



Patient Registration Form (v8.06.1)



I. RESPONSIBLE PARTY OR GUARANTOR

Patient Name			Date of First Visit	D.O.B.	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other			FD Staff verify that info is correct. Init.	BC Dept. com- pares data to MM print-out. Init.	
Responsible Party Last Name		First	M.I.	Address						
City	State	Zip	Home Phone ()		Work Phone ()		Cell Phone ()			
E-mail	SSN		# Dependents	# of Insurance Plans	Physician					
Employed by	Years	Address		City		State	Zip	Phone ()		

II. RESPONSIBLE PARTY OR GUARANTOR (IF DIFFERENT FROM ABOVE)

Patient Name			Date of First Visit	D.O.B.	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other			FD Staff verify that info is correct. Init.	BC Dept. com- pares data to MM print-out. Init.	
Responsible Party Last Name		First	M.I.	Address						
City	State	Zip	Home Phone ()		Work Phone ()		Cell Phone ()			
E-mail	SSN		# Dependents	# of Insurance Plans	Physician					
Employed by	Years	Address		City		State	Zip	Phone ()		

III. RESPONSIBLE PARTY APPROVAL SIGNATURE

As the responsible party, I agree that all charges that are not paid by the insurance company will be my responsibility.

Responsible Party
Signature _____

FD Init. BC Init.

IV. SPOUSE/DEPENDENT INFORMATION

Spouse/Dependent Last Name			First	M.I.	2nd Dependent Last Name			First	M.I.
D.O.B.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship	SSN		D.O.B.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship	SSN	
Employer Name		Phone ()			Employer Name		Phone ()		
Employer Address				Is the Dependent the Patient?	Employer Address				Is the Dependent the Patient?
City	State	Zip	<input type="checkbox"/> Yes <input type="checkbox"/> No		City	State	Zip	<input type="checkbox"/> Yes <input type="checkbox"/> No	

V. INSURANCE COMPANY INFORMATION

Primary Insurance Co. Name		Group I.D. #	Secondary Insurance Co. Name		Group I.D. #
Address		Member I.D. #	Address		Member I.D. #
City / State / Zip		Phone ()	City / State / Zip		Phone ()
Name & Address of Insured IF NOT RESPONSIBLE PARTY			Name & Address of Insured IF NOT RESPONSIBLE PARTY		

PAYMENT OF BENEFITS I authorize payment of benefits, as determined by the company, directly to Surgeon/Physician Yes No

I understand that unless I have checked "yes" above, I may still be responsible for any amounts not paid by my insurance company in the event that the charges made are not reasonable and customary.

Female Date

Male Date

MEDICAL INFORMATION RELEASE AUTHORIZATION
Insured party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to processing insurance claims. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false, or to leave out facts I know are important.

Female Date

Male Date



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Authorization for Release of Medical Information (v8.06.1)



Patient Name _____ Date _____
(Last, First, Middle)

Address _____

E-mail Address _____ Date of Birth _____

Telephone: Home _____ Work _____

Information
Confirmed by:

I hereby authorize Advanced Reproductive Health Centers, Ltd. to release photocopies of my records into my own keeping or to the following individual or organization:

Name _____

Address _____

City / State _____

Phone _____

Information
Confirmed by:

This facility, its employees, officers and the attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized by the release. I understand this consent can be revoked at any time except for disclosure already made in good faith in reliance on this release. I realize by the receipt or authorized release of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

Information
Confirmed by:

Signature of Patient

Date

Signature of Person Authorized to Sign if Other than Patient

Relationship to Patient



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Notice of Privacy Practices

(v8.06.1)

C-1

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.

USES AND DISCLOSURES:

- 1. Treatment:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
- 2. Payment:** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
- 3. Health Care Operations:** Your health information may be used as necessary to support the day-to-day activities and management of Advanced Reproductive Health Centers, Ltd. for example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote reporting.
- 4. Law Enforcement:** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.
- 5. Public Health Reporting:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.
- 6. Other Uses and Disclosures Require Your Authorization:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation for the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.
- 7. Right to Revise Privacy Practices:** As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.
- 8. Requests to Inspect Protected Health Information:** You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.
- 9. Complaints:** If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Privacy Officer, Advanced Reproductive Health Centers, Ltd., 5225 Old Orchard Road, Suite 10, Skokie, IL 60077. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.
- 10. Contact Person:** The name and address of the person, as listed above, you may contact for further information concerning our privacy practices.
- 11. Effective Date:** This notice is effective on or after April 14, 2003.
- 12. Additional Uses of Information:**
 - a. Appointment Reminders:** Your health information will be used by our staff to send you appointment reminders.
 - b. Information About Treatments:** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services we believe may interest you.
- 13. Individual Rights:** You have certain rights under the federal privacy standards. These include:
 - a.** The right to request restrictions on the use and disclosure of your protected health information.
 - b.** The right to receive confidential communications concerning your medical condition and treatment.
 - c.** The right to inspect and copy your protected health information.
 - d.** The right to amend or submit corrections to your protected health information.
 - e.** The right to receive an accounting of how and to whom your protected health information has been disclosed.
 - f.** The right to receive a printed copy of this notice
- 14. Advanced Reproductive Health Centers, Ltd. Duties:** We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.



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Confidential Communications Request (v8.06.1)



I, _____ and _____
(Patient) (Partner)

request confidential communications of our health information when our health information is disclosed on our behalf. Please use the following address or manner in disclosing our health information to me(us).

(Please be as specific as possible.)

_____ Work Phone _____ Home Phone _____ Cell Phone

May we leave a message on your answering machine with your results? Yes No

_____/_____/_____ Our initials here affirm that failure to disclose our health information other than the manner stated above could endanger me(us).

Patient Signature

Partner Signature

Date

Date

Printed Name and Date of Birth

Printed Name and Date of Birth

Effective Date

Effective Date

PRACTICE'S RESPONSE TO REQUEST

- Agrees to entire request
- Denies part of requested action: _____
- Requires more complete/specific information to assess your request.
- The Practice cannot reasonably accommodate your request.

Signed by ARHC, Ltd. Manager

Date



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New Patient Financial Education Checklist (v8.06.1)



Patient Name _____

Dear New Patient,

Thank you for choosing our centers. We hope to “*exceed your expectations...*” Please feel free to speak with our billing department should you need more detailed information.

1. Health Insurance: When appropriate, we will bill your insurance. You will receive Explanation of Benefits (EOB) from your insurance carrier. Please save these in an orderly file.

Patient Initials

2. Billing Codes: Infertility and gynecology services often overlap. We will code all insurance claims according to documentation in the medical record. If you are experiencing infertility, we must use an infertility modifier (ICD9 code series 628.x's). We will bill according to established guidelines following all applicable laws. Please do not ask us to alter or change billing codes.

Patient Initials

3. Your Financial Responsibility: We will bill and re-bill your insurance company in an attempt to receive payment for all covered benefits. Please be aware that you are ultimately responsible for all charges should your insurance company decline payment.

Patient Initials

4. Co-Pays: Co-pays will be collected at each visit. Please bring a form of payment to each visit.

Patient Initials

5. Monthly Statements: You will receive monthly statements from our billing staff. Please pay your portion in a timely manner. Insurance monies outstanding will be clearly indicated.

Patient Initials

6. Insurance Cards: Please bring your insurance card with you to each visit.

Patient Initials

7. Receipts: Any time you make a payment at one of our offices, you should receive a receipt. If you do not, please speak with a manager.

Patient Initials

8. Payment Method: We accept cash, Visa, MasterCard, Discover, and personal checks. We do not accept American Express.

Patient Initials

9. Questions: Our front desk staff can often handle your billing questions. If they are unable, you will be referred to our billing staff.

Patient Initials



Pre-Visit Questionnaire

(v8.06.1)



Date _____

Female Partner Name _____ (Last, First, Middle) DOB _____

Home Phone _____ Business Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip Code _____

Occupation _____

Male Partner Name _____ (Last, First, Middle) DOB _____

Occupation _____

SOCIAL HISTORY

Are you married? Yes No

If yes, how many years have you been married? _____

How long have you been trying to get pregnant? _____

How long have you been trying to get pregnant with a doctor's help? _____

Was the doctor a Gynecologist
or a Reproductive Endocrine/Infertility Specialist?

About how many times a month do you have intercourse? _____

Does either partner smoke? Yes No

How much? _____ packs per day

Does either partner use recreational drugs? Yes No

Which one(s)? _____

FEMALE HISTORY

Age _____ Height _____ Weight _____

Menstrual periods occur every _____ days.
Are they regular? Yes No

For how many days do you bleed? _____

Do you have endometriosis? Yes No

Do you have any medical problems? Yes No

If yes, please give details, including any medications

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

What pelvic surgeries have you had, if any?

What were the findings?

Number of pregnancies with this partner	_____	Number of tubal pregnancies	_____
Number of pregnancies with a previous partner	_____	Number of abortions	_____
Number of miscarriages	_____	Number of live births	_____

MALE HISTORY



Age _____ Number of pregnancies with a previous partner _____

Male medical problems and current medications _____

Do you have problems with erection or ejaculation? Yes No

TESTING & TREATMENT HISTORY *Have you had:*

Test	Yes	No	Result
Hysterosalpingogram (dye test)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day 3 FSH test (blood test)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antral follicle counts of ovaries (an ultrasound evaluation)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Semen analysis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Procedure	Yes	No	How Many?	Any Success?
Clomiphene stimulation with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Clomiphene stimulation with insemination	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Injectable FSH stimulation with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
(Follistim, Gonal-F, Repronex, etc.)				
Injectable FSH stimulation with insemination	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Inseminations without any drug stimulation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
In vitro fertilization	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
In vitro fertilization with ICSI	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
In vitro fertilization with donor eggs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

OTHER

What else should we know about your case? _____

Are there other pertinent test results, procedures or problems that have been identified? _____

Give details of IVF results, if applicable. _____

Are there specific questions that you would like addressed? _____

* END *



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Verification of S.I.P. (Sexually Intimate Partner) (v8.06.1)



ARHC-OP: CLIA 14D0920474 ARHC-VP: CLIA 15D1044050
 ARHC-MV: CLIA 15D1044097 ARHC-SC: CLIA 14D0994325

Patient Name (Female) _____ D.O.B. _____

Patient Name (Male) _____ D.O.B. _____

Dear Patient,

Please be aware that the U.S. Food and Drug Administration (FDA) has established laws and regulations to prevent spreading infectious diseases at fertility centers. Because of these regulations, ARHC is required to verify your status as a sexually intimate partner (SIP).

1. Are you and your above-listed partner sexually active with each other? Yes No Yes No

_____ _____
Male Initials Female Initials

2. If yes, are you sexually active whereby bodily fluids are exchanged? Yes No Yes No

_____ _____
Male Initials Female Initials

Management:

If patient answers “no” to either of the above questions —
an FDA 1271 panel must be obtained prior to IUI, OD, IVF or related procedures.

FDA 1271 Required? Yes No

ARHC Staff _____ Name _____ Signature _____ Date _____ Time _____

SEMEN SPECIMEN QC			
<input type="checkbox"/> Sample Acceptance Form	<input type="checkbox"/> N/A: Init _____	<input type="checkbox"/> Consent-Cryo	<input type="checkbox"/> N/A: Init _____
<input type="checkbox"/> SIP Form	<input type="checkbox"/> N/A: Init _____	<input type="checkbox"/> Consent-Cryo Storage	<input type="checkbox"/> N/A: Init _____
<input type="checkbox"/> Consent-Procedure	<input type="checkbox"/> N/A: Init _____	<input type="checkbox"/> Chain of labeling per ARHC SOP	<input type="checkbox"/> N/A: Init _____

* END *