Austin Fertility & Reproductive Medicine

Westlake IVF

DATE _____

NAME _____**DOB**_____**SSN**_____
LAST **FIRST** **MI**

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

OCCUPATION_____**EMPLOYER**_____**ADDRESS**_____

HOME PHONE_____**CELL PHONE**_____**WORK PHONE**_____

EMAIL_____

May our office contact you via e-mail concerning clinical information and laboratory results? YES NO

SIGNATURE: _____

REFERRED BY_____ _____**Phone #**_____

PRIMARY CARE PHYSICIAN_____ **Phone #**_____

MARTIAL STATUS_____**DRUG ALLERGIES**_____ _____

PREFFERED PHARMACY_____**PHONE #**_____

EMERGENCY CONTACT_____**PHONE #**_____

SPOUSE'S NAME_____**DOB**_____**SSN**_____

SPOUSE'S OCCUPATION_____**EMPLOYER**_____**PHONE #**_____

FINANCIAL POLICY

Austin Fertility & Reproductive Medicine (AFRM) has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. Following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. WE encourage you to discuss your account, and any payment arrangements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1. **Insurance**-As a courtesy to our patients, we will file claims on all visits and procedures, whether they are delivered in our office or the hospital. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to AFRM. You are responsible for payment of all deductibles, co-insurance and non-covered services. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.

2. **Referrals**-You are required to 1) know whether or not your insurance requires a referral; and 2) obtain that referral before you are scheduled to see our physicians. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor you wish to see and your covered benefits. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor the dates and visits. Our office will not see a patient who does not have a valid referral.

3. **Prior Authorizations**-You are required to know whether or not your insurance requires a prior authorization. You should take the time to call your insurance company whenever a procedure is being requested as whether a prior authorization is required and advise our office prior to procedure.

4. **No Insurance**-Patients who do not have insurance are expected to pay for all services rendered. We will request a payment for outpatient procedures in advance of having the procedure performed. We understand that individual situations may make it difficult to meet these financial expectations and are happy to discuss other payment arrangements as needed.

5. **Returned Checks**-Your account will be charged a $30 fee for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and the fee.

6. **No Show/Late Cancellations**-In order to provide the best possible service and availability to all patients, we require the following fees for all late cancellations or no shows:

*Office Visit-We require a 24 Hour cancellation notice for all office visit appointments. If the required notice is not given, a $25 charge will be assessed to the patient account. The missed appointment charge must be paid prior to or upon the next office visit.
*Procedure-We require a 48 hour cancellation notice for all procedure appointments. If the required notice is not given, a $50 charge will be assessed to the patient account. The missed procedure charge must be paid prior to or upon the next scheduled procedure

7. **Past Due Accounts**-Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned over to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance, before being seen by our physicians.

8. **Out of Network Services**-Austin Fertility & Reproductive Medicine does not make any guarantees that any laboratory, anesthesiology or other professional services are in-network providers for your contracted insurance plan. You are responsible for any professional charges in conjunction with the services you receive at the facility whether these services are considered in or out of network with your insurance plan.

9. **Non-Covered Services**-You have scheduled a visit with one of our physicians or physician assistants that the physician believes to be relevant to evaluate, monitor and protect your health. However, Medicare and certain other insurance companies will only pay for services that ***they*** determine to be "reasonable and necessary." If Medicare or another insurance company determines that your visit with our physician or physician assistant is not "reasonable and necessary," then they will deny payment for that service. Sometimes insurance companies will not cover an office visit prior to a procedure when the patient comes to the doctor with no symptoms and is requesting a screening procedure. Denial of payment by your insurance company does not mean that you do not need to visit with the physician or physician assistant beforehand.

An office visit prior to the performance of any procedure is necessary in order to evaluate the patient's general health within 30 days of the procedure. In addition, this will ensure that the patient is well informed about any recommended procedure and allow the opportunity to obtain Informed Consent for the procedure. We are required to inform you that your insurance company may not cover the office visit and that you will be responsible for payment.

Patient Statement:

I have been informed of Austin Fertility & Reproductive Medicine's financial policy and agree to its terms. I have been notified that Medicare and other insurance companies may deny payment for my initial office visit for the reasons stated above.

_____ _____

Signature of Patient or Legal Representative Date

Austin Fertility & Reproductive Medicine
Westlake IVF

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Austin Fertility & Reproductive Medicine
Westlake IVF

Authorization to Disclose Information to Relative

I, _____(name), authorize that my medical information, included but not limited to lab results, appointment scheduling, and clinical instructions, may be discussed with my family members as listed below:

Person: _____ Person: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. A photocopy of this consent shall be considered valid. This authorization expires automatically in one year.

Patient Signature: _____

Date: _____ Date of Birth: _____

Annual Review

By signing and dating below, I authorize Dr. Kavoussi and staff to discuss details of my care with the above-named individuals.

Year 2 – Signature: _____ Date: _____

Year 3 – Signature: _____ Date:_____

Year 4 – Signature: _____ Date:_____

Austin Fertility and Reproductive Medicine

K.M. Kavoussi, M.D., F.A.C.O.G. Shahryar K. Kavoussi, M.D., M.P.H., F.A.C.O.G.

NEW PATIENT QUESTIONNAIRE

1. GENERAL INFORMATION

Name: _____ Date of Birth _____ Age_____

Partner's Name (if applicable): _____ Date of Birth _____ Age_____

Who referred you/how did you hear about us?

Dr. _____ or Internet _____ or Friend/Family _____

2. PROBLEM

Briefly state your main problem as you see it.

_____

3. MENSTRUAL HISTORY

Age when you had your first period	years old
# of periods you have per year	(**without** medication to induce)
# of days between the start of one period to the start of next	days
# of days flow usually lasts	Days
Do you have discomfort (cramps) during your period?	❑ No ❑ Yes – take anything to relieve? _____

Do you have or have you had:

- ❑ Hot flashes
- ❑ Increased facial/body hair
- ❑ Breast discharge
- ❑ Increased acne
- ❑ Thyroid disorder
- ❑ Special diet habits
- ❑ Weight increase > 10 lbs
- ❑ Weight loss > 10 lbs
- ❑ Rigorous exercise

4. REPRODUCTIVE ANATOMY

Have you ever had:

- ❑ Uterine fibroids (leiomyomata)
- ❑ Endometriosis
- ❑ Pelvic adhesions
- ❑ Abnormally shaped uterus
- ❑ Ovarian cysts

5. SEXUAL HISTORY

How long have you been having intercourse without using any form of birth control?

_____ months OR years (circle one) OR ❑ Not applicable

Have you used over-the-counter ovulation kits to time intercourse? ❑ No ❑ Yes

Do they turn positive for you? ❑ No ❑ Yes

Do you use lubricants (K-Y Jelly, etc.) during intercourse? ❑ No ❑ Yes Type:_____

Do you have pain with intercourse? ❑ No ❑ Yes *If yes, Frequency:* ❑Rarely ❑Usually ❑Almost always

Type ❑ At the beginning ❑ Deep penetration ❑ Both

Severity ❑ Mild ❑ Moderate ❑ Severity .

Have you had any of the following sexually transmitted diseases/pelvic infections? ❑ No ❑ Yes (check all that apply):

- ❑ Chlamydia – date _____
- ❑ Gonorrhea – date_____
- ❑ Genital warts/HPV – date_____
- ❑ Hepatitis – date_____
- ❑ Syphilis – date_____
- ❑ HIV/AIDS – date_____
- ❑ Herpes – date_____
- ❑ Other – date_____

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6. GYNECOLOGIC HISTORY

When was your last Pap smear (month and year)?_____/_____ ❑ Normal ❑ Abnormal

When was your last abnormal Pap smear (month and year)?_____/_____ ❑ Not applicable

Have you undergone any procedures due to an abnormal Pap smear? ❑ No ❑ Yes (check all that apply):

❑ Colposcopy ❑ Cryosurgery (Freezing) ❑Laser treatment ❑ Conization ❑ LEEP procedure

Have you ever had a mammogram? ❑ No ❑ Yes – date_____ Result: ❑ Normal ❑ Abnormal

7. CONTRACEPTIVE HISTORY

Type	From When to When	Reason Discontinued

8. PREGNANCY SUMMARY

How many times have you been pregnant? _____

Number of:

Miscarriages (less than 20 weeks)	Ectopic/Tubal Pregnancies	Elective Terminations (Abortions)	Full-Term Deliveries	Premature Deliveries (before 37 weeks)

Any pregnancies with birth defects? ❑ No ❑ Yes – explain _____

Date Delivered (or Pregnancy Ended)	Months to Conception	Treatment(s) to Conceive	Delivery Type / D&C / Complications	With Current Partner?
				❑ No ❑ Yes
				❑ No ❑ Yes
				❑ No ❑ Yes
				❑ No ❑ Yes
				❑ No ❑ Yes
				❑ No ❑ Yes

9. FERTILITY

Have you been trying to get pregnant? ❑ No ❑ Yes for _____ years and _____ months

Have you consulted another doctor about fertility? ❑ No ❑ Yes _____(name)

Have you and your partner had any of the following tests?

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	Not Done	Normal	Abnormal	Approx. Date	Results (if known)
Semen Analysis	❑	❑	❑		
Female hormone tests	❑	❑	❑		
Hysterosalpingogram	❑	❑	❑		
Laparoscopy	❑	❑	❑		
Hysteroscopy	❑	❑	❑		
Blood Type	❑	❑	❑		

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Prior Fertility Treatment (check all that apply):

Previous Treatment	# of Cycles	Date(s)	Outcome
❑ Clomid – IUI? ❑ No ❑ Yes			
❑ Femara – IUI? ❑ No ❑ Yes			
❑ Daily injections – IUI? ❑ No ❑ Yes			
❑ IVF: # eggs retrieved: _____ # embryos transferred: _____ # embryos frozen: _____			
❑ FET: # embryos transferred: _____			

10. MEDICAL HISTORY

Do you or have you had:

Cancer ❑ No ❑ Yes
Diabetes ❑ No ❑ Yes
Hypertension ❑ No ❑ Yes
Asthma ❑ No ❑ Yes
High Cholesterol ❑ No ❑ Yes
Mitral valve prolapse ❑ No ❑ Yes
Blood clots in lungs/legs ❑ No ❑ Yes
Thyroid disorder ❑ No ❑ Yes
Hepatitis/Liver disorder ❑ No ❑ Yes

Do you have any other medical conditions? ❑ No ❑ Yes (please describe):

_____

11. SURGICAL HISTORY

Month / Year of Surgery	Reason for Surgery	Operation	Hospital	Surgeon/Physician

Did you have any anesthesia problems? ❑ No ❑ Yes – describe_____

12. MEDICATIONS (please list all **prescription** and **over-the-counter drugs** that you are currently taking)

Drug: Dose/Frequency	From When to When	Reason

List any herbal medicines/vitamins or health food store supplements that you are currently taking:

_____

13. ALLERGIES

❑ No Known Drug Allergies
Allergies (meds, foods) as follows: _____

14. EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate your stress level due to infertility and other pressures _____
Do you see a counselor? ❑ No ❑ Yes – For how long?_____ Frequency?_____

15. SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ ❑ None
Do you smoke cigarettes? ❑ No ❑ Yes How many/day?_____ How many years?_____ ❑ Quit – when?_____
Do you drink alcohol? ❑ No ❑ Yes – Beer: #/wk _____ Wine: #/wk _____ Liquor: # /wk _____
Do you use marijuana, cocaine, or any other similar drug? ❑ No ❑ Yes – if so, what? _____
Do you exercise? ❑ No ❑ Yes – describe _____
Are you aware of any radiation exposure other than X-rays? ❑ No ❑ Yes – describe_____

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16. FAMILY HISTORY

Ailment		Relation	Age Afflicted
Colon Cancer	❑ No ❑ Yes		
Breast Cancer	❑ No ❑ Yes		
Ovarian Cancer	❑ No ❑ Yes		
Uterine Cancer	❑ No ❑ Yes		
Cervical Cancer	❑ No ❑ Yes		
Thyroid Disease	❑ No ❑ Yes		
Lupus	❑ No ❑ Yes		

What is your Ancestry?

❑ African American
❑ American Indian/Native American
❑ Ashkenazi Jewish
❑ Asian-American
❑ Cajun/French Canadian
❑ Caucasian
❑ Eastern European
❑ Hispanic/Caribbean
❑ Northern European
❑ Southern European
❑ Other: _____

PATIENT'S SIGNATURE_____ **DATE**_____

17. MALE MEDICAL HISTORY AND INFORMATION:

Complete with/by your male partner if applicable.

Have you previously conceived with:

Your current partner? ❑ No ❑ Yes

Another woman? ❑ No ❑ Yes – how long ago? _____

List any current medical problem(s):_____

List your current medication(s):_____

List any herbal medicines/vitamins/supplements:_____

Have you been evaluated by a urologist? ❑ No ❑ Yes – MD name:_____

Have you had a **semen analysis**? ❑ No ❑ Yes – date: _____ results: _____

Have you had a vasectomy? ❑ No ❑ Yes – year: _____ If yes, have you had a reversal? ❑ No ❑ Yes

Have you had surgery for a varicocele repair? ❑ No ❑ Yes – date: _____

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ ❑ None

Do you smoke cigarettes? ❑ No ❑ Yes How many/day?_____ How many years?_____ ❑ Quit – when?_____

Do you drink alcohol? ❑ No ❑ Yes – Beer: #/wk _____ Wine: #/wk _____ Liquor: # /wk _____

Do you use marijuana, cocaine, or any other similar drug? ❑ No ❑ Yes – if so, what? _____

What is your Ancestry?

❑ African American
❑ American Indian/Native American
❑ Ashkenazi Jewish
❑ Asian-American
❑ Cajun/French Canadian
❑ Caucasian
❑ Eastern European
❑ Hispanic/Caribbean
❑ Northern European
❑ Southern European
Other: _____

PATRTNER'S SIGNATURE_____ **DATE**_____

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Genetic Carrier Testing

Genetic carrier testing is the use of specific tests to characterize the genetic status of an individual, to learn of potential diseases and conditions one could pass along to child(ren) – even when the individual has no symptoms of disease. According to the American College of Obstetricians and Gynecologists (ACOG), carrier screening and counseling ideally should be performed before pregnancy as this allows couples to learn about their reproductive risk and consider the most complete range of reproductive options.

Testing Considerations for All Women Considering Pregnancy:

- ❑ Cystic fibrosis – progressive multi-systemic disease primarily affecting pulmonary, pancreatic and GI systems; affects 1 in 2,500 individuals in non-Hispanic white population, notably less in other ethnic groups
- ❑ Spinal Muscular Atrophy (SMA) – disease characterized by degeneration of spinal cord motor neurons leading to atrophy of skeletal muscle and overall weakness; affects 1 in 6,000-10,000 live births, is leading cause of infant death
- ❑ Complete blood count with red blood cell indices (not genetic, assesses for anemias) – to test for hemoglobinopathies such as Sickle Cell Disease (approx. 1 in 10 African Americans carries sickle cell trait), Thalassemias (consider if of African, Mediterranean, Middle Eastern, Southeast Asian, and West Indian descent)

Testing Considerations for Specific Populations:

- ❑ Fragile X Syndrome – testing for women with family history of intellectual disability or personal history of unexplained ovarian insufficiency or elevated FSH level before age 40; affects 1 in 3,600 males and 1 in 4,000-6,000 females
- ❑ Tay-Sachs Disease – testing for individuals of Ashkenazi Jewish, French-Canadian, or Cajun descent; affects 1 in 30 individuals of Ashkenazi Jewish descent, 1 in 300 for non-Jewish individuals

In reading the above information, I elect:

_____ Testing of individual diseases/conditions as checked above

_____ Carrier testing including all of the above and totaling 100+ genetic conditions

_____ To discuss more with a provider before testing ordered/declined

_____ To decline genetic testing at this time

Signature of Patient: _____ Date: _____