HIPAA

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

Reproductive Medicine Associates of Michigan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact

Reproductive Medicine Associates of Michigan

Of our office at

130 Town Center Drive Suite 106

Troy, MI 48084

248-619-3100

248-619-9031

Who Will Follow This Notice

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

Your Health Information

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How We May Use and Disclose Health Information About You

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays.

Family and Friends

We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may use and disclose medical information to contact and remind you about appointments for treatment or medical care at the office. If you are not home, we may leave this information on your answering machine or in a message left with person answering the phone.

Sign-in Sheet

We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security & Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Proof of Immunization

We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.

Specialized Government Functions

We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Change of Ownership

In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Breach Notification

In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Other Uses and Disclosures Of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

Reproductive Medicine Associates of Michigan

Of our office at

130 Town Center Drive Suite 106
Troy, MI 48084

248-619-3100
248-619-9031

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend or Supplement

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

We may not (and are not required to) agree to your restrictions with one exception: If you pay in full (out of pocket) for a service you receive from us, and you request that we do not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

If we do agree we will comply with your request unless the information is needed to provide you emergency treatment.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

Reproductive Medicine Associates of Michigan

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

Reproductive Medicine Associates of Michigan

Of our office at

130 Town Center Drive Suite 106
Troy, MI 48084

248-619-3100
248-619-9031

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to:

Reproductive Medicine Associates of Michigan

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Reproductive Medicine Associates of Michigan

You will not be penalized for filing a complaint.

Signature _____

TO MAKE THE MOST OF YOUR FIRST VISIT

It is important that we have all fertility related medical records for you and your partner on file at our office before your visit. This allows the doctor adequate time to review these records before meeting with you. It also helps us to avoid duplicating tests that you have already had done.

These records include any recent care provided by:

- Your gynecologist (including your most recent pap smear and mammogram results)
- Your urologist
- Another reproductive endocrinologist (fertility doctor)

Please contact all of the above offices to have the requested information sent to us. Our fax number is (248) 619-9031.

WHAT TO EXPECT AT YOUR INITIAL APPOINTMENT

Part 1: Please plan on your consultation lasting 1 – 1 ½ hours. Your evaluation starts with a consultation with either Dr. Brad Miller or Dr. Lynda Wolf (both of whom are board certified reproductive endocrinologists). The doctor you meet during your initial consultation will direct your care. However, since the nature of our practice requires that monitoring & treatment be provided 365 days a year, some of your monitoring ultrasounds and/or your procedures may be performed by the other physician.

During this initial consultation, a comprehensive history will be taken. A physical exam may be performed. The doctor will discuss possible causes of your infertility and make recommendations about testing that may be helpful in determining a treatment plan. Some of this testing (including blood work and ultrasounds) may be done during this visit; some testing must be delayed until an appropriate time in your menstrual cycle.

Please Note: Exams, blood work and ultrasounds are not part of the $280 consultation fee and incur an additional cost that may or may not be covered by insurance. If your blood work needs to be sent to a specific lab due to insurance coverage please notify the lab tech who draws your blood of this fact.

Part 2: You will be introduced to your primary nurse. This nurse has special training in infertility care. She follows you through your treatment cycle and is your primary point of contact for any questions or concerns. She will schedule all diagnostic testing and order medications for you.

Part 3: You will have the opportunity to meet with a financial coordinator to discuss insurance coverage, available financial resources, multi-cycle plans, refund programs and the typical costs associated with your recommended treatment plan.

The Source for New Beginnings

RMA Michigan

Reproductive Medicine Associates of Michigan

REGISTRATION PACKET

FORMS TO BE COMPLETED

PATIENT REGISTRATION

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

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

LEGAL NAME: _____
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY PHONE _____ ☐ HOME ☐ CELL ☐ WORK DOB ____/____/____

SECONDARY PHONE _____ ☐ HOME ☐ CELL ☐ WORK AGE _____

SSN # ____-____-____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED
(THE LAST 6 DIGITS ARE REQUIRED)

MAY WE CONTACT YOU VIA EMAIL? □ YES □ NO IF YES, EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE _____

ARE YOU EMPLOYED? □ YES □ NO IF YES, YOUR EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE _____ MAY WE CONTACT YOU THERE? □ YES □ NO

PARTNER NAME _____
(LAST) (FIRST) (MIDDLE)

SSN # ____-____-____ DOB ____/____/____ AGE _____ □ Male □ Female

EMPLOYED BY _____ OCCUPATION _____

WORK PHONE _____ CELL PHONE _____

DOES YOUR LEGAL NAME MATCH YOUR INSURANCE? YES □ NO □

IF NO, PLEASE WRITE YOUR NAME AS SHOWN IN YOUR INSURANCE: _____

PATIENT INSURANCE COVERAGE

NAME OF INSURANCE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE _____
POLICY # _____
GROUP # _____
POLICY HOLDER _____
PARTNER COVERED UNDER THIS POLICY? □ YES □ NO

SPOUSE/PARTNER INSURANCE COVERAGE

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 *****

REFERRED BY (MARK ALL THAT APPLY)

Yes No

- ❒ ❒ DOCTOR (PLEASE LIST NAME) _____ ❒ MD ❒ DO
- ❒ ❒ FRIEND / WORD OF MOUTH (PLEASE LIST NAME) _____
  MAY WE CONTACT THIS PERSON FOR REFERRING YOU? ❒ YES ❒ NO, I PREFER TO BE DISCREET
- ❒ ❒ INSURANCE CO. _____
- ❒ ❒ RMA OF MI EMPLOYEE _____
- ❒ ❒ RMA OF MI WEBSITE
- ❒ ❒ RMA OF MI SEMINAR
- ❒ ❒ RADIO
- ❒ ❒ BILLBOARD
- ❒ ❒ INTERNET

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 effecting collection on the debt. I understand that should my account become delinquent or should I fail to pay as promise; RMA of Michigan reserves the right to deny further care to me either temporarily or permanently.

SIGNATURE _____ DATE _____

Shared Protected Health 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

The Source for New Beginnings
RMA Michigan
Reproductive Medicine Associates of Michigan

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE FOR WOMEN

Patient Name: _____ Today's Date: _____

Partner Name: _____

What are your expectations for this visit and what questions would you like answered?

GYNECOLOGICAL HISTORY

Current Gynecologist or Primary Care Physician: _____ Phone: _____

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

Age at first period: _____ Date of first day of last period: _____

Are your periods: ❒ 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 periods (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: _____

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

If yes, when? / which brand? _____

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

If yes, when? _____

How many months have you had unprotected intercourse: _____months

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

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: _____

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 times have you been pregnant? _____

Number of abortions: _____ Number of miscarriages (<20 weeks): _____

Number of ectopic pregnancies: _____ Number of pre-term (<37 weeks) births: _____

Number of full term (>37 weeks) births: _____ How many children are alive and well: _____

Do any of your children have birth defects? ❒ Yes ❒ No ❒ NA

If yes, please explain: _____

Please list all pregnancies:

Pregnancy #	Year Delivered	How many weeks?	Pregnancy Outcome: Live Birth? Miscarriage? Abortion? Ectopic? Complications?	Infertility therapy required to conceive?	How long in months did it take to conceive?	Is current partner the father?
1st Pregnancy						
2nd Pregnancy						
3rd Pregnancy						
4th Pregnancy						
5th Pregnancy						

MEDICAL HISTORY

Age _____ Weight _____ Height _____ Blood Type (if known) _____

Do you have anything in your health history that your partner is not aware of that you wish to keep confidential? ❒ Yes ❒ No

If yes, please specify: _____

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 _____

Within the last year, have you taken any prescription medications? If taking prenatal vitamins please include.

Medication	Diagnosis	Dosage / Frequency	Duration

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

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

Medication	Diagnosis	Dosage / Frequency	Duration

Please provide us with the phone number to your local pharmacy _____

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

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
- ❒ Other:_____
- ❒ 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

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

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) _____

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

Do you read and write English? ❒ Yes ❒ No
If no, what is your primary language?_____Who will be your interpreter? _____

Do you or have you ever used:

Alcohol ❒ Yes ❒ No If yes, how many glasses per week? Wine _____ Beer _____ Cocktails _____

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 currently smoke cigarettes? ❒ Yes ❒ No Have you ever smoked? ❒ Yes ❒ No

If yes, when did you quit? _____

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 your 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: _____

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
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

What is your Ancestry?

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

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 PARTNER (IF APPLICABLE)

Name: _____ Height: _____ Weight: _____ Age: _____

Have you ever conceived a pregnancy with a different partner? ❒ Yes ❒ No Email: _____

Please give approximate dates and outcomes of any pregnancies conceived with a different 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: _____

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:

Alcohol ❒ Yes ❒ No If yes, how many glasses per week? Wine _____ Beer _____ Cocktails _____

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 currently smoke cigarettes? ❒ Yes ❒ No Have you ever smoked? ❒ Yes ❒ No

If yes, when did you quit? _____

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 been exposed in last 3 months to excessive heat, hot tubs, saunas or fevers? ❒ Yes ❒ No

Have you had any serious injuries to your genitals? ❒ Yes ❒ No

Do you use your laptop on your lap? ❒ 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 ❒Don't Know

Is there any history of recurrent miscarriage or infertility in your family? ❒ Yes ❒ No ❒Don't Know

Do you have any allergies? ❒ Yes ❒ No

If yes, check all that apply: ❒ Medication ❒ Food ❒ Latex

If yes, please specify: _____

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

Do you use heated driver's seat at the highest setting? ❒ 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	_____

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

What is your Ancestry?

❒ African American

❒ American Indian or Alaskan Native

❒ Ashkenazi Jewish

❒ Asian

❒ Native Hawaiian or otherPacific Islander

❒ White

❒ Hispanic or Latino

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

PATIENT COMMENTS

Do you or your partner (if applicable) have personal / religious objections to intrauterine insemination (IUI), invitro fertilization (IVF), Donor Sperm, Donor Egg, and Genetic Testing (PGD)? If yes, please list:

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

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 at Reproductive Medicine Associates of Michigan. Spouses cannot sign this Agreement on behalf of the patient. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. Reproductive Medicine Associates of Michigan will do its best to verify your insurance benefits. However, Reproductive Medicine Associates of Michigan 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.

Financing Options
Reproductive Medicine Associates of Michigan has established relationships with financing companies for those interested in obtaining financing. Reproductive Medicine Associates of Michigan does not carry balances. Our Financial Counselor is available to discuss these program details.

If We Participate With Your Insurance Company
The extent of coverage, benefits and authorization process vary from policy to policy. It is important that you understand what is covered before you begin treatment or what the necessary requirements are to get the maximum reimbursement. The finance department can provide some general guidelines on the most common policies within each plan. We encourage all patients to check the infertility benefits under your specific plan as well as confirm in-network status. Our participation with your insurance does not guarantee coverage for our services.

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

- Aetna (excluding HMO)
- Blue Cross Blue Shield of Michigan
- Carrot
- Cofinity
- HAP – HMO (excluding Henry Ford network) & HAP Preferred
- Priority Health – PPO & Priority Health – HMO (Corewell Health network only)
- Progyny
- UnitedHealthcare (excluding HMO)
- WINFertility

Patient is responsible to pay all non-covered services, deductibles and co-pays/co-insurance. You agree to take full responsibility for any and all non-covered charges incurred due to an out-of-network and/or Reproductive Medicine Associates of Michigan's non-participation status with your insurance company. Patient acknowledges and understands that it is their responsibility to verify the participation status of Reproductive Medicine Associates of Michigan with their insurance carrier prior to any services being rendered this includes but is not limited to: Bradley Miller M.D., Lynda Wolf M.D., and Reproductive Medicine Associates of Michigan.

Reproductive Medicine Associates of Michigan will make every attempt to resolve insurance claim issues with your insurance company. However, if your insurance company does not pay us within 120 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. Most carriers have timely filing limits and if the office is not notified of coverage within this filing limit you will be responsible for charges in full.

If We Do Not Participate With Your Insurance Company
Reproductive Medicine Associates of Michigan does not verify benefits or submit claims for insurance companies that they do not participate with. All same day services must be paid in full.

Payment Methods
The following payment methods are accepted: Cash, personal check, money order, cashier check, Visa, MasterCard, Discover, and American Express. IVF deposits may be paid by certified check or credit card 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 cash, credit card, money order, or a certified check.

Cryopreservation and Storage Fees
If you have consented to freeze your embryos, oocyte, and/or sperm, an annual 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 cycle deposit and is due when the service is performed. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees. Additionally, Reproductive Medicine Associates 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 will 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 three 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. Any 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 will provide you with the necessary prescriptions for your treatment cycle. You may have the prescriptions filled at your local pharmacy or we can recommend a specialty pharmacy that may offer a cost advantage if your fertility medications are not covered by insurance. Some insurance companies require prior authorization before they will cover the cost of the fertility medications. We will complete the paperwork necessary to obtain this authorization when necessary.

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.

It is at the discretion of Reproductive Medicine Associates of Michigan to allow you to proceed with the start of a subsequent cycle or future treatment when the account is not $0.00 on both your patient account and insurance account. When allowed, this does not omit any payments due to Reproductive Medicine Associates of Michigan.

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 one another. Copying fees are based upon the Michigan Medical Records Access Act, Public Act 47 of 2004, MCL section 333.26269 and can change on an annual basis. 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 seven (7) business days for us to respond to your copying request.

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 three weeks to be processed.

Delinquent Accounts
All accounts that cannot be collected by Reproductive Medicine Associates 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.

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/co-insurance and deductibles, are my responsibility and I guarantee that my account with Reproductive Medicine Associates of Michigan will be paid in full per the terms of the Agreement.

_____
Print Patient Name

_____
Print Guardian Name (if applicable) If Guardian, Relationship to Patient

_____
Signature of Patient / Guardian Date