoenix.com

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ART: RELEASE OF MEDICAL INFORMATION

Date: _____

Patient's Name: _____ Date of Birth: _____

Name at time of service (if different):_____

To (Name/Practice):_____

Address: _____ Phone:_____

_____ Fax:_____

Please check all that are being requested:

❒ H & P, Physician notes
❒ ALL DOCUMENTS FOR ART CYCLES & RECORDS OF ALL CRYOPRESERVATION
❒ Ultrasounds
❒ SONOHYST/ HSG
❒ ART CYCLE FLOWSHEET & GENETIC REPORTS
❒ SURGICAL PROCEDURES inclusive of OP REPORTS
❒ All Blood Lab results
❒ Andrology Reports

OR

The following described records only (specify types and dates):

_____

_____

Please release my medical records to: John L Couvaras, MD of IVF PHOENIX™

Your prompt response is greatly appreciated.

Sincerely,

_____ _____
Patient's Signature Date

INSURANCE STATEMENT/MEDICARE or AHCCCS DISCLAIMER:

To my patients and prospective patients: Please read and sign this statement to ensure there is no confusion amongst anyone as to whether my office accepts Medicare patients or AHCCCS. We have never enrolled to participate and do not intend to participate with Medicare nor AHCCCS. Because of the current Medicare and AHCCCS situation, it is necessary to inform you of this and have you sign and date this declaration.

I,_____ , understand that John L Couvaras, MD, and/or his office have informed me that he does not accept patients with Medicare or Medicaid nor AHCCCS, either as primary or secondary insurance.

I,_____ , declare that I will not attempt to bill Medicare, Medicaid, nor AHCCCS for services rendered in his office.

I,_____ , am making these declarations under penalty of perjury.

In signing this statement, I fully understand that I have represented to them that I am not covered by Medicare or by Medicaid or by AHCCCS, nor do I intend to seek such coverage.

I realize that it is my responsibility to notify this office of any change in my insurance status, especially regarding Medicare.

I realize that failure to notify this office of Medicare or AHCCCS eligibility prior to services rendered constitutes fraud.

By signing this statement, I admit that the above is true and I will notify the doctor and the office staff prior to any change in my insurance status, especially Medicare or AHCCCS status. I have been counseled of this situation and will be expected to pay in full on the day of service, unless I have other insurance with which Dr. Couvaras is a participant.

_____ _____

Patient signature Date

_____ _____

Doctor/Staff signature Date

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OUR PRACTICE FINANCIAL POLICY

IVF Phoenix™ is dedicated to providing you with the best possible care and service available and we feel an understanding of our financial policies is an essential element of your care and treatment. The following is a copy of our financial policy. If you have any questions after reviewing this information, please feel free to discuss them with a member of our billing staff.

YOUR INSURANCE

We will bill those insurance companies with whom we have a contract and will collect any required co-payment at time of service. This co-payment will be collected when you arrive for your appointment. If the services you receive are **not covered** by your insurance plan, you will be responsible for the total charges and payment will be expected upon receipt of your statement.

If you have insurance coverage with a plan with which we do not participate, payment for your care and treatment are **due at the time of service**. We will prepare and send a claim to your insurance company, however, any applicable insurance payments will be made directly to you.

We will bill your insurance company for all services we provide in the practice. Any charges that are not covered by your plan are your responsibility and due upon receipt of a statement from our office.

MINOR PATIENTS

The responsible adult accompanying any patient who is a minor will be responsible for payment of any and all services rendered.

MISSED APPOINTMENTS

We want to thank you for choosing IVF Phoenix™ and the office of John L Couvaras, MD as your healthcare provider. In order to give you and all our patients the best possible care, we request that you review our policy regarding missed appointments. (A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours).

Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24-hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee. This charge is not covered by insurance.

Your phone call is critical in helping us provide continuous care to all of our valued patients. If you fail to give us a notice of your missed appointment, you will be charged a **$50 missed appointment fee**.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

If you are scheduled for surgery and decide to cancel, 48 hours is required for the cancellation or a fee of $200 will be charged to you.

FMLA PAPERWORK

Initial: _____ We would be pleased to complete paperwork for you, however, we charge a fee of $100. This is a legal document which requires clinical staff time to complete and review by Dr. Couvaras. Please initial that you understand there is a fee to complete Family and Medical Leave Act (FMLA) certifications.

_____ _____
Signature of Patient (or Responsible Party if the patient is a minor) Date

_____ _____
Signature of Co-Responsible Party Date

_____
Print Name of Responsible Party

THIRD PARTY LAB TESTING

Laboratory testing is recommended based on clinical necessity and not on insurance reimbursement considerations. While we do all we can to work with you to manage costs, we are unable to verify your insurance coverage or third-party fees for any given test or lab service. It is your responsibility to verify third-party charges and insurance reimbursement rates, including laboratory fees. If you have questions or concerns about fees or coverage, please be aware that these issues must be addressed directly with the lab or your insurance company.

Initial: _____

MEDICAL RECORDS

A medical request form must be completed by you and signed before any medical records are released from our practice. You may request medical records to be sent to another practice. There is no charge for the first request. At IVF PHOENIX™, we strive to protect your medical records and subsequently provide them on a CD that is password protected. In the event that you would like an additional copy of your medical records for your own files there will be charge of $30 for us to pull the records and save in the same format. If you request to send more than once to another practice or facility there will be a charge for certified mail of $20 (per request). Medical records can be picked up in person only by the person requesting them or by another person, on your behalf, only if we have received notification in writing that you authorize another person can pick up from our office. Please kindly give us 3-5 days to process requests for you.

Initial: _____

I acknowledge receipt and understanding of the above information.

_____	_____	_____
Printed name	Patient signature	Date

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but you must do this in writing. Under this law, we have the right to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Rhoda Rizkalla.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____ Signature _____ Date _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) wit particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

AGREEMENT OF UNDERSTANDING AND ACKNOWLEDGMENT OF INFORMED CONSENT

CYCLE SPECIFIC DATA RELEASE

The Center for Disease Control (CDC) under the authority of the Fertility Clinic Success Rate and Certification Act of 1992 requires all infertility centers to report cycle- specific information about all assisted reproductive technologies (ART) procedures that they perform. To undergo an ART procedure such as IVF, GIFT, ZIFT, ICSI, or Frozen Embryo Transfer, you must agree to release information about your cycle to the CDC and the Society for Assisted Reproductive Technologies (SART). This cycle-specific information is used to calculate statistics for individual and national programs that are published each year. It is also used for epidemiologic analysis. The information we release about your specific cycle, it is only used to calculate program and national statistics. This information, as well as any personal identifiers, is protected under the Privacy Act, but is used to verify the information that we provide.

As part of the verification process, you may be contacted by professional reviewers. The purpose of this contact is to validate and confirm the information we provided to the CDC. Personal contact is strictly voluntary, so you can agree or refuse to participate in the validation process. The process, however, has been accepted by the CDC, SART, RESOLVE and other professionals in the reprod uctive medical field as necessary to assure the credibility of the statistics.

If you do not wish to participate in the validation process, please initial the sentence below. Ifyou initial this sentence, understand that your cycle-specific information will still be released but you will not be contacted.

_____ I do not wish to be contacted by a professional reviewer to validate information provided to the CDC and SART by IVF Phoenix™.

IN ORDER TO COMPLY WITH THE LAW, WE CANNOT PERFORM ANY ASSISTED REPRODUCTIVE TECHNOLOGIES PROCEDURE WITHOUT REPORTING CYCLE-SPECIFIC INFORMATION TO THE CDC AND SART. IF YOU DECLINE TO HAVE YOUR INFORMATION RELEASED, WE CANNOT PERFORM ANY OF THOSE PROCEDURES IN OUR FACILITY.

I have had the opportunity to ask any questions I might have about the release of cycle-specific information to the CDC and SART and understand that my participation is voluntary. By signing this form, I agree to allow that information to be released.

_____ _____

Patient's Signature Date

_____ _____

Spouse's/Partner's Signature Date

_____ _____

Witness Date

NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES

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

Purpose and Policy:

This office is committed to compliance with all federal and state laws that pertain to any aspect of the clinical practices of business procedure of this office. In particular, privacy and security rules relating to the Health Insurance Portability and Accountability Act (HIPAA), along with related state laws, are integral to matters of privacy, medical records, the confidentiality of communications, and other topics addressed throughout this policy and procedure manual. The HIPAA Privacy Rule applies to all protected health information (PHI) in this office including but not limited to your name, address, phone number, social security number, health history, symptoms, examination and test result, diagnoses, procedures, treatment, and plans for the future care or treatment, information stored and transmitted electronically, paper records, and oral communications. PHI includes any information as it related to the past, present, or future physical or mental health condition of any of our patients; any treatment they have received; and health care payment information.

This Notice of Privacy Practices describes how IVF Phoenix™ may use and disclose your information and the right that you have regarding your health information. When using, disclosing or requesting your information, we are normally required to make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. This limitation does not apply in situations involving disclosures to you or made pursuant to your authorization, to a health care provider for treatment, to the Secretary of Human Services for HIPAA compliance and enforcement purposes, or as otherwise required by law.

Uses and Disclosures of Health Information Without Authorization:

When you obtain services from IVF Phoenix™, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment. ***Example:*** Disclosure of medical information about you may be made to doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories, or radiology center for the coordination of different treatments.

Your health information will be used for payment. ***Example:*** Health information about you may be disclosed so that services provided to you may be billed to an insurance company or third party.

Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.

Your health information will be used for health care operations. ***Example:*** The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

_____ _____ _____
Patient Initials Date IVF Phoenix™

Disclosures Required by Law or otherwise Allowed Without Authorization or Notification:
The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:
When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse, or responding to court orders;

For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medications, or devices;
For health oversight activities, such as audits, inspections, or licensure investigations; To organ procurement organizations for the purpose of tissue donation and transplant;
To coroners and funeral directors for the purpose of identification, determination of the cause of death, or to perform their duties as authorized by law;
To avoid a serious threat to the health or safety of a person or the public;
For specific government functions, such as protection of the President of the United States For Worker's compensation purposes;
To military command authorities as required for members of the armed forces;
To authorized federal officials for national security and intelligence activities as authorized by law;
To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by law.

Other Allowable Uses and Disclosures Without Authorization: Other uses or disclosure of your health information that may be made include:
Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives;
Notifying you of health-related benefits and services that may be of interest to you.

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

Uses and Disclosures Requiring Authorization:
Any other uses of disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

Your individual rights under HIPAA:
You have the right to request restriction on certain uses and disclosures of your PHI or amend your PHI. In some cases we may require these requests to be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address and phone number changes. Regardless of your request, please know that the HIPAA rules allow our office to share your PHI with the Covered Entities and our physicians may deny the request for an amendment, in whole or in part if; 1) is not create by the physician, 2) is not part of the designated record set, 3) is not available for inspection because of an appropriate denial to access of the information, or 4) is accurate and complete;

You have the right to receive your PHI in a confidential communication from our office, such as the U.S. Mail;
You have the right to inspect and copy your PHI. Copies of your PHI are available for a reasonable fee paid to our office to cover our expenses of reproducing them;
You have the right to receive, upon request, an accounting of your PHI that we have provided to Non-Covered entities;
If you have read and responded to this notice through electronic media such as our practice website or email, you have the right to receive a paper copy of this notice upon request.

In keeping with HIPAA compliance, the IVF Phoenix™ has appointed a Privacy Officer to continually evaluate our privacy practices, train our staff about privacy issues, supervise the sharing of information with third parties, and address any complaints from patients.

_____ _____ _____
Patient Initials Date IVF Phoenix™

All staff members will be trained on this policy and procedure manual, which will help ensure that the procedures in effect in our office are in keeping with both state and federal law. The privacy Officer is responsible for both the training of staff, as well as continual review and of this manual as necessary. A Notice of PHI Privacy Practices is reviewed by all patients to increase their understanding of how their PHI is stored, used and shared beyond this practice, and to notify them of their new rights created under HIPAA.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for the entire PHI we maintain. In the event we elect to change the terms of this notice, a new notice will posted in our office and in additions you may receive notification by mail, e-mail, or other such communication as our practice makes any new provisions.

Should you ever believe your privacy rights have been violated, we request you file a complaint with our Privacy Officer, Rhoda Rizkalla, at 602-765-2229. You may also register your complaint with the Secretary of the U.S. Department of Health and Human Services, office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy. Any complaint you file will be used strictly to improve our operating procedures and in doing so, you will not be retaliated against for filing a complaint.

I have reviewed the above Notice of Privacy Practice, which explains how my medical information wi ll be used and disclosed. By signing below, I acknowledge that I have read and understand the above and understand my rights to privacy of Protected Health information.

_____
Printed Patient Name

_____ _____
Patient Signature/Legal Representative Date

_____
Relationship of Representative

Dear Patients:

We ask your cooperation when coming to our practice.

WE ARE A FRAGRANCE-FREE WORK PLACE.

In order to ensure our practice remains fragrance-free, please refrain from using natural or artificial scents or volatile organic compounds (hand sanitizers) that could be distracting or harmful to patients and/or our laboratory.

Personal fragrant products include:

- perfumes
- colognes
- lotions
- powders
- hand sanitizers
- other similar products

Any personal fragrant products that are perceptible to others should not be worn at any time while in our office. We have an onsite IVF Lab and fragrance of any kind is not permitted.

Thank you for understanding and for your cooperation.

John L Couvaras, MD, FACOG
Medical Director

_____ _____ _____
Patient Initials Date IVF Phoenix™

Please do not wear any fragrance when at our practice.