



# PATIENT REGISTRATION

PLEASE PRINT. ALL INFORMATION WILL REMAIN CONFIDENTIAL. THANK YOU!

PATIENT \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTRY \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY PHONE \_\_\_\_\_  HOME  CELL  WORK DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

SECONDARY PHONE \_\_\_\_\_  HOME  CELL  WORK AGE \_\_\_\_\_

SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS  MARRIED  SINGLE  DIVORCED  SAME SEX COUPLE

MAY BE CONTACT YOU VIA EMAIL?  YES  NO IF SO, EMAIL ADDRESS: \_\_\_\_\_

HAVE YOU OR YOUR SPOUSE BEEN HERE BEFORE:  YES  NO

YOUR EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ ARE WE ABLE TO CONTACT YOU THERE?  YES  NO (WE DO NOT SAY THE NAME OF OUR FACILITY.)

PARTNER'S NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**INSURANCE COVERAGE (Primary)  This a FSA or HSA**

NAME OF INSURANCE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_

POLICY # \_\_\_\_\_

GROUP # \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_

PARTNER COVERED?  YES  NO

**INSURANCE COVERAGE (Secondary)  This a FSA or HSA**

NAME OF INSURANCE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_

POLICY # \_\_\_\_\_

GROUP # \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_

PARTNER COVERED?  YES  NO

\*\*\* PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD AND VALID PHOTO ID TO THE RECEPTIONIST \*\*\*

CONTINUED ON BACK

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**REFERRED BY (MARK ALL THAT APPLY)**

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- |  |                             |                             |   |   |
|--|-----------------------------|-----------------------------|---|---|
| <input type="checkbox"/> Dr _____                          | <input type="checkbox"/> MD | <input type="checkbox"/> DO | Previous Patient of:                            |   |
| <input type="checkbox"/> Resolve                           |                             |                             | <input type="checkbox"/> Dr. Keye               | <input type="checkbox"/> Henry Ford Hospital    |
| <input type="checkbox"/> IntegraMed /Attain Refund Program |                             |                             | <input type="checkbox"/> Dr. Miller             | <input type="checkbox"/> Wayne State University |
| <input type="checkbox"/> In Vitro Sciences Refund Program  |                             |                             | <input type="checkbox"/> Dr. Wolf               | <input type="checkbox"/> Oakwood Hospital       |
| <input type="checkbox"/> RMA Employee _____                |                             |                             | <input type="checkbox"/> William Beaumont Hosp. | <input type="checkbox"/> IVF Michigan           |
| <input type="checkbox"/> Insurance Co. _____               |                             |                             |   |   |
| <input type="checkbox"/> Friend/Word of Mouth _____        |                             |                             |   |   |
- May we thank this person for referring you?     Yes     No, I prefer to be discrete

- |   |  |  |
|---|--|--|
| Internet:                                   | Saw / Heard Ad:                        | Attendance at:                           |
| <input type="checkbox"/> RMA Website        | <input type="checkbox"/> Radio         | <input type="checkbox"/> RMA Seminar     |
| <input type="checkbox"/> IntegraMed Website | <input type="checkbox"/> TV            | <input type="checkbox"/> Resolve Seminar |
| <input type="checkbox"/> CDC Website        | <input type="checkbox"/> Yellow Pages  |  |
| <input type="checkbox"/> Google             | <input type="checkbox"/> Word of Mouth |  |
| <input type="checkbox"/> Other _____        | <input type="checkbox"/> Other _____   |  |

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THIS FACILITY/DOCTOR. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO PROCESS THE CLAIM. I HEREBY AGREE TO PAY FOR ALL SERVICES RENDERED TO THE ABOVE MENTIONED PATIENT AS INCURRED. I UNDERSTAND THERE IS NO GUARANTEE ANY OR ALL SERVICES WILL BE COVERED BY MY INSURANCE COMPANY. IN THE EVENT OF ACCOUNT DEFAULT, I PROMISE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES AS REQUIRED TO EFFECT COLLECTION ON THE INDEBTNESS. I UNDERSTAND THAT SHOULD MY ACCOUNT BECOME DELINQUENT OR SHOULD I FAIL TO PAY AS PROMISED; RMA RESERVES THE RIGHT TO DENY FURTHER CARE TO ME EITHER TEMPORARILY OR PERMANENTLY.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



Brad T. Miller, M.D.  
Lynda J. Wolf, M.D.

## HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been offered, received, read and/or understand Reproductive Medicine Associates of Michigan's Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of Reproductive Medicine Associates of Michigan. I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

\_\_\_\_\_  
Please Print Patient / Guarantor Name

\_\_\_\_\_

Signature of Patient / Guarantor

\_\_\_\_\_

Date



# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE FOR WOMEN

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## MEDICAL HISTORY

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type (if known) \_\_\_\_\_

Have you lost or gained greater than 20 lbs. of weight in the last year:  Yes  No

Do you follow a particular food diet or have any special dietary habits:  Yes  No

If yes, please specify: \_\_\_\_\_

Have you ever had an eating disorder (anorexia or bulimia):  Yes  No

If yes, please specify: \_\_\_\_\_

Do you have any allergies (check all that apply):  Yes  No

If yes, please specify:  Medication \_\_\_\_\_

Food \_\_\_\_\_

Latex

Do you exercise:  Yes  No

If yes, please specify the form and frequency of regular vigorous exercise (swimming, cycling, etc.):

Exercise \_\_\_\_\_ Hours/Week \_\_\_\_\_

Exercise \_\_\_\_\_ Hours/Week \_\_\_\_\_

Exercise \_\_\_\_\_ Hours/Week \_\_\_\_\_

Within the last year, have you taken any prescription medications? Please note below.

Medication	Diagnosis	Dosage / Frequency	Duration

Are you taking any over the counter medications / supplements on a regular basis? Please note below.

Medication	Diagnosis	Dosage / Frequency	Duration

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Scarlet fever                                | <input type="checkbox"/> Kidney Infection               | <input type="checkbox"/> Breast Tenderness   |
| <input type="checkbox"/> Rheumatic fever                              | <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Breast Soreness     |
| <input type="checkbox"/> Tuberculosis                                 | <input type="checkbox"/> Hirsutism (Excess Hair Growth) | <input type="checkbox"/> Breast Discharge    |
| <input type="checkbox"/> Hepatitis                                    | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Breast Cancer       |
| <input type="checkbox"/> Syphilis                                     | <input type="checkbox"/> Gallbladder Problems           | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Gonorrhea                                    | <input type="checkbox"/> Liver Problems                 | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Pelvic Infection                             | <input type="checkbox"/> Ulcers                         | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Chlamydia                                    | <input type="checkbox"/> Appendicitis                   | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Herpes (HSV)                                 | <input type="checkbox"/> Colitis                        | <input type="checkbox"/> Dizziness           |
| <input type="checkbox"/> Chronic Bronchitis                           | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Loss of Balance     |
| <input type="checkbox"/> Measles: Regular                             | <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Chronic Headaches   |
| <input type="checkbox"/> Measles: German (Rubella)                    | <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Blood Transfusions  |
| <input type="checkbox"/> Chickenpox (Varicella)                       | <input type="checkbox"/> Thyroid Problems               | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Nongonococcal Urethritis                     | <input type="checkbox"/> Ovarian Cysts                  | <input type="checkbox"/> Endometriosis       |
| <input type="checkbox"/> Pneumonia                                    | <input type="checkbox"/> Cervical Dysplasia/Cancer      | <input type="checkbox"/> Ovarian cancer      |
| <input type="checkbox"/> Neurological Problems                        | <input type="checkbox"/> HPV or genital warts           |  |
| <input type="checkbox"/> Vaginitis: Trichomoniasis or yeast infection |   |  |
| <input type="checkbox"/> Other: _____                                 |   |  |

**Physical Symptoms:**

**General:**

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other \_\_\_\_\_
- None

**Endocrine/Hormonal:**

- Diabetes       Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance- hot flashes or feeling cold
- Other \_\_\_\_\_
- None

**Gastrointestinal:**

- Nausea/Vomiting       Ulcers
- Hepatitis       Diarrhea
- Blood in your stools       Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other \_\_\_\_\_
- None

**Musculoskeletal:**

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_
- None

**Mental Health Problems:**

- Depression       Anxiety disorder       Schizophrenia
- Other \_\_\_\_\_
- Do you see a counselor? \_\_\_\_\_ How long? \_\_\_\_\_
- None

**Head, Eyes, Ears, Nose, and Throat:**

- Dizziness       Loss of sense of smell
- Headaches       Chronic nasal congestion
- Blurred vision       Ringing ears
- Hearing loss/deafness
- Other \_\_\_\_\_
- None

**Breasts:**

- Discharge (clear? \_\_\_ bloody? \_\_\_ milky? \_\_\_)
- Lumps     Pain     Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants (saline? \_\_\_ silicone? \_\_\_)
- Other \_\_\_\_\_
- None

**Genito-Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination     Leaking urine
- Blood in urine
- Herpes
- Other \_\_\_\_\_
- None

**Hematologic:**

- Blood clotting disorder/Blood clot
- Sickle cell Anemia
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons)
- Thrombophlebitis
- Other \_\_\_\_\_
- None

**Respiratory:**

- Shortness of breath
- Asthma       Bronchitis
- Pneumonia       Tuberculosis
- Bloody cough
- Other \_\_\_\_\_
- None

**Neurological Problems:**

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other \_\_\_\_\_
- None

**Skin/Extremities:**

- Unexplained rash
- Acne
- Skin cancer
- Burn injury
- Moles changing appearance
- Excess hair growth
- Other \_\_\_\_\_
- None

**Cardiovascular:**

- Palpitations/Skipped beats
- Chest pain
- Stroke
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse
- (Abx before dental procedures? Yes / No)
- Heart attack
- Murmurs
- Other \_\_\_\_\_
- None

Patient Name: \_\_\_\_\_

**Vaccinations:**

Chickenpox (Varicella)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
MMR	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
BCG (Tuberculosis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Polio	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Hepatitis A	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Hepatitis B	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Tetanus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Influenza	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know

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**GYNECOLOGICAL HISTORY**

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Age at first menses: \_\_\_\_\_ Date of first day of last menses: \_\_\_\_\_

Are your menses:  Regular  Irregular Amount of flow:  Light  Moderate  Heavy

What are the usual # days from cycle day 1 to your next day 1? Minimum \_\_\_\_\_ Maximum \_\_\_\_\_

What is the usual duration of your menses (full flow): Minimum \_\_\_\_\_ Maximum \_\_\_\_\_

Do you have PMS:  Yes  No

If yes:  Mild  Moderate  Severe

Do you have painful periods?  Yes  No

If yes:  Mild  Moderate  Severe

Do you take pain medication for cramps:  Yes  No

If yes, please specify medication: \_\_\_\_\_

Do you bleed or spot in between periods:  Yes  No

Have you ever taken oral contraceptives:  Yes  No

If yes, please list date(s): \_\_\_\_\_

Were your cycles regular after discontinuing the oral contraceptives:  Yes  No

Have you used other forms of contraception:  Yes  No

If yes, what: \_\_\_\_\_

When was your last PAP smear performed: \_\_\_\_\_ Was it Normal?  Yes  No

If abnormal, please indicate date(s): \_\_\_\_\_

Treatment:  None or repeated  Colposcopy/biopsy  Laser

Conization  LEEP  Unknown

Is intercourse painful:  Yes  No

If Yes:  Mild  Moderate  Severe

Do you use lubricants:  Yes  No

If yes, which brand? \_\_\_\_\_

Do you douche before or after intercourse:  Yes  No

How many times per week do you and your partner have intercourse: \_\_\_\_\_

How many months have you had unprotected intercourse: \_\_\_\_\_

How many months have you been actively trying to achieve pregnancy: \_\_\_\_\_

Have you used Basal Body Temperature Charts (BBT):  Yes  No

If yes, what cycle day did you ovulate: \_\_\_\_\_

Have you used an ovulation predictor kit (OPK):  Yes  No

If yes, what cycle day did you ovulate: \_\_\_\_\_

Do you take prenatal vitamins:  Yes  No

If yes, what kind and how much: \_\_\_\_\_

Have you been exposed to any toxins or radiation:  Yes  No

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

Do you perform self breast exams on a regular basis:  Yes  No

Have you had a mammogram performed:  Yes  No

If yes, date of last one: \_\_\_\_\_

If yes, was it normal?  Yes  No

If no, treatment: \_\_\_\_\_

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### OBSTETRICAL HISTORY

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How many pregnancies (including abortions) have you had: \_\_\_\_\_

How many spontaneous abortions or miscarriages (<20 weeks) have you had: \_\_\_\_\_

Number of elective terminations: \_\_\_\_\_ Number of ectopic pregnancies: \_\_\_\_\_

Number of full term (>37 weeks) births: \_\_\_\_\_ Number of pre-term (<37 weeks) births: \_\_\_\_\_

How many children are alive and well: \_\_\_\_\_

Do any have birth defects:  Yes  No

If yes, please explain: \_\_\_\_\_

Please list all pregnancies:

Pregnancy #	Year Delivered	How many weeks?	Baby born alive? Any birth defects?	Infertility therapy required to conceive?	How long in months did it take to conceive?	Is current partner the father?	Did pregnancy end in Abortion? Miscarriage? Ectopic? Complications?
1 <sup>st</sup> Pregnancy							
2 <sup>nd</sup> Pregnancy							
3 <sup>rd</sup> Pregnancy							
4 <sup>th</sup> Pregnancy							
5 <sup>th</sup> Pregnancy							

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### SURGICAL HISTORY

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Have you ever been surgically sterilized:  Yes  No

If yes, date reversal performed: \_\_\_\_\_

Any complications from anesthesia:  Yes  No

If yes, explain: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Please list all surgeries:

Date	Hospital	Procedure	Findings	Surgeon

**PREVIOUS FERTILITY TESTING**

	Yes	No	Date	Results (If Known)
Hysterosalpingogram (HSG)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Saline Sonogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endometrial Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Day 3 FSH, Estradiol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Postcoital Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mycoplasma / Chlamydia Cultures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**INFERTILITY TREATMENT**

Have you been treated for infertility before:  Yes  No

If yes, Diagnosis: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

Have you taken any of the following medications?  Thyroid (e.g. Synthroid)  Bromocriptine (Parlodel)

**Clomid or Letrozole Cycles**

Cycle #	Dates	Starting Dose	Number of Follicles	Insemination? Yes or No	Pregnancy Outcome
1					
2					
3					
4					
5					

**Follistim, Gonal-F, Menopur, Bravelle, etc. Cycles**

Cycle #	Dates	Starting Dose	Maximum Estradiol level	Number of Follicles	Insemination? Yes or No	Pregnancy Outcome
1						
2						
3						
4						
5						

**IVF History**

	Cycle # 1	Cycle # 2	Cycle # 3	Cycle # 4	Cycle # 5	Cycle # 6
Date						
IVF Center						
Frozen Cycle?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Max Start Dose						
Max Estradiol						
# Eggs Retrieved						
# Eggs Fertilized						
ICSI?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
# Embryos Transferred						
Embryo Age at Transfer Date (day 2, 3, 5 or 6)						
Pregnancy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Delivered?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**SOCIAL HISTORY**

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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

Alcohol  Yes  No

If yes, how many glasses per week? Wine \_\_\_\_\_ Beer \_\_\_\_\_ Cocktails \_\_\_\_\_

Cigarettes  Yes  No

If yes, number of packs per day? \_\_\_\_\_ Number of years: \_\_\_\_\_

Caffeinated beverages  Yes  No

If yes, how many do you consume per day? \_\_\_\_\_

Recreational drug use, past or current:  Yes  No

If Yes, what \_\_\_\_\_ and when \_\_\_\_\_

Current Gynecologist or PCP: \_\_\_\_\_ Phone: \_\_\_\_\_

May we keep this Dr. informed of your care: (Please check one)  Yes  No

**FAMILY HISTORY**

Did your mother have any difficulty with conception or pregnancy:  Yes  No

Did your mother take diethylstilbestrol (DES) when she was pregnant with you:  Yes  No

At what age did your mother begin menopause: \_\_\_\_\_

Is there a family history of infertility:  Yes  No

If yes, who / relationship: \_\_\_\_\_

Is there a history of hormonal disorders in you family:  Yes  No

If yes, who / relationship: \_\_\_\_\_

Is there a family history of birth defects:  Yes  No

If yes, who / relationship: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Is there a family history of habitual pregnancy loss:  Yes  No

If yes, who / relationship: \_\_\_\_\_

Have you ever used an intrauterine device (IUD):  Yes  No

If yes, who / relationship: \_\_\_\_\_

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

If yes, who / relationship: \_\_\_\_\_

Please list information below:

	<u>Living</u>		<u>Cause of Death/age at Death</u>
Mother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Father	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Brother(s)	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Sister(s)	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Maternal Grandmother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Maternal Grandfather	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Paternal Grandmother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Paternal Grandfather	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____

**Disorders in Your Family:**

	<u>Relationship to You</u>		
Breast Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Ovarian Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Colon Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Other Cancer _____	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Diabetes	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Thyroid problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Heart disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Blood clots	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Obesity	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Psychiatric problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Tuberculosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Endometriosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Infertility	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Menopause before age 40	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Birth defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Cystic Fibrosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Tay-Sachs disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Canavan disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Bloom syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Gaucher disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Niemann-Pick disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Fanconi Anemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Familial Dysautonomia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Muscular Dystrophy	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know

**What is your Ancestry?**

African American  
 American Indian  
or Alaskan Native  
 Ashkenazi Jewish  
 Asian  
 Native Hawaiian or  
other Pacific Islander  
 White  
 Hispanic or Latino

- |                           |                                    |                                   |   |
|---------------------------|------------------------------------|-----------------------------------|---|
| Neurologic (brain/spine)  | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Neural Tube Defects       | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Bone/skeletal Defects     | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Dwarfism                  | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Developmental delay       | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Learning problems         | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Polycystic kidney disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Heart defect from birth   | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Down syndrome             | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Other chromosome defects  | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Marfan Syndrome           | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Hemophilia                | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Sickle Cell Anemia        | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Thalasemia                | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Galactosemia              | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Deafness/Blindness        | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Color Blindness           | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Hemochromatosis           | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Other _____               | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |

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**MALE DATA (IF APPLICABLE)**

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Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Number of pregnancies conceived with current partner: \_\_\_\_\_ Previous partner: \_\_\_\_\_

Please give approximate dates and outcomes of any pregnancies conceived with a previous partner:

Date of Pregnancy	Delivered	Aborted	Miscarried
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Have you ever seen an Urologist?  Yes  No If yes, why: \_\_\_\_\_

Have you ever had antisperm antibody testing?  Yes  No If yes, result: \_\_\_\_\_

Have you ever had a semen analysis (sperm count):  Yes  No If yes, please list below:

Date	Location	Count (Million/ml)	Motility	Grade	Morphology

Do you have any medical problems unrelated to your fertility? For example: Diabetes, Multiple Sclerosis, Hypertension, Prostate Disease, urinary Tract or Kidney Infections.

Nature of Problem (Diagnosis)	Treatment	Physician

Patient Name: \_\_\_\_\_

Have you had any surgeries?

Date	Type of Surgery	Physician

Do you take any medications? Indicate medication, dosage, frequency and duration:

Medication	Diagnosis	Dosage / Frequency	Duration

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

- Alcohol  Yes  No  
 If yes, how many glasses per week? Wine \_\_\_\_\_ Beer \_\_\_\_\_ Cocktails \_\_\_\_\_
- Cigarettes  Yes  No  
 If yes, number of packs per day? \_\_\_\_\_ Number of years: \_\_\_\_\_
- Caffeinated beverages  Yes  No  
 If yes, how many do you consume per day? \_\_\_\_\_
- Recreational drug use, past or current:  Yes  No  
 If Yes, what \_\_\_\_\_ and when \_\_\_\_\_

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

- Erection:  Yes  No  
 If yes, please explain: \_\_\_\_\_
- Ejaculation:  Yes  No  
 If yes, please explain: \_\_\_\_\_

- Have you ever been exposed in last 3 months to excessive heat, hot tubs or fevers?  Yes  No
- Have you had any serious injuries to your genitals requiring hospitalization?  Yes  No
- Have you had scrotal or testicular pain?  Left  Right  Both  Yes  No
- Have you had undescended testes?  Left  Right  Both  Yes  No
- Have you had a hernia repair, bladder or penis surgery as a child?  Yes  No
- Have you had a varicocele?  Left  Right  Both Date of Repair \_\_\_\_\_  Yes  No
- Have you had a vasectomy? Date \_\_\_\_\_ Reversed? Date \_\_\_\_\_  Yes  No
- Have you ever been exposed to radiation, chemotherapy or other toxins?  Yes  No
- Have you had any infections of your penis, testicles or prostate gland?  Yes  No

Have you ever had any sexually transmitted diseases? Check all that apply below:  Yes  No

- HIV/AIDS  Herpes  Chlamydia  Gonorrhea  HPV/warts  Hepatitis A, B or C  
 Syphilis  Mumps

Is there any history of birth defects in your family?  Yes  No

Is there any history of recurrent miscarriage or infertility in your family?  Yes  No

Do you have any allergies (check all that apply):  Medication  Food  Latex  None

If yes, please specify: \_\_\_\_\_

Please list information below:

	<u>Living</u>		<u>Cause of Death/age at Death</u>
Mother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Father	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Brother(s)	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Sister(s)	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Maternal Grandmother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Maternal Grandfather	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Paternal Grandmother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Paternal Grandfather	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____

**Disorders in Your Family:**

	<u>Relationship to You</u>		
Breast Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Ovarian Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Colon Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Other Cancer _____	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Diabetes	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Thyroid problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Heart disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Blood clots	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Obesity	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Psychiatric problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Tuberculosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Endometriosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Infertility	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Menopause before age 40	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Birth defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Cystic Fibrosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Tay-Sachs disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Canavan disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Bloom syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Gaucher disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Niemann-Pick disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Fanconi Anemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Familial Dysautonia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know

**What is your Ancestry?**

- African American  
 American Indian  
or Alaskan Native  
 Ashkenazi Jewish  
 Asian  
 Native Hawaiian or  
other Pacific Islander  
 White  
 Hispanic or Latino







Brad T. Miller, M.D.  
Lynda J. Wolf, M.D.

## Patient Financial Agreement

### General Financial Provisions:

The patient, or their legal guardian, is ultimately responsible for all services incurred. Spouses cannot sign this Agreement in behalf of the patient. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. RMA will do its best to verify your insurance benefits. However, RMA is not responsible if your insurance company provides incorrect or false information which results in unexpected out-of-pocket expenses. We strongly suggest you attempt to verify your own insurance benefits and ensure all necessary pre-authorizations are in place prior to the date of service. IVF is seldom a covered benefit.

### We Do Not Carry Balances

RMA requires that you keep a credit/debit card authorization on file. This is required for instances of charges being generated on a day you do not visit us or when a balance results after your insurance processes claims. With the very busy lives of our patients, it is difficult to reach patients to come in and settle balances as they arise. Therefore, we require a credit/debit card authorization be maintained on file so that your balances can be settled as they occur. Our patients like this strategy for convenience. We will mail to you a copy of your credit/debit card receipt and your statement on the day the charge is made.

### Financing Options:

RMA of Michigan has established relationships with several financing companies for those interested in obtaining a low-interest/no interest financing. RMA does not carry balances or offer payment plans. Please discuss with a Patient Services or Patient Account Specialist for details.

### If We Participate With Your Insurance Company:

RMA of Michigan participates and submits claims to the following insurance carriers provided we have all required information and you have granted Assignment of Benefits so that payment is made to us:

- Aetna
- Blue cross Blue Shield of Michigan (excluding Blue Choice)
- Beaumont Insurance
- Cofinity
- United HealthCare

Patient must pay the difference between the charges and the anticipated insurance payment at the time the services are incurred. This includes all non-covered services, unpaid deductibles and co-pays. If your insurance company pays less than anticipated; we will bill you for the balance. You agree to clear that balance within 30 days. We are not able to offer payment plans.

RMA will make every attempt to resolve insurance claim issues with your insurance company. However, if your insurance company does not pay us within 60 days; we will seek payment from you.

Please inform us upon receipt of a new insurance card or any changes in coverage. This prevents delays in processing claims.

### Master Medical Policy Holders:

We require all services are paid in full as you go. As a courtesy, we will submit claims to Blue Cross Blue Shield for you. Blue Cross Blue Shield will send any payments directly to the insured; they do not pay us.

130 Town Center Drive, Suite 106 ▪ Troy, Michigan 48084  
Phone (248) 619-3100 ▪ Fax (248) 619-9031 ▪ [www.rmami.com](http://www.rmami.com)

### **If We Do Not Participate With Your Insurance Company Or You Are Uninsured:**

All services must be paid in full prior to the services being incurred. We do not carry balances or offer payment plans. RMA of Michigan does not verify benefits or submit claims for insurance companies not listed above.

### **Payment Methods**

The following payment methods are accepted: cash for payments not to exceed \$500, personal check, money order, cashier check, Debit Card, Visa, MasterCard, and Discover. IVF deposits may be paid by certified check or credit and must be paid at least one week in advance of your cycle start.

### **NSF Check Policy**

Returned checks will incur a \$25.00 fee for each returned check. Once we receive a returned check, future payments must be made by credit card, money order, and cashier check. Cash can be used when payment does not exceed \$500.

### **Cryopreservation and Storage Fees**

If you have consented to freeze your embryos, oocyte, and/or sperm, a storage fee will occur. If storage fees are not paid within 30 days, the fee will be considered delinquent. Cryopreservation is not included in your cost estimate and is due within 5 days of the service being performed. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees. Additionally, RMA of Michigan reserves the right to consider unpaid cryopreserved items as unwanted or abandoned and has the right to discard after all internal attempts to obtain payment have been exhausted.

### **Cancellation of Cycle**

If your cycle is cancelled for any reason, you will be charged for all services up to that point. Any cycle deposit money remaining after those services are paid can be refunded to you. Please notify the financial department when the cycle is cancelled so that your refund request can be processed timely. Refunds take approximately 2 weeks from the date of request.

If you are undergoing an IVF cycle and convert to an insemination cycle, you will only be charged for the actual procedures performed during both cycles. An excess amount paid in your cycle deposit will be refunded to the patient/guarantor once the patient has been released from care and all insurance dispositions received.

### **Medications**

Your physician or nurse coordinator will provide you with the necessary prescriptions for your treatment cycle. You can take your prescriptions to your pharmacy and deal with them as you would any other prescription. You can also use one of the mail order pharmacies that we work with such as Schraft's, Freedom Drug, or Ferring Direct. If you have a prescription plan that requires insurance authorization, please advise your nurse immediately so that any necessary authorizations are obtained. Failure to do so may cause a delay in picking up your medications as most insurance companies take several days to process these requests.

### **Anesthesia**

Anesthesia Staffing Consultants, Inc. (a separate entity) provides our patients with anesthesia services. The anesthesia fee for egg retrieval is **\$350.00** and will be **billed to you directly by Anesthesia Staffing Consultants, Inc. (ASC)**. Anesthesia payment is due at the same time your IVF payment is due. ASC accepts checks, Visa, MasterCard, Discover and American Express as method of payment. Any questions regarding your anesthesia charges and to make payment please contact them directly at **248.258.5058**.

### **Subsequent Cycles and Treatment**

Your account must be reconciled prior to any new cycle start. This means that you must have a \$0.00 balance on both your patient account and insurance account. If it is not, you will not be able to proceed with the start of further treatment until it is reconciled.

**130 Town Center Drive, Suite 106 • Troy, Michigan 48084**  
Phone (248) 619-3100 • Fax (248) 619-9031 • [www.rmami.com](http://www.rmami.com)

**Requests for Medical Records**

We will gladly provide you with copies of your medical records. For each request we must have a signed medical records release form which contains the name, address and fax number of the healthcare provider where you wish the records to be sent. This form is available on our website at [www.rmami.com](http://www.rmami.com). Spouses cannot authorize record release for each other. Each individual must sign a form regarding their own records. For each request, there is a minimum fee \$5.00 for 5 pages or less and \$25.00 for 6 pages and up. The amount due will be pre-calculated and must be prepaid before the medical records are copied. This fee may be waived when your medical records are for the purpose of sharing with your primary care doctor or your ob-gyn. We cannot copy your medical records that were provided to us from your other healthcare providers. You will need to contact those healthcare providers directly. Please allow at least ten (10) days for us to respond to your copying request. We can accommodate your requests with shorter notice but an additional \$25.00 may apply.

**Refunds**

Overpayments and credit balances will be refunded to the appropriate party after review of the account. Patient refunds will not be processed until all insurance dispositions are received, if applicable. Once a refund is requested, it may take up to 2 weeks to be processed. If payment was made by credit card; we are required to process the refund to that card.

**Delinquent Accounts**

All accounts that cannot be collected by RMA of Michigan will be referred to a collection agency or attorney for further collection action in accordance with established guidelines as deemed appropriate. Any fees assessed will be the responsibility of the debtor. Additionally, RMA will no longer be able to offer care to those whose accounts needed third-party assistance to collect on the debt.

**Patient Acknowledgement and Guarantee**

I have read, understand, and agree to the Patient Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility and I guarantee that my account with RMA will be paid per the terms of the Agreement.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



## Credit Card Authorization Form

Patient Name: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

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

### Payment Information



Accepted payment methods:

16 Digit Card Number: \_\_\_\_\_

Expiration Date (mm/yyyy): \_\_\_\_\_

3 Digit Security Code: \_\_\_\_\_ (on back of card in signature box)

This authorizes Reproductive Medicine Associates of Michigan, PLC (RMA) to charge the credit card listed above for any balance due on my account that I do not pay in person at the time of a visit using this or any other acceptable form of payment. I understand that I will receive a printed itemized receipt of any charge made to my credit card. I understand RMA will destroy this document within 30 days after my balance is zero once I have been discharged from care or otherwise completed.

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

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



# AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_  
(First) (M.I.) (Last)

SS #: \_\_\_\_\_ DOB: \_\_\_\_\_

Dear Dr. \_\_\_\_\_ I have an appointment at RMA of Michigan. I request that my medical records are released and forwarded by my appointment date on: \_\_\_\_\_ with  Brad Miller, M.D.  Lynda Wolf, M.D.

Please include the following:

- Recent Pap Smear result
- All Lab results
- Any other pertinent records related to infertility including notes on IUI or IVF
- Hysterosalpingogram (HSG) report
- Any operative records and pathology results
- Semen Analysis result
- Other: \_\_\_\_\_

Send records to:

RMA of Michigan  
Attn: Patient Services  
130 Town Center Drive, Suite 106  
Troy, MI 48084  
Fax: (248) 619-9031

I request that RMA sends my medical records for my appointment on \_\_\_\_\_ to:

Practice Name: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

I request and authorize the above named physician to release information as described above. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I understand that medical records provided by another healthcare provider or entity and that once the requested records are in RMA of Michigan's possession; they will not be copied or redistributed. I understand I am responsible for any fee the releasing entity may impose for processing this request.

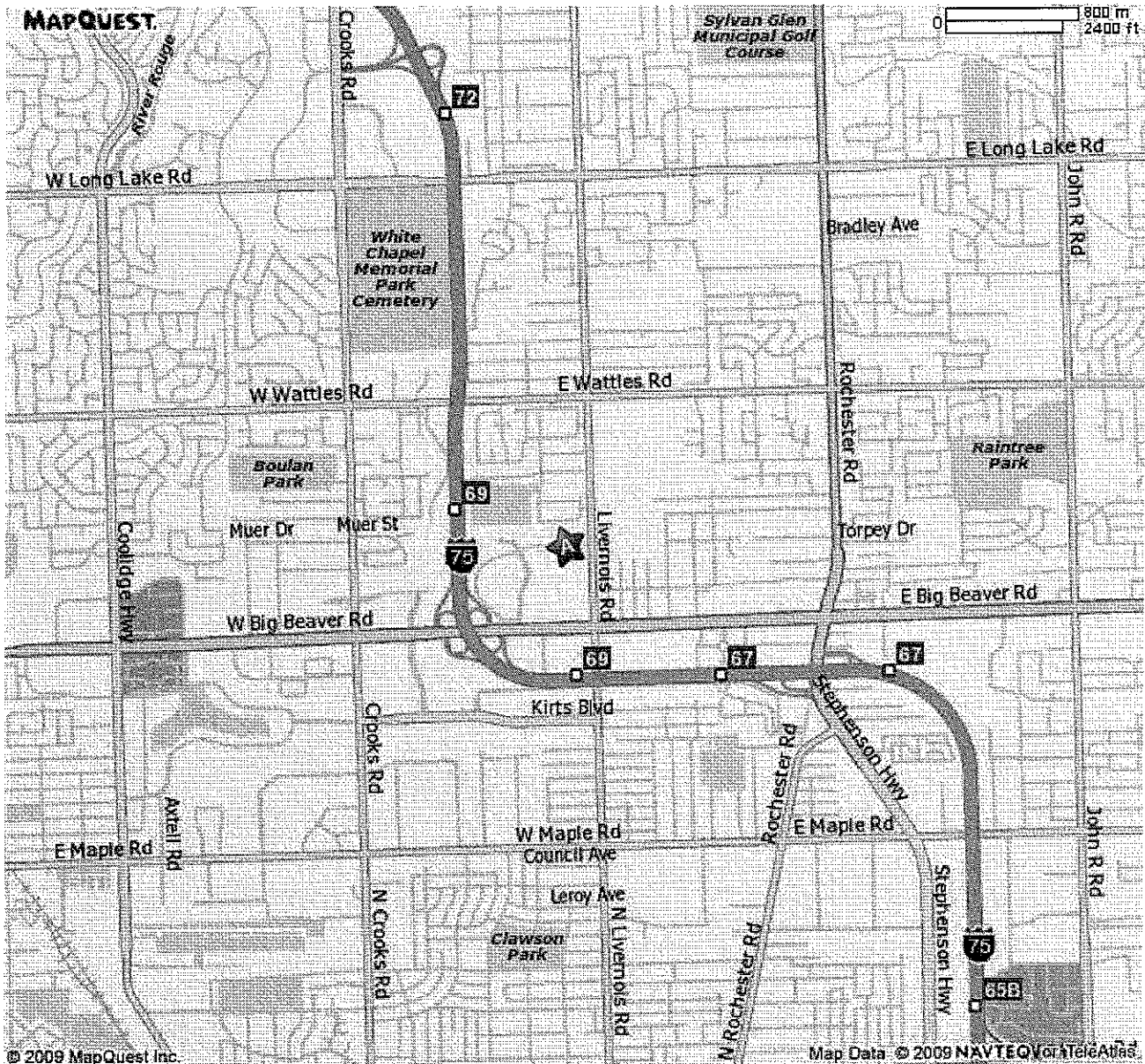
The information requested may be faxed or emailed. This Authorization expires in 90 days.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Reproductive Medicine Associates of Michigan

130 Town Center Drive, Suite 106 ▪ Troy, Michigan 48084  
Phone (248) 619-3100 ▪ Fax (248) 619-9031 ▪ [www.rmami.com](http://www.rmami.com)



## From I-75

Take the Big Beaver (East) exit. As you are driving East on Big Beaver turn North on Livernois. About ½ mile down Livernois turn left onto Town Center Drive. We are the first building on your right. Parking is located behind the building, the entrance to RMA is also located behind the building (blue awning).