BOSTONIVF
THE ARIZONA CENTER

HIPAA Notice of 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other required by law.

Treatment: We will use and disclose your protected health information (PHI) to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Example 1: We would disclose your PHI, as necessary, to a home health agency that provides care to you.

Example 2: Your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as Required by Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

(over)

Your Rights: Following is a statement of your rights with respect to your protected health information (PHI). You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your protected health information (PHI). This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information (PHI), your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before: **October 24, 2009**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer, Erica Beam, in person or by phone at our main phone number, 480-559-0252.

Signature below is only acknowledgement that you have received this notice of our privacy practices:

Print Name: _____ Signature: _____ Date: _____

Print Name: _____ Signature: _____ Date: _____
(Spouse or partner – if having services)

Boston IVF of Arizona
8901 E. Mountain View Road, Suite 201
Scottsdale, AZ 85258
480-559-0252 • 480-661-4141 (fax)

Rita Sneeringer, M.D., FACOG, *Medical Director*
Linda Nelson, M.D., Ph.D., FACOG
Rekha Matken, RNC, MS, WHNP-BC, *Clinical Director*

BOSTONIVF
THE ARIZONA CENTER

New Patient Information

Thank you for choosing Boston IVF – The Arizona Center for your care. This sheet outlines what to expect at your first visit as well as our insurance and financial policies. Should you have questions at any time, please don't hesitate to ask a member of our staff. We welcome the opportunity to serve you and to make your visit with us a pleasurable and informative experience.

Please Note: You must sign the back page of this document

NEW PATIENT FORMS

You will need to complete new patient paperwork prior to your first visit. If you do not choose to have these emailed to you, the new patient packet is on our website FertilityCentersArizona.com, and may be downloaded, printed and filled out prior to your appointment. If you do not fill out these intake forms prior to your appointment, please arrive 30 minutes before your appointment time to complete this paperwork in our office.

INSURANCE COVERAGE

Should you have coverage questions, our billing office will be happy to check your benefits prior to the day of your appointment. Please call Marie as far in advance with your insurance information so you won't find any surprise charges. Should you have a specialist co-pay, that will apply to our office. We accept Aetna, BCBS, Cigna, Humana, PHCS, TriCare and UnitedHealthcare. We also accept AHCCS, with the exception of Care First.

Please see reverse side for additional insurance information and our Financial Policy

YOUR APPOINTMENT

When you arrive at Boston IVF – The Arizona Center, please sign in at the front desk and take a seat in the waiting room (straight ahead, behind the glass panels). A member of our staff will come in to greet you and to collect your new patient forms. We will also make a copy of your insurance card at this time.

Your appointment will start with a member of our medical staff taking your vital signs, including your blood pressure, pulse and respiratory rate. The results of these will be recorded in your patient chart and reviewed by the physician.

If becoming pregnant is the reason for your visit, we will perform a routine physical exam at your initial appointment.. Pregnancy is quite taxing on the body and can take the same toll as running a marathon for 9 months! To protect your health and the health of your future baby, we want to be certain any areas of concern have been identified before you become pregnant.

With the above information at hand, your doctor can spend your consultation time asking directed questions about your specific situation. The information you discuss with the doctor will be integrated with the history you've provided in the intake forms to determine the best course of action to help you achieve pregnancy. This may include suggestion for further testing or possible treatment options.

If the doctor suggests the drawing of blood for testing, in-depth review of treatment options and scheduling follow-up visits, you will meet with a member of our medical staff after your consultation.

If you have benefits questions, a co-pay or are self-paying for services, you will also meet with a member of our billing department during your new patient visit. All financial information will be reviewed with you including applicable insurance coverage and the costs of various procedures. Our goal is to always ensure you are aware of the true costs of all suggested testing and therapy.

(over)

PARTICIPATING / CONTRACTED INSURANCE PLANS

Prior to your visit, we will *verify** your insurance benefits for the services you may receive. You are encouraged to also verify coverage. Upon receipt of an insurance Explanation of Benefits (EOB), we will review your account and send you a statement for any balance due. If required, we will seek authorization prior to your visit. We will advise you if your insurance company requires that you register with their women's health or infertility department before beginning services.

NON-PARTICIPATING / NON-CONTRACTED INSURANCE PLANS

Because infertility benefits are so specialized, and many health plans have consolidated, we always *verify** your insurance benefits for the services you may receive. We will report our findings to you prior to your appointment. If you have coverage, we will file a claim and ask that you pay your co-payment and co-insurance on the date of service. If required, we will seek authorization prior to your visit. We will advise you if your insurance company requires that you register with their women's health or infertility department before beginning services. Upon receipt of an insurance Explanation of Benefits (EOB), we will review your account and send you a statement for any balance due.

****Despite our best efforts, verification of benefits is NOT A GUARANTEE OF COVERAGE. Your insurance makes this point very clear to us. Final disposition of coverage is made when they process a claim.***

SECONDARY INSURANCE PLANS

We will bill secondary insurance whenever applicable. The same provisions as listed above, apply.

CREDIT / REFUND

If a credit results on your account after an insurance claim is processed and posted, we are prepared to leave it on your account for future services or we can issue a refund to you. If you have an unpaid balance on another claim, we will apply your credit there and issue an updated account statement to you.

FINANCIAL RESPONSIBILITY

I understand that I am fully responsible to pay for any and all charges not otherwise covered by my insurance, if applicable. If an insurance payment for services rendered to Boston IVF – The Arizona Center, the Fertility Centers of Arizona or the Surgery Centers of Arizona is sent to me, I will promptly submit the payment to Boston IVF – The Arizona Center / the Fertility Centers of Arizona along with a copy of the related Explanation of Benefits (EOB). Should I not forward the insurance payment, I understand that I will be liable for the amount of the check and will remit payment by check, credit card or cash to Boston IVF – The Arizona Center / the Fertility Centers of Arizona.

Boston IVF – The Arizona Center promotes a positive account management experience. However, on the rare occasion that an account issue cannot be resolved, Boston IVF – The Arizona Center reserves the right to refer it to a third-party for collection. Any fees associated with this will be charged to the patient.

I have reviewed and understand this policy.

Responsible Party: _____
(Printed Name)

Responsible Party: _____ _____
(Signature Required) **(Date)**

BOSTONIVF
THE ARIZONA CENTER

FEMALE INTAKE FORM

PT ACCT #: _____
SP/PTN ACCT #: _____

TODAY'S DATE: _____

☐ I authorize medical reports and information relating to my services at BostonIVF – The Arizona Center to be sent to my physician: ☐ OB/GYN ☐ PCP ☐ Other

Physician Name: _____ Address: _____

NAME: _____ DOB: ____/____/____ AGE: _____
Last First month day year

OCCUPATION: _____ EMPLOYER: _____

MARITAL STATUS *(circle one)*: Single Separated Divorced Married _____ years

ADDRESS: _____
Street City State Zip

PHONE: _____ _____ _____
Home Cell Work

SSN: _____ EMAIL: _____

EMERGENCY CONTACT / RELATIONSHIP _____ PHONE # _____

PARTNER'S NAME: _____ AGE: _____ DOB: ____/____/____

REASON FOR VISIT: _____

TRYING TO CONCEIVE? ☐ No ☐ Yes If so, how long without protection? _____ years _____ months

REFERRING PHYSICIAN: _____ Referring Physician Phone: _____

PRIMARY CARE PHYSICIAN: _____ PCP Phone: _____

OB/GYN: _____ OB/GYN Phone: _____

PHARMACY: _____ Pharmacy Phone: _____ Pharmacy Fax: _____

PRIMARY INSURANCE

POLICYHOLDER _____ INSURANCE CO. _____

ADDRESS _____
Street City State Zip

SUBSCRIBER # _____ GROUP # _____ PLAN # _____

SECONDARY INSURANCE

POLICYHOLDER _____ INSURANCE CO. _____

ADDRESS _____
Street City State Zip

SUBSCRIBER # _____ GROUP # _____ PLAN # _____

RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from the Fertility Centers of Arizona / BostonIVF – The Arizona Center, whether covered by insurance or not. **AUTHORIZATION:** I authorize payment of benefits directly to the Fertility Centers of Arizona / BostonIVF – The Arizona Center (if applicable).

****REQUIRED**** (if left blank, we will NOT share any information with anyone other than you, your physician & insurance co.)
Do you authorize this office to discuss your care, treatment and/or billing information with any other party? YES ☐ NO ☐

If yes, whom _____ Relationship _____

PATIENT _____ DATE _____
SIGNATURE

PARENT / GUARDIAN (IF MINOR) _____ DATE _____

I was referred to your office by: ☐ Physician (please enter details above) ☐ Friend / Relative / Patient ☐ Other _____
☐ Internet (site) _____ ☐ Ad (site) _____ ☐ Seminar (site) _____

Please answer the following questions. Do not write in the "Comments" section.

Please answer the following questions. Do not write in the "Comments" section. Enter additional comments on reverse side

Menstrual History

Age you started to have periods _____ yrs

Are your periods regular? ☐ Yes ☐ No

If cycle is irregular, number cycles/year: _____ cycles

On average, how many days between periods? _____ days

How long do your periods last? _____ days

Menstrual flow: ☐ Normal ☐ Light ☐ Heavy

Pain with your periods? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Cramping pain with your periods ☐ Yes ☐ No

Pain not associated with your periods? ☐ Yes ☐ No

Do you have symptoms before your menses? ☐ Yes ☐ No

Bleeding between periods? ☐ Yes ☐ No

Date of last menstrual period: ____/____/____

Frequency of intercourse: _____ times/week

Gynecological History

Gonorrhea	☐ Yes	☐ No	Chlamydia	☐ Yes	☐ No
Pelvic infection	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Painful sex	☐ Yes	☐ No	Excessive hair	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No	Prior IUD use	☐ Yes	☐ No
Birth control pill	☐ Yes	☐ No	Mom took DES	☐ Yes	☐ No
Vaginal lubricants	☐ Yes	☐ No	Douche	☐ Yes	☐ No
Sexual abuse	☐ Yes	☐ No	Physical abuse	☐ Yes	☐ No
Abnormal Pap	☐ Yes	☐ No	Mammogram	☐ Yes	☐ No
Date last Pap ____/____/____			Acne	☐ Yes	☐ No

Obstetric History

Date (mo /yr)	Outcome (circle one)	Comments/Complications?
____/____	Miscar / Nml deliv / Cesar / Tubal / Abortion	_____
____/____	Miscar / Nml deliv / Cesar / Tubal / Abortion	_____
____/____	Miscar / Nml deliv / Cesar / Tubal / Abortion	_____
____/____	Miscar / Nml deliv / Cesar / Tubal / Abortion	_____
____/____	Miscar / Nml deliv / Cesar / Tubal / Abortion	_____

Prior Infertility Evaluation (if applicable)

		Year	Result	
Basal temp records	No	_____	Normal	Abnormal
Urine ovulation kits	No	_____	Normal	Abnormal
Endometrial biopsy	No	_____	Normal	Abnormal
Semen analysis	No	_____	Normal	Abnormal
Hysterosalpingogram	No	_____	Normal	Abnormal
Postcoital test	No	_____	Normal	Abnormal
Laparoscopy	No	_____	Normal	Abnormal
Hysteroscopy	No	_____	Normal	Abnormal
FSH blood test	No	_____	Normal	Abnormal

Comments:

Prior Infertility Treatments (if applicable)

			Year	
Clomid or Serophene	No	Yes	_____	# cycles _____
FSH injectable meds.	No	Yes	_____	# cycles _____
hCG injectable meds.	No	Yes	_____	# cycles _____
Intrauterine insemin.	No	Yes	_____	# cycles _____
IVF or GIFT	No	Yes	_____	# cycles _____

Do you take Medications? (If yes, please list with dosage information)

Name	Dosage	Prescribing Physician

Do you take folic acid or vitamins? ☐ Yes ☐ No
Do you take herbal remedies? ☐ Yes ☐ No

Allergies

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO

If yes, describe: _____
Do you have any other allergies? ☐ Yes ☐ No
If yes, please provide additional information: _____

What is your blood type? ☐ Unknown ☐ Blood Type _____

Social

Smoke	☐ Yes	☐ No	Alcohol weekly	☐ Yes	☐ No
Cocaine	☐ Yes	☐ No	Marijuana	☐ Yes	☐ No
IV drugs	☐ Yes	☐ No	Weight change	☐ Yes	☐ No
Regular Exercise	☐ Yes	☐ No	Caffeine	☐ Yes	☐ No

Family History (*Has anyone in your family had any of the following?*)

Early menopause	☐ Yes	☐ No	Breast cancer	☐ Yes	☐ No
Ovarian Cancer	☐ Yes	☐ No	Muscular dystrophy	☐ Yes	☐ No
Stillbirth	☐ Yes	☐ No	Sickle-cell anemia	☐ Yes	☐ No
Cystic fibrosis	☐ Yes	☐ No	Mental retardation	☐ Yes	☐ No
Tay-Sachs	☐ Yes	☐ No	Spina bifida	☐ Yes	☐ No
Down's Syndrome	☐ Yes	☐ No	Tuberous sclerosis	☐ Yes	☐ No
Birth defects	☐ Yes	☐ No	Heart attack (<50 years)	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No	Psychiatric disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Blindness	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Chromosome problem	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Recurrent miscarriage	☐ Yes	☐ No
Deafness	☐ Yes	☐ No	Other/Genetic issues	☐ Yes	☐ No
Polycystic kidneys	☐ Yes	☐ No	_____		
Bleeding disorders	☐ Yes	☐ No	_____		

Comments:

Ancestral Background

Certain ancestral backgrounds have increased frequency of some genetic diseases. Please indicate if either of your parents are of any of the following:

☐ African ☐ Caribbean ☐ Jewish ☐ Indian ☐ Native American

☐ French-Canadian ☐ Latin-American ☐ Mediterranean ☐ Asian

Past surgeries (If yes, please enter below)

Date	Type	Hospital

Medical History (Review of Symptoms) *Have you ever had:*

Abdominal pains	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No
Antibiotics	☐ Yes	☐ No	Fainting	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Fibroids	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Exces. constipation	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Severe headaches	☐ Yes	☐ No
Blood clots	☐ Yes	☐ No	Urinary infections	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No	Heat/cold intolerance	☐ Yes	☐ No
Problem with vision	☐ Yes	☐ No	Hepatitis, liver prob.	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hot flashes / sweats	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Lack bladder control	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No	Mitral valve prolapsed	☐ Yes	☐ No
Neck/back pain	☐ Yes	☐ No	Thrombophlebitis	☐ Yes	☐ No
Neurological prob.	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Nose/gum bleeds	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Stomach problems	☐ Yes	☐ No	Swollen joints	☐ Yes	☐ No
German measles	☐ Yes	☐ No	Chicken pox	☐ Yes	☐ No

Comments:

I have reviewed the information contained in the entire questionnaire, all accompanying couples intake sheets and have reviewed the key findings with the patient and the patient's partner (if applicable). Patient and partner have had the opportunity to ask any and all questions.

Printed Physician Name _____ Physician Signature _____ Date _____

BOSTON IVF
THE ARIZONA CENTER

Authorization to Release Medical Records

Patient Name: _____ Account #: _____

Address: _____ Date of Birth: _____

_____ Phone (Day): _____

Social Security #: _____ Phone (Home): _____

I hereby authorize _____
to send / release photocopies of medical records concerning the above named patient to:

☐ Rita Sneeringer, MD, FACOG, *Medical Director*
☐ Linda Nelson, MD. PhD, FACOG
☐ Rekha Matken, RNC, MS, WHNP-BC, *Clinical Director*

Boston IVF – The Arizona Center
8901 E. Mountain View Road, Suite 201
Scottsdale, AZ 85258
480-559-0252
FAX: 480-661-4141

For the purpose of: _____

MEDICAL RECORDS

I authorize the release of the photocopies of the following medical records and/or x-ray films in the possession or control of the above named party acknowledged to release requested records, it's employees and/or agents. [For purposes hereof, "Medical Records" shall include all confidential HIV related information (as defined in A.R.S. Section 36-661), confidential communicable disease related information (as defined in 42 CFR, Section 2.1 et seg), and confidential mental health diagnosis / treatment information..]

(CHECK ONE)

☐ All medical records of the past two (2) years of treatment (or)

☐ The following described records ONLY (specify type and dates): _____

_____

This consent will expire sixty (60) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify the above named physician in writing to that effect. I understand that any release which has been 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 of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature Date

_____ _____
Records prepared and transmitted by Date