North Shore Fertility, S.C.
Infertility History Form

Please answer all of the following questions about your medical history and contact information.

Part I: Patient Information

First Name _____Middle Initial_____ Last Name_____

Date of Birth _____/_____/_____ Age_____ Occupation _____

Social Security _____

Home Address _____

City _____ State_____ Zip Code_____

Indicate Which Number to Call or Leave Message

[ ] Home Telephone _____ [ ] Work Telephone _____

[ ] Cell Phone _____ E-Mail _____

Spouse/Partner's Information

First Name _____ Middle Initial _____Last Name _____

Date of Birth _____/_____/_____ Age _____ Occupation _____

Social Security_____

Indicate Which Number to Call or Leave Message

[ ] Home Telephone _____ [ ] Work Telephone _____

[ ] Cell Phone _____ [ ] E-Mail _____

Nearest Relative not living with you_____ Phone:_____

Whom may we contact in case of emergency?_____ Phone:_____

Who referred you?

[ ] Physician Name_____ Phone _____

Address _____

[ ] Former Patient / Friend _____

[ ] Other _____

Who is your OB/Gyn? Name _____

Address _____ Phone _____

Who is your Primary Care Physician? Name _____

Address _____ Phone _____

Part II: Female Medical History & Information

Reason For Visit: [ ] Infertility Evaluation [ ] Gynecological Visit

Medical History

Do **YOU** have a history of any of the following medical problems? (Please circle)

Anemia	NO	YES	Heart Problem	NO	YES
Asthma	NO	YES	Hepatitis	NO	YES
Birth Defect	NO	YES	High Blood Pressure	NO	YES
Blood Clot in Leg or Lung	NO	YES	Migraine Headaches	NO	YES
Cancer	NO	YES	Mitral Valve Prolapse	NO	YES
Cystic Fibrosis	NO	YES	Ovarian Cysts	NO	YES
Depression	NO	YES	Polycystic Ovaries	NO	YES
Diabetes	NO	YES	Seizures or Epilepsy	NO	YES
Endometriosis	NO	YES	Thalassemia	NO	YES
Uterine Fibroids	NO	YES	Thyroid Problem	NO	YES
Genetic or Inherited Disease	NO	YES			

Do you have any other medical problems not listed? (please list below) NO YES

_____

_____

Surgical History Please list any surgeries you have had. Please list dates.

_____

_____

Medications Please list all medications, vitamins, and herbs you are taking:

_____

_____

Allergies

Do you have any allergies to medications, foods, or to latex? NO YES
(If yes, please describe reactions) _____

_____

Pregnancy Summary:

Number of ALL pregnancies: _____ Number of miscarriages: _____

Number of full term deliveries: _____ Number of abortions: _____

Number of pre-term deliveries: _____ Number of ectopic (tubal) pregnancies: _____

Gynecological History

When was the first day of your last period? _____/_____/_____

Menstrual Cycle Pattern (check all that apply):

[ ] Regular Periods [ ] Irregular Periods [ ] No periods

[ ] Heavy Periods [ ] Light Periods [ ] Bleeding Between Periods

Age when you had your first period: _____ years old

Number of days from the start of one period to the start of the next? _____days

How many days do your periods last? _____

When was your last pap smear? _____ Result _____

Have you ever had an abnormal pap smear? NO YES If yes, when_____

Have you ever had treatment for an abnormal pap smear with LEEP, laser, cone biopsy or cryosurgery (freezing)? NO YES If yes, when?_____

Have you ever had a sexually transmitted disease (STD) such as Gonorrhea, Chlamydia, Trichomonas or Syphilis? NO YES _____

Have you ever had a pelvic infection (PID) or tubal infection? NO YES

Have you ever had a mammogram? NO YES If yes, please list the date and result of your last mammogram _____

Infertility History:

How many months have you been having intercourse without using any form of Birth control/contraception? _____

Have you ever had a hysterosalpingogram (HSG)/X-Ray test of your uterus to check to see if your fallopian tubes are open? NO YES If yes, please list date and result_____

Has your husband/partner ever had a semen analysis done? NO YES

If yes, please list date and result: _____

Have you ever had infertility treatment? NO YES

If yes, please list:

Number of Clomid (Clomiphene citrate) cycles _____

Number of Injectable medication cycles _____

Intrauterine Inseminations: YES NO

IVF: NO YES If yes: Number of Oocyte Retrievals _____

Number of Embryo Transfers _____

Was a successful pregnancy achieved with above treatment(s)? _____

Genetic History

Have any of your blood relatives or your husband/partner's blood relatives had any of the following problems:

Autism	NO	YES	Gaucher's Disease	NO	YES
Canavan disease	NO	YES	Heart defect	NO	YES
Cystic Fibrosis	NO	YES	Mental retardation	NO	YES
Down Syndrome	NO	YES	Sickle Cell Anemia	NO	YES
Fanconi anemia	NO	YES	Tay Sachs disease	NO	YES
Fragile X Syndrome	NO	YES	Thalassemia	NO	YES

•Other Genetic, Inherited diseases, or Birth defects not listed? NO YES
If yes, please describe: _____

Family History

Do any of YOUR relatives have the following medical problems?

If yes, list the relation to you.

Blood clots in leg or lungs	NO	YES	_____
Cancer	NO	YES	_____
Diabetes	NO	YES	_____
Heart problem	NO	YES	_____
Hypertension	NO	YES	_____

Social History

Are you married? YES NO

How many caffeinated beverages do you consume a day? _____

Do you smoke cigarettes? NO YES How many/day? _____ # Years? _____

Do you drink alcohol? NO YES How many /week? _____

Do you use marijuana, cocaine or any other similar drug? NO YES
If yes, please describe_____

Do you exercise? NO YES If yes, please describe _____

Patient's Signature _____ **Date** _____

Insurance Providers

Primary_____

Member ID_____

Group Number _____

Member Services Number_____

Secondary_____

Member ID_____

Group Number_____

Member Services Number_____

Spouse or Significant Other

Primary_____

Member ID_____

Group Number_____

Member Services Number_____

*Please provide us with a copy of your insurance card(s) and drivers license. Thank you.

North Shore Fertility, S.C. Financial Packet

Dear Patient,

The Financial Department of North Shore Fertility, S.C., ("NSF") would like to welcome you. We are here are to assist you with any questions you may have regarding your coverage and pricing. In order to provide you with the most accurate information regarding your benefits, we will need your most current insurance information. In addition we will require the following:

- You will need to provide NSF with copies of your current primary and secondary medical insurance cards. (We understand that there may not always be a secondary).
- You will notify NSF immediately of any changes made to your primary or secondary medical insurance plans.
- **You understand that a verification of benefits obtained by the NSF billing department from your insurance company is not a guarantee of payment. The actual availability of benefits is subject to the terms, conditions, limitations and exclusions of your health care benefit plan.**
- You agree to pay co-payment at time of service.
- **You understand and agree that you are responsible for obtaining all necessary referral authorizations from your primary care physician.** Your failure to do so may result in a denial of benefits by your health insurance company leaving you financially responsible for the entire balance.
- You understand and agree that you are responsible for obtaining any necessary pre-certification for all services rendered. We ask that you obtain an authorization letter or confirmation number to assist with the billing process. NSF, will assist you if requested to do so.
- You agree to pay for all non-covered services rendered at the time of service.

- You agree to pay all previous balances **before** the start of a new cycle. (This includes co-insurance, deductibles, and non-covered procedures.)

- You understand and agree that NSF can only bill your health insurance company for a diagnosis documented in your medical records. NSF will not change the diagnosis for the purpose of securing payment from your health insurance carrier.
- You agree and consent to NSF releasing copies of your medical records to your health insurance company.

We encourage you to notify your health insurance company and request a letter of pre-determination for infertility benefits prior to undergoing treatment.

The main goal of the NSF billing department is to assist you with all questions regarding your account, possible medical insurance benefits and to inform you of costs that you may incur during any given cycle. The billing department is available Monday thru Friday from 7:00 am to 2:00 pm and we look forward to assisting you.

Best of Luck,

The Financial Department of North Shore Fertility, S.C.
dranneborkowski@gmail.com

Date: _____

I/we have read and understand the information contained in this Financial Packet. I/we understand that by signing this waiver, I/we are authorizing North Shore Fertility, S.C., to release my/our medical records to my/our insurance company.

_____ _____

Patient Signature Partner Signature

Witness: _____

I authorize North Shore Fertility, S.C. to phone my home with appointment reminders and to share information about my health care with my:

[ ] wife _____

[ ] husband _____

[ ] other _____

[ ] My health care information should be shared with no one.

NORTH SHORE FERTILITY, S.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW NORTH SHORE FERTILITY, S.C. MAY USE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private and to give you this Notice ("Notice"). We are also required to provide you with a paper copy of this Notice, which describes our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

> *Treatment*. Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.
>
> *Payment*. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
>
> *Health Care Operations*. Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical, information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI

may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, x-rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Continuing Care. Based on your PHI, we may provide you with appointment reminders or information concerning health issues, benefits and services, or treatment alternatives that we believe may be of interest to you.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation, or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence, or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy officer regarding our copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting of certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request, but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of wich will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints. If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying the Privacy Officer. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Us:

Privacy Officer
North Shore Fertility, S.C.
4250 Dempster Street
Skokie, IL 60076

I represent that I have read and understand this Notice of Privacy Practices.

_____
(Signature)

_____
(Print Name)

_____
(Date)