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

For Your Initial Appointment

<u>It is imperative you read and fill out the enclosed forms prior to your appointment. Incomplete forms and failure to receive them prior to your scheduled appointment may cause the need to reschedule you.</u>

- Registration Packet
- Information Packet

Please fax all completed forms for your appointment in advance to (248) 619-9031 or you may email them to rmapatientservices@rmami.com . We recommend that you do not mail them.

MEDICAL RECORDS INFORMATION

In preparation for your first visit, you should complete the Authorization for the Release of Medical records form and fax it to your physician(s) so they can forward the requested information to us. The form can be found in the registration packet. This information is needed for your first visit. Our knowledge of your prior history and treatment is essential in properly assessing your current circumstances.

PRE-CONCEPTUAL SCREENING LABS

For those preparing for pregnancy, we obtain pre-conceptual screening lab information on each new patient. These lab tests are:

<u>Female Screening Labs</u>

Blood Type & RH
CBC
Cystic Fibrosis
ESR (Sed Rate)
Hepatitis B & C
HIV 1 & 2
Gonorrhea
Prolactin (fasting)
RPR (VDRL)
Rubella
TSH
Varicella IgG
Chlamydia

<u>Male Screening labs</u>

Blood Type & RH
CMV
Cystic Fibrosis
Hepatitis B & C
HIV 1 & 2
HTLV 1 & 2
RPR (VDRL)

If you or your partner have had any of these tests performed in the last 12 months, please obtain a copy of the results from the physician/facility where the tests were performed and provide it to our office. If you have not had these tests performed in the last 12 months, we will order them if you decide attempt achieving pregnancy.

It is your responsibility to inform the phlebotomist if your laboratory tests should be sent to a specific laboratory for billing purposes at the time your blood is drawn. Unless we are notified otherwise, all tests that are not performed by RMA of Michigan will be sent to LabCorp of America.

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

What to Expect During Your Initial First Visit for Infertility Evaluation and Treatment

To make the most out of your first visit, we feel it is important that we have all fertility-related medical records on file from you and your partner's current and/or past physician's that could give us insight to why you are having trouble achieving pregnancy on your own. Additionally, we can avoid duplicating items to save you time and money having these records.

Consultation / Initial Appointment
Part 1. Your evaluation starts with a consultation with one of our board certified reproductive endocrinologists. During this initial consultation, a comprehensive history will be taken. A physical exam may be performed to identify all possible causes of infertility for you, and if applicable, your partner. Often an ultrasound evaluation of the uterus and ovaries is suggested to help assess their shape and physiologic status. The physical exam nor ultrasound are part of the consultation and are billed separately. Next will be a discussion of the possible etiologies of your infertility and recommended lab tests that will help to establish the diagnosis. Lab testing is not part of the consultation and is also billed separately. You may opt not to proceed with these additional services until such time that you are ready. At the conclusion of your assessment, treatment options will be discussed along with their advantages and disadvantages.

Part 2. Next you will be introduced to a fertility nurse who will be assigned to your care. She will be in charge of helping schedule your diagnostic tests and starting your treatment plan. Your fertility nurse follows you through treatment and is your primary point of contact for any questions or concerns.

Part 3. Next you will have an opportunity to meet with a financial coordinator to discuss any insurance coverage, available financing resources, multi-cycle programs and the typical costs associated with your recommended treatment plan.

We strive to provide you with all the information and guidance necessary to make informed and appropriate treatment decisions. Your satisfaction is very important to us. We understand the volume of information received during the initial visit may be overwhelming. Please feel free to contact our office if you have questions or need information.

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

REGISTRATION PACKET

FORMS TO BE COMPLETED

PATIENT REGISTRATION

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

SCHEDULED APPOINTMENT DATE: ______________________ HAVE YOU OR YOUR SPOUSE EVER BEEN HERE BEFORE? ☐ YES ☐ NO

PATIENT ____
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS ____

CITY ______________________ STATE ________ ZIP ____________

PRIMARY PHONE ______________________ ☐ HOME ☐ CELL ☐ WORK DOB ______/______/______

SECONDARY PHONE ______________________ ☐ HOME ☐ CELL ☐ WORK AGE ________

SSN # ________-______-__________ MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SAME SEX COUPLE

MAY WE CONTACT YOU VIA EMAIL? ☐ YES ☐ NO IF SO, EMAIL ADDRESS: ______________________

EMERGENCY CONTACT NAME ______________________ RELATIONSHIP __________ PHONE ______________

YOUR EMPLOYER ______________________ OCCUPATION ______________________

EMPLOYER'S ADDRESS ______________________ CITY ______________ STATE ______ ZIP ________

WORK PHONE ______________________ ARE WE ABLE TO CONTACT YOU THERE? ☐ YES ☐ NO

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 UNDER THIS POLICY? ☐ YES ☐ NO

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

NAME OF INSURANCE ______________________

ADDRESS ______________________

CITY ______________ STATE ______ ZIP ________

TELEPHONE ______________________

POLICY # ______________________

GROUP # ______________________

POLICY HOLDER ______________________

PARTNER COVERED UNDER THIS POLICY? ☐ YES ☐ NO

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

CONTINUED ON BACK

REFERRED BY (MARK ALL THAT APPLY)

- ❐ DOCTOR ______________________________ ❐ MD ❐ DO
- ❐ FRIEND / WORD OF MOUTH ______________________________
  MAY WE CONTACT THIS PERSON FOR REFERRING YOU? ❐ YES ❐ NO, I PREFER TO BE DISCRETE
- ❐ INSURANCE CO. ______________________________
- ❐ RMA OF MI EMPLOYEE ______________________________
- ❐ RMA OF MI WEBSITE
- ❐ RMA OF MI SEMINAR
- ❐ RESOLVE SEMINAR
- ❐ INTERNET
- ❐ 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. I ALSO UNDERSTAND THAT A MONTHLY $15.00 RE-BILL FEE MAY BE ASSESED WHEN BALANCE IS CARRIED LONGER THAN 30 DAYS.

SIGNATURE ______________________________ DATE ______________________________

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 identify those with whom we may share your protected health information, including your spouse/partner. Sharing protected health information with anyone you do not authorize below will require a separate record release to be completed prior to releasing any information.

Name	Results / Medical Info	Bills / Account
	❐ Yes ❐ No	❐ Yes ❐ No
	❐ Yes ❐ No	❐ Yes ❐ No
	❐ Yes ❐ No	❐ Yes ❐ No

______________________________ ______________________________
Please Print Patient / Guardian Name — If Guardian, Relationship to Patient

______________________________ ______________________________
Signature of Patient / Guardian — Date

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE FOR WOMEN

Patient Name: ______________________________ Today's Date: ______________

Partner Name: ______________________________

MEDICAL HISTORY

Age ________ 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):

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

Physical Symptoms:

General:
- ❐ Recent weight gain or loss
- ❐ Anorexia/Bulimia
- ❐ Lack of energy
- ❐ Fever/Chills
- ❐ Other___________________
- ❐ 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

Respiratory:
- ❐ Shortness of breath
- ❐ Asthma
- ❐ Bronchitis
- ❐ Pneumonia
- ❐ Tuberculosis
- ❐ Bloody cough
- ❐ 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

Breasts:
- ❐ Discharge (clear?____ bloody? ____ milky? ____)
- ❐ Lumps ❐ Pain ❐ Cancer
- ❐ Abnormal mammogram
- ❐ Reduction
- ❐ Augmentation/Breast implants (saline?___ silicone?___)
- ❐ Other__________________
- ❐ None

Neurological Problems:
- ❐ Weakness/Loss of balance
- ❐ Seizures/Epilepsy
- ❐ Headaches
- ❐ Migraine headaches
- ❐ Numbness
- ❐ Memory loss
- ❐ 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

Genito-Urinary:
- ❐ Bladder infections
- ❐ Kidney infections
- ❐ Vaginal infections
- ❐ Frequent urination
- ❐ Leaking urine
- ❐ Blood in urine
- ❐ Herpes
- ❐ Other_____________________
- ❐ None

Skin/Extremities:
- ❐ Unexplained rash
- ❐ Acne
- ❐ Skin cancer
- ❐ Burn injury
- ❐ Moles changing appearance
- ❐ Excess hair growth
- ❐ Other ____________________
- ❐ None

Musculoskeletal:
- ❐ Unusual muscle weakness
- ❐ Decreased energy/stamina
- ❐ Rheumatoid arthritis
- ❐ Lupus Erythematosus
- ❐ Myasthenia gravis
- ❐ Other_________________
- ❐ None

Hematologic:
- ❐ Blood clotting disorder/Blood clot
- ❐ Sickle cell Anemia
- ❐ Easy bruising
- ❐ Swollen glands/lymph nodes
- ❐ Blood transfusions (dates/reasons)
- ❐ Thrombophlebitis
- ❐ 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

Mental Health Problems:
- ❐ Depression
- ❐ Anxiety disorder
- ❐ Schizophrenia
- ❐ Other______________________
- ❐ Do you see a counselor?_______ How long?_________
- ❐ None

Patient Name: ______________________________

Vaccinations:

Chickenpox (Varicella)	❒ No	❒ Yes	Date(s)________________	❒ Don't Know
MMR	❒ No	❒ Yes	Date(s)________________	❒ Don't Know
BCG (Tuberculosis)	❒ No	❒ Yes	Date(s)________________	❒ Don't Know
Polio	❒ No	❒ Yes	Date(s)________________	❒ Don't Know
Hepatitis A	❒ No	❒ Yes	Date(s)________________	❒ Don't Know
Hepatitis B	❒ No	❒ Yes	Date(s)________________	❒ Don't Know
Tetanus	❒ No	❒ Yes	Date(s)________________	❒ Don't Know
Influenza	❒ No	❒ Yes	Date(s)________________	❒ Don't Know

GYNECOLOGICAL HISTORY

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

Have you ever had an abnormal PAP? ❒ Yes ❒ No

If yes, 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: ____________________________________

Obstetrical History

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?
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

Patient Name: ______________________________

SURGICAL HISTORY

Have you ever been surgically sterilized: ❒ Yes ❒ No
If yes, date reversal performed: ______________________________
Any complications from anesthesia: ❒ Yes ❒ No
If yes, explain: ______________________________

Please list all surgeries:

Date	Hospital	Procedure	Findings	Surgeon

PREVIOUS FERTILITY TESTING

	Yes	No	Date	Results (If Known)
Hysterosalpingogram (HSG)	❒	❒	________	______________________
Saline Sonogram	❒	❒	________	______________________
Hysteroscopy	❒	❒	________	______________________
Laparoscopy	❒	❒	________	______________________
Endometrial Biopsy	❒	❒	________	______________________
Day 3 FSH, Estradiol	❒	❒	________	______________________
Postcoital Test	❒	❒	________	______________________
Mycoplasma / Chlamydia Cultures	❒	❒	________	______________________
Thyroid Tests	❒	❒	________	______________________

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?	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
Max Start Dose						
Max Estradiol						
# Eggs Retrieved						
# Eggs Fertilized						
ICSI?	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
# Embryos Transferred						
Embryo Age at Transfer Date (day 2, 3, 5 or 6)						
Pregnancy?	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
Delivered?	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N

SOCIAL HISTORY

Date of Birth: ____________________________ Age: ___________

What language(s) do you speak? ____

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

Patient Name: ______________________________

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: ______________________________

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:

	Living		Cause of Death/age at Death
Mother	❒ Yes-age ________	❒ No	____________________
Father	❒ Yes-age ________	❒ No	____________________
Brother(s)	❒ Yes-age ________	❒ No	____________________
	❒ Yes-age ________	❒ No	____________________
	❒ Yes-age ________	❒ No	____________________
Sister(s)	❒ Yes-age ________	❒ No	____________________
	❒ Yes-age ________	❒ No	____________________
	❒ Yes-age ________	❒ No	____________________
Maternal Grandmother	❒ Yes-age ________	❒ No	____________________
Maternal Grandfather	❒ Yes-age ________	❒ No	____________________
Paternal Grandmother	❒ Yes-age ________	❒ No	____________________
Paternal Grandfather	❒ Yes-age ________	❒ No	____________________

Disorders in Your Family:	**Relationship to You**		
Breast Cancer	❒ Yes ____________	❒ No	❒ Don't Know
Ovarian Cancer	❒ Yes ____________	❒ No	❒ Don't Know
Colon Cancer	❒ Yes ____________	❒ No	❒ Don't Know
Other Cancer________	❒ Yes ____________	❒ No	❒ Don't Know
Diabetes	❒ Yes ____________	❒ No	❒ Don't Know
Thyroid problems	❒ Yes ____________	❒ No	❒ Don't Know
Heart disease	❒ Yes ____________	❒ No	❒ Don't Know
Blood clots	❒ Yes ____________	❒ No	❒ Don't Know
Obesity	❒ Yes ____________	❒ No	❒ Don't Know
Psychiatric problems	❒ Yes ____________	❒ No	❒ Don't Know
Tuberculosis	❒ Yes ____________	❒ No	❒ Don't Know

What is your Ancestry?

❒ African American
❒ American Indian or Alaskan Native
❒ Ashkenazi Jewish
❒ Asian
❒ Native Hawaiian or otherPacific Islander
❒ White
❒ Hispanic or Latino

Endometriosis	❒ Yes ____________	❒ No	❒ Don't Know
Infertility	❒ Yes ____________	❒ No	❒ Don't Know
Menopause before age 40	❒ Yes ____________	❒ No	❒ Don't Know
Birth defects	❒ Yes ____________	❒ No	❒ Don't Know
Cystic Fibrosis	❒ Yes ____________	❒ No	❒ Don't Know
Tay-Sachs disease	❒ Yes ____________	❒ No	❒ Don't Know
Canavan disease	❒ Yes ____________	❒ No	❒ Don't Know
Bloom syndrome	❒ Yes ____________	❒ No	❒ Don't Know
Gaucher disease	❒ Yes ____________	❒ No	❒ Don't Know
Niemann-Pick disease	❒ Yes ____________	❒ No	❒ Don't Know
Fanconi Anemia	❒ Yes ____________	❒ No	❒ Don't Know
Familial Dysautonia	❒ Yes ____________	❒ No	❒ Don't Know
Muscular Dystrophy	❒ Yes ____________	❒ No	❒ Don't Know
Neurologic (brain/spine)	❒ Yes ____________	❒ No	❒ Don't Know
Neural Tube Defects	❒ Yes ____________	❒ No	❒ Don't Know
Bone/skeletal Defects	❒ Yes ____________	❒ No	❒ Don't Know
Dwarfism	❒ Yes ____________	❒ No	❒ Don't Know
Developmental delay	❒ Yes ____________	❒ No	❒ Don't Know
Learning problems	❒ Yes ____________	❒ No	❒ Don't Know
Polycystic kidney disease	❒ Yes ____________	❒ No	❒ Don't Know
Heart defect from birth	❒ Yes ____________	❒ No	❒ Don't Know
Down syndrome	❒ Yes ____________	❒ No	❒ Don't Know
Other chromosome defects	❒ Yes ____________	❒ No	❒ Don't Know
Marfan Syndrome	❒ Yes ____________	❒ No	❒ Don't Know
Hemophilia	❒ Yes ____________	❒ No	❒ Don't Know
Sickle Cell Anemia	❒ Yes ____________	❒ No	❒ Don't Know
Thalasemia	❒ Yes ____________	❒ No	❒ Don't Know
Galactosemia	❒ Yes ____________	❒ No	❒ Don't Know
Deafness/Blindness	❒ Yes ____________	❒ No	❒ Don't Know
Color Blindness	❒ Yes ____________	❒ No	❒ Don't Know
Hemochromatosis	❒ Yes ____________	❒ No	❒ Don't Know
Other ____________________	❒ Yes ____________	❒ No	❒ Don't Know

MALE DATA (IF APPLICABLE)

Height: _____________ Weight: ______________ Age: _________

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
	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N

Have you ever seen an Urologist: ❒ Yes ❒ No If yes, why: ______________________________

Have you ever had antisperm antibody testing? ❒ Yes ❒ No If yes, result: ____________________

Patient Name: ____

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, Uinary Tract or Kidney Infections.

Nature of Problem (Diagnosis)	Treatment	Physician

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: ____________________

Do you have/use heated car seats? ❒ Yes ❒ No

Please list information below:

	Living		Cause of Death/age at Death
Mother	❒ Yes-age ________	❒ No	____________________
Father	❒ Yes-age ________	❒ No	____________________
Brother(s)	❒ Yes-age ________	❒ No	____________________
	❒ Yes-age ________	❒ No	____________________
	❒ Yes-age ________	❒ No	____________________
Sister(s)	❒ Yes-age ________	❒ No	____________________
	❒ Yes-age ________	❒ No	____________________
	❒ Yes-age ________	❒ No	____________________
Maternal Grandmother	❒ Yes-age ________	❒ No	____________________
Maternal Grandfather	❒ Yes-age ________	❒ No	____________________
Paternal Grandmother	❒ Yes-age ________	❒ No	____________________
Paternal Grandfather	❒ Yes-age ________	❒ No	____________________

Patient Name: ______________________________

Disorders in Your Family:	Relationship to You		
Breast Cancer	❐ Yes ______________	❐ No	❐ Don't Know
Ovarian Cancer	❐ Yes ______________	❐ No	❐ Don't Know
Colon Cancer	❐ Yes ______________	❐ No	❐ Don't Know
Other Cancer_________	❐ Yes ______________	❐ No	❐ Don't Know
Diabetes	❐ Yes ______________	❐ No	❐ Don't Know
Thyroid problems	❐ Yes ______________	❐ No	❐ Don't Know
Heart disease	❐ Yes ______________	❐ No	❐ Don't Know
Blood clots	❐ Yes ______________	❐ No	❐ Don't Know
Obesity	❐ Yes ______________	❐ No	❐ Don't Know
Psychiatric problems	❐ Yes ______________	❐ No	❐ Don't Know
Tuberculosis	❐ Yes ______________	❐ No	❐ Don't Know
Endometriosis	❐ Yes ______________	❐ No	❐ Don't Know
Infertility	❐ Yes ______________	❐ No	❐ Don't Know
Menopause before age 40	❐ Yes ______________	❐ No	❐ Don't Know
Birth defects	❐ Yes ______________	❐ No	❐ Don't Know
Cystic Fibrosis	❐ Yes ______________	❐ No	❐ Don't Know
Tay-Sachs disease	❐ Yes ______________	❐ No	❐ Don't Know
Canavan disease	❐ Yes ______________	❐ No	❐ Don't Know
Bloom syndrome	❐ Yes ______________	❐ No	❐ Don't Know
Gaucher disease	❐ Yes ______________	❐ No	❐ Don't Know
Niemann-Pick disease	❐ Yes ______________	❐ No	❐ Don't Know
Fanconi Anemia	❐ Yes ______________	❐ No	❐ Don't Know
Familial Dysautonia	❐ Yes ______________	❐ No	❐ Don't Know
Muscular Dystrophy	❐ Yes ______________	❐ No	❐ Don't Know
Neurologic (brain/spine)	❐ Yes ______________	❐ No	❐ Don't Know
Neural Tube Defects	❐ Yes ______________	❐ No	❐ Don't Know
Bone/skeletal Defects	❐ Yes ______________	❐ No	❐ Don't Know
Dwarfism	❐ Yes ______________	❐ No	❐ Don't Know
Developmental delay	❐ Yes ______________	❐ No	❐ Don't Know
Learning problems	❐ Yes ______________	❐ No	❐ Don't Know
Polycystic kidney disease	❐ Yes ______________	❐ No	❐ Don't Know
Heart defect from birth	❐ Yes ______________	❐ No	❐ Don't Know
Down syndrome	❐ Yes ______________	❐ No	❐ Don't Know
Other chromosome defects	❐ Yes ______________	❐ No	❐ Don't Know
Marfan Syndrome	❐ Yes ______________	❐ No	❐ Don't Know
Hemophilia	❐ Yes ______________	❐ No	❐ Don't Know
Sickle Cell Anemia	❐ Yes ______________	❐ No	❐ Don't Know
Thalasemia	❐ Yes ______________	❐ No	❐ Don't Know
Galactosemia	❐ Yes ______________	❐ No	❐ Don't Know
Deafness/Blindness	❐ Yes ______________	❐ No	❐ Don't Know
Color Blindness	❐ Yes ______________	❐ No	❐ Don't Know
Hemochromatosis	❐ Yes ______________	❐ No	❐ Don't Know
Other ________________________	❐ Yes ______________	❐ No	❐ Don't Know

What is your Ancestry?

❐ African American
❐ American Indian or Alaskan Native
❐ Ashkenazi Jewish
❐ Asian
❐ Native Hawaiian or otherPacific Islander
❐ White
❐ Hispanic or Latino

PATIENT COMMENTS

What are your expectations for this visit and what questions would you like answered?
What do you understand about the cause of your infertility and possible treatment options?
Do you have personal / religious objections to IUI, IVF, Donor Sperm, Donor Egg, and Genetic Testing (PGD)?

Patient Name: ______________________

Please use this space to add any additional comments or information you feel our physician should know.

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

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 $500.00, personal check, money order, cashier check, Debit Card, Visa, MasterCard, and Discover. IVF deposits may be paid by certified check or credit and must 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 $500.00.

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 charge 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 <u>must</u> 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.

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. 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: VISA MasterCard DISCOVER

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: ______________________

❑ I request that my medical records are released and forwarded by my appointment date on: ______________________ with ❑ Brad Miller, M.D. ❑ Lynda Wolf, M.D.

Physician: ______________________________________
Practice Name: ______________________________________
Address: ______________________________________
City, State, Zip: ______________________________________
Phone: ______________________________________
Fax: ______________________________________

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:

Reproductive Medicine Associates of Michigan, PLC
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

Genetic Family History

Name: ______________________ **Birth date:** __________ **Occupation:** ______________

Name of Spouse/Partner: ______________________ **Birth date:** __________ **Occupation:** ______________

General

	Yes	No
Will you or your partner be 35 (female) or 40 (male) or older by the end of this year?	❍	❍
Are you and your partner related to each other by blood (such as cousins, etc)?	❍	❍
Are you or your partner adopted?	❍	❍

Questions below are based on your current relationship and previous relationships, if applicable

How many times have you been pregnant? ________ How many living children do you have? ________

How many miscarriages have you had? ________ How many stillbirths have you had? ________

How many terminations have you had? ________

Are you or your partner from any of the following ethnic backgrounds? (Check all that apply.)

	You	Partner
Jewish, French Canadian, and/or Cajun	❍	❍
Italian, Greek, Spanish, Portuguese, Mediterranean, and/or Middle Eastern	❍	❍
Caucasian	❍	❍
African American, African ancestry	❍	❍
Hispanic, Latino, and/or Caribbean	❍	❍
Asian, Asian Indian	❍	❍
Other (please specify): ______________	❍	❍

If you are currently pregnant, please answer the following questions:

	Yes	No
Was this pregnancy achieved through assisted reproductive technologies?	❍	❍
Was an egg and/or sperm donor used for this pregnancy?	❍	❍
Did you have preimplantation genetic diagnosis (PGD) and/or intracytoplasmic sperm injection (ICSI)?	❍	❍

Do you, your partner or anyone in either of your families have any of the following conditions?

	Yes	No
Birth defects (heart defects, cleft lip/palate, spina bifida, anencephaly, etc)	❍	❍
Down syndrome/other chromosome disorder	❍	❍
Mental retardation and/or autism	❍	❍
Learning disabilities or developmental delay	❍	❍
Behavioral/mental health problems (ADHD, bipolar disorder, schizophrenia, etc)	❍	❍
Stillborn, two or more pregnancy losses, infertility	❍	❍
Baby who died at birth or within the first year	❍	❍
Blindness or early vision loss	❍	❍
Deafness or early hearing loss	❍	❍
Short stature (skeletal disorder, dwarfism, etc)	❍	❍
Alzheimer's disease, Parkinson's disease, dementia	❍	❍
Brain, nerve, and/or muscle problems	❍	❍
Seizure disorder/epilepsy	❍	❍

	Yes	No
Respiratory problem (COPD, emphysema, etc)	❍	❍
Heart disease and/or stroke before age 50	❍	❍
Problems with excessive bleeding or clotting	❍	❍
Unexplained liver disease	❍	❍
Kidney problems	❍	❍
Cancer (breast, ovarian, colon, other)	❍	❍
Relative who died unexpectedly before age 50	❍	❍
Other inherited condition(s): ______________	❍	❍

One of the conditions below (please circle):

Cystic fibrosis	Spinal muscular atrophy	Hemochromatosis
Tay-Sachs disease	Fragile X syndrome	Huntington disease
Sickle cell anemia	Hemophilia	Neurofibromatosis
Thalassemia	Muscular dystrophy	Charcot-marie-tooth

Please check any of the following to which you may have been exposed during the past year or during this pregnancy, if you are currently pregnant (please provide details):

❍ Medication(s):______________ ❍ Fever/infection:______________

❍ Vitamins/herbal supplements: ________ ❍ Cigarettes: ________ ❍ Sauna/hot tub: ________

❍ Raw meat/fish or under-cooked meat/ fish: ________ ❍ Alcohol: ________ ❍ Pets: ________

❍ Eat fish frequently: more than 12 oz/week: ________ ❍ Recreational drugs: ________ ❍ X-rays/radiation: ________

Is there any other information you feel your health care provider should know about your genetic family history? ❍ Yes ❍ No If yes, please explain.

____

I have answered the above questions to the best of my knowledge. **Signature:** ______________ **Date:** ________

FOR OFFICIAL USE ONLY: Reviewed by: ______________ Date: ________

❍ No referral indicated ❍ Refer for genetic counseling ❍ Refer for genetic screening for:______________

©2009 Laboratory Corporation of America® Holdings All rights reserved. 7306-0909

Reproductive Genetic Assessment Fact Sheet

What are the benefits of having a genetic assessment?

- To assist you in understanding genetic risks concerning your health, your reproductive history, and/or your family's health.
- Review your family history for inherited conditions.
- Identify and inform you of appropriate tests available based on your genetic history.
- Discuss the advantages and disadvantages of various types of genetic testing.
- Answer your questions and get your consent to conduct any tests you might choose.
- Explain your genetic test results to you and how they pertain to your health, your reproduction, and your family.

Who should have a genetic assessment?

Individuals who:

- Are concerned about reproductive issues.
- Have a history of infertility.
- Are considering pregnancy and are in their mid-30s or older.
- Have an abnormal genetic test result.
- Have a history of multiple miscarriages.
- Are considering Intra-cytoplasmic Sperm Injection (ICSI).
- Are considering Preimplantation Genetic Diagnosis (PGD).
- Are considering being a gamete (egg or sperm) donor.
- Have a family history of an inherited condition (cystic fibrosis, sickle cell anemia, fragile X, muscular dystrophy, etc…).
- Were born with or have a child or other relative with a birth defect, developmental delay, or mental retardation.
- Have questions or concerns about the risk for birth defects or inherited conditions in their children.
- Would like more information about the availability of genetic testing.

Who does the genetic assessment?

- A board certified genetic counselor with a Masters of Science degree in Human Genetics
- The genetic counselor works under the supervision of a board certified M.D. medical geneticist
- A genetic counselor will do a detailed analysis of your family and medical history, and will provide you with an in depth discussion of the benefits, risks, and limitations of the genetic tests and procedures available to you based on your medical and family histories.
- Each genetic risk assessment is provided to you in writing.

What about insurance reimbursement?

LabCorp is a company that works with your doctor in providing genetic assessment/genetic counseling and genetic testing services. **Charges for LabCorp's services are separate from those incurred by visiting your physician**. LabCorp will be happy to file a claim with your insurance carrier upon presentation of necessary insurance documentation. You will be responsible for payment of any remaining balance after insurance benefits have been applied, including any deductibles or coinsurance responsibility you may have. It is suggested that you contact your insurance provider in advance to verify that your benefits include genetic counseling and/or genetic testing based on your referral indication. If you have additional billing questions after talking with your insurance provider, feel free to contact the Northeast Division of Genetic Services at LabCorp at (888) 699-2078.

Please sign below and check the appropriate box:

I have read the above information and am informed of the benefits and risks of genetic counseling.

☐ I am interested in genetic counseling.
☐ I decline genetic counseling at this time.

Signature____

Date__________________________________

Witness____

Date__________________________________

5/3/2004

INFORMATION PACKET

PLEASE REVIEW

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

General Information

Telephone Number: (248) 619-3100 **Fax Number: (248) 619-9031**

Please note: We reserve the right to reschedule anyone arriving more than 15 minutes after their scheduled appointment time so the patients following you can be seen on time.

Office Hours:
Morning Monitoring: 6:30 am - 7:30 am, Monday thru Sunday.
You should arrive no later than 7:15 am.
Morning Monitoring is reserved specifically to conduct blood work and ultrasounds only. This time is not intended for lengthy discussions about your treatment. Call your Fertility Nurse with questions or concerns. Your Fertility Nurse will forward matters to your physician that require their expertise. Some matters are not appropriate to handle by phone and an appointment will be needed.

Physician and Nurse Appointments: 8:00 am - 4:00 pm, Monday thru Friday.

Andrology Lab Appointments: These services are by appointment only.
Sperm Wash for Intrauterine Insemination (IUI) - 6:30 am - 9:00 am, Monday thru Sunday
Sperm Analysis - 9:30 am - 11:30 am and 1:00 pm - 1:30 pm, Monday thru Friday

Telephone Availability:
8:00 am - 4:30 pm, Monday thru Friday
Fertility Nurse calls received after 2:30 pm are returned the next business day except the rare occasion when urgent or emergent circumstances surface.

Pregnancy Monitoring:
RMA's physicians will monitor pregnancy until approximately 7 weeks of gestation or 6 weeks from your first positive pregnancy test. These additional ultrasounds and blood work charges are not included in the IUI or IVF estimated cycle deposit and are billed separately. We do not bill for pre-natal office visits which are often a global packages with insurance companies. This ensures your obstetrician does not have to 'share' the specified amount of ob visits with us.

After-Hour Emergencies:
In the event you have an after hours emergency, call (248) 619-3100. Our answering service will refer emergency calls to the nurse or physician on call. Messages taken for non-emergent calls are handled the following business day. Please do not use the after hour service to relay non-emergent messages.

Children In Our Office:
For the comfort of the patients around you, and for the safety of your children, we must ask that you arrange for childcare during visits to our office. Children cannot be left in our waiting room and they are not allowed in our clinical area or exam rooms. Infants secured in carriers are permitted provided there is another individual accompanying you to remain with the child in the event that you need testing or other procedures.

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

FINANCIAL FAQ's

Do you accept my insurance?
RMA of Michigan participates as an in-network provider for Aetna, Blue Cross Blue Shield of Michigan (excluding Blue Choice), Beaumont Insurance, Cofinity, and United HealthCare. However, we are considered an out-of-network provider for most other insurance companies.

Most insurance plans will allow you to see out-of-network providers. Deductibles and coverage levels vary, but often there is little difference in coverage between in-network and out-of-network providers. A Patient Account Specialist can discuss detailed information of how your specific insurance coverage will apply at RMA.

What does it mean if RMA is an out-of-network provider?
An "out-of-network provider" means that RMA is not directly contracted with your insurance carrier. However, because your insurance carrier values your right to choose your own care provider, your plan may include out-of-network benefits. Just because we are an out-of-network provider does not mean you will not receive reimbursement for care received at RMA. Most carriers require a deductible be satisfied (the deductible amount is determined by your policy). A slightly higher out-of-pocket expense may apply if you opt to see an out-of-network provider. Often this amount is around 10% and the co-pay and deductible may be slightly higher.

This means that while you may have more responsibility up front; your additional coverage may be quite comparable to in-network providers. This is not always the case, however, so we encourage you to check your benefits directly with your carrier. Also make sure to find out if you have coverage for infertility, because if you do not have infertility benefits, your coverage will not vary whether you go to an in-network provider or not.

What will my insurance cover?
Due to the number of different types of policies, we are unable to tell you exactly what your insurance will and will not cover. We would encourage you to contact your insurance carrier for this information. In an effort to assist you, we have enclosed a sample pre-determination of benefits letter that you would send to your insurance. We can attempt to contact your carrier but cannot guarantee their accuracy of any statements they make or that their payment will be made.

What are my financial responsibilities?
Regardless if RMA is an in-network or out-of network provider with your insurance, you are ultimately responsible for all services, paid or not paid by your insurance. This includes all "Usual and Customary" reductions, non-covered or non-eligible services, deductibles, co-insurances and co-pays. Simply, you are responsible for all services incurred. You will receive a statement indicating any insurance payments and your amount due. Payment is due in 30 days.

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

Following your new patient appointment, you will meet with a financial counselor. During this meeting, the financial counselor will be able to give you more detailed information about your insurance coverage, the costs associated with your treatment options, and how/when any payment will be required.

Will I have to submit a claim to my insurance company?
RMA will be happy to submit claims for contracted insurance companies on your behalf. If the patient has insurance that RMA is not contracted with, you submit claims to seek reimbursement. In this case, RMA will supply you with all the information you will need to submit claims yourself. The insurance company should reimburse you; not send payment to RMA.

How much does a cycle of IUI/IVF cost?
One cycle with IUI will cost approximately $600 to $2,200 per cycle. Please note these estimates do not include medications.

One fresh cycle of in vitro fertilization will cost $6,655 to $11,295. If a third party (egg donor, gestational carrier) is involved, the costs will range from $17,176 to $21,696. These estimates do not include medications. For more specific information, please call our Billing Office at (248) 619-3100.

Please be careful when comparing prices with other IVF centers. All centers put their packages together differently. Make sure you are aware of what is and is not included in the package price that is quoted.

When will I have to pay for IVF?
We require pre-payment on IVF procedures. Approximately two weeks prior to the start of the cycle, we will send you a letter requesting the pre-payment amount. The payment is due one week prior to the cycle start date. For more specific information regarding your pre-payment amount, please contact our Billing Office at (248) 619-3100. Paying with less than one week in advance can cause your cycle to cancel or be rescheduled to a later date.

How will payment be accepted?
RMA does not accept personal checks or cash for procedure payments. Payment may be made by money order, certified check or for your convenience we accept Visa, MasterCard and Discover. We accept cash for services not exceeding $500.

Will RMA submit charges to my insurance company but not mention IVF?
Accuracy is important to our practice and for your care. This applies to billing as well. We assure you that we bill for the exact services we provide, using accurate diagnosis codes. In so doing, we can avoid any semblance of fraud with insurance companies.

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

What if I need Surgery?
Dr. Miller and Dr. Wolf are skilled at performing a wide variety of surgical procedures. Currently, our surgeries are done at Beaumont Royal Oak, Beaumont Troy, and Dr. Miller is on staff at Crittenton. Many surgeries are covered by your insurance plan, but in cases where a procedure is not covered or instances in which Dr. Miller or Dr. Wolf is not a "participating" physician, you will be responsible for payment. In those cases, RMA will require a pre-payment. Please contact our Billing Office to make sure you have a clear understanding of your financial responsibilities.

Can a visit be "coded" as something other than infertility?
We have had circumstances where patients have questioned whether a visit can be "coded" as something other than infertility, with the intent to falsely trigger insurance benefits. Not only is such action unethical, but it also constitutes insurance fraud which is illegal. Just as we commit to our patients to be honest and forthright, we to are honest and straightforward with the insurance companies.

Lastly, it is important that you know that your insurance companies have the right to review claims for proper reimbursement for up to one year after the claim is paid. This means that payments made previously for what services were communicated by the insurance company as a covered diagnosis or service can be reversed. When this occurs, the insurance company can demand a refund. Should an insurance company demand a refund from RMA; we are obligated to cooperate if their reason is found to be valid. The involved amount then becomes the responsibility of the patient and you will subsequently receive a bill. If the reason seems to be invalid, RMAMI will contact you to discuss prior to returning money to an insurance company if possible.

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

What Questions Should I Ask My Insurance Company?

- Does my plan have benefits for infertility treatment?
  - What is included?
  - What is excluded?

- If I have benefits for infertility, are Dr. Miller and/or Dr. Wolf in-network or out-of-network provider?
  - If out-of-network, will I have to meet a deductible?

- What level of coverage will be applied to covered treatments? (70%,80%, 90%?)
  - Will I have to meet a deductible first?
  - How much is my deductible?
  - After my deductible is satisfied, are coverage levels the same for participating and non-participating providers?

- Will my level of coverage be based on the allowable amount or the billed amount?

- Will my plan require a referral?
  - Will I have to contact my primary care provider or my OB/GYN?

- Will diagnostic physician office visits be covered?

- Will laboratory treatments (blood draws, ultrasounds, etc.) be covered?

- What types of treatments will be covered?
  - Intrauterine inseminations? (IUI)
  - In vitro fertilization? (IVF)
  - Embryo Cryopreservation?

- Will infertility medications be covered?
  - Do I have to use a certain pharmacy?
  - Will I need a prior authorization?

- How many treatment cycles will be covered?
  - How many cycles of IUI can I try?
  - How many cycles of IVF can I try?
  - How many cycles of medications can I try?

- Do I have a maximum calendar year and/or lifetime maximum benefit?

- Is preauthorization needed for any services?

Sample Letter for Insurance Pre-Determination

Date :

Insurance Company:
Address:
City, State, Zip:

Pre-determination of benefits for: (patient's name)

Group or Group Number:
ID Number: (also known as contract, member or subscriber number)

Dear Insurance Company:

My spouse/partner and I are considering In Vitro Fertilization (IVF). This procedure is needed to attempt pregnancy due to (explain your situation, i.e. blocked fallopian tubes, male factor, previous sterilization, unexplained infertility, etc). A generic list of IVF procedure codes with a description is attached for your review.

Please provide me with a written response to each question below:

1. Will IVF be a payable procedure under my current coverage?
2. If yes, is there a limit of any kind (dollars and/or number of attempts)? If number of attempts, define an attempt.
3. If no, are any portions of the charges payable (pre-retrieval charges such as prescription drugs, laboratory test and/or ultrasounds)?
4. If yes, are there any exclusions?
5. Is Embryo Cryopreservation a covered expense?
6. If yes, is a separate storage charge after the initial 12 months covered?
7. Are Frozen Embryo Transfers covered? If so, is there a limit on the number of attempts?

The primary diagnosis is Infertility (628.9). Based on the diagnosis, tests performed, and/or treatments rendered thus far, the next viable treatment is In-vitro Fertilization. Please respond in writing and address **all** questions above based on the benefit plan.

I would appreciate a response as soon as possible. Thank you.

Sincerely,

Your name
Street
City, state, zip

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

IVF Procedure Codes

58970	Follicle Aspiration
76948	Ultrasound guidance at follicle aspiration
89254	Oocyte identification
89261	Sperm preparation, complex
89268	Oocyte fertilization
89250	Embryo culture
89253	Assisted hatching
89272	Blastocyst culture
89255	Preparation of embryo(s) for transfer
76941	Ultrasound guidance at embryo transfer
58974	Uterine embryo transfer
89258	Embryo cryopreservation
89342	Yearly embryo cryopreservation storage
89352	Embryo thaw

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

IVF PROGRAM'S

We understand how stressful fertility treatments can be, especially for those who do not have insurance coverage for the treatments they need. We know that your dream is to have a baby, but that planning for the financial aspect can be stressful and frustrating. We have some options that might help reduce the financial stress.

RMA'S MULTI-CYCLE PROGRAM:
All applicants are eligible for the Multi-Cycle program, in which you pay a single discounted fee (less than the cost of 2 fresh IVF cycles) and receive up to four treatment cycles, two fresh IVF cycles and two frozen embryo cycles. The Multi-Cycle program does not offer a refund, but does offer a lower cost for greater treatment access. Additionally, most of the many patients that did not meet all of the medical requirements for the refund program usually qualify for this program.

PREMIER IVF'S REFUND PROGRAM:
Premier IVF's Refund program offers qualified patients up to six treatment cycles (3 fresh IVF and 3 frozen embryo transfers) for a fixed, discounted fee. If you do not take a baby home from the hospital, the Program offers a refund of 100% of the Program fee. The cost of an egg donor can be included for those interested.

Please call 1-855-IVF-BEST for more information.

FINANCE OPTIONS

SPRINGSTONE PATIENT FINANCING
- No initial payment
- No prepayment penalty
- Flexible terms 24-84 months
- Low fixed interest rates – as low as 5.99%

Please visit www.SpringstonePlan.com/fertility or call 1-800-630-1663 for more information.