



CRM

Center for Reproductive Medicine

Where dreams are conceived™

NEW PATIENT PACKET

Thank you for choosing Center for Reproductive Medicine. In order to prepare your file, please complete the enclosed forms. Fax or mail completed paper work, **along with your medical records,** at least 24 hours prior to your appointment time to:

CRM

Attn: Medical Records

3435 Pinehurst Avenue

Orlando, FL 32804

Fax: 407-740-7262

IF WE DO NOT RECEIVE YOUR MEDICAL RECORDS PRIOR TO YOUR VISIT, YOUR APPOINTMENT MAY BE CANCELLED. PLEASE MAKE EVERY EFFORT TO KEEP YOUR APPOINTMENT. IF YOU DO NOT SHOW UP FOR YOUR APPOINTMENT OR DO NOT CANCEL AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT, WE RESERVE THE RIGHT TO CHARGE YOU A NOMINAL FEE.

While our goal is to help you achieve pregnancy, most office visits during the course of treatment are not appropriate for children. If you have children, please make arrangements for childcare outside your office visit. This will allow us to give you our full attention at your visit and will give you the opportunity to maximize your time with our staff. We thank you for your understanding and cooperation.

*Thank you and we look forward to meeting you!
The Physicians and Staff at the Center for Reproductive Medicine*

IF YOU HAVE AETNA US HEALTHCARE, AV-MED, BCBS HMO, CIGNA HMO, FLORIDA HOSPITAL HEALTHCARE SYSTEMS, HEALTHCHOICE SELECT, OR ANY OTHER INSURANCE THAT REQUIRES AUTHORIZATION, YOU MUST CALL YOUR PRIMARY CARE PHYSICIAN TO OBTAIN REFERRAL. OTHERWISE, YOU WILL BE EXPECTED TO PAY YOUR VISIT IN FULL UNTIL SUCH AUTHORIZATION IS RECEIVED. PLEASE BRING YOUR AUTHORIZATION OR REFERRAL NUMBER WITH YOU TO YOUR FIRST VISIT. FAILURE TO OBTAIN THIS AUTHORIZATION MAY RESULT IN A DELAY IN YOUR APPOINTMENT TIME OR CANCELLATION OF YOUR VISIT.

INITIAL SELF PAY VISIT FEES (NEW PATIENTS)

(Ultrasound and lab charges not included in this fee)

_____ \$310.00--SECOND OPINION

_____ \$220.00-300.00--INFERTILITY (INCLUDING REPEATED PREGNANCY LOSS, ARTIFICIAL INSEMINATION, ETC.); ENDOCRINOLOGY OR OTHER GYN

****IMPORTANT**** *Not all insurance companies allow us to perform most of your lab tests. If you require any laboratory testing that must be sent to an outside lab (such as Quest, LabCorp, Florida Pathology Laboratory, etc.), please notify the laboratory staff of the reference lab required by your insurance carrier. It is your responsibility to provide this information so that your lab tests are sent to the correct laboratory. Failure to provide the correct information may result in incorrect billing from the lab.*



CRM

CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909

Orlando, FL Celebration, FL Lake Mary, FL

PATIENT INFORMATION RECORD

Date: _____ Marital Status: M S W D

Name: _____ / _____ / _____ Birth date: _____ Age: _____

Address: _____ Email: _____

City/State/Zip: _____ Soc. Sec. #: _____ - _____ - _____

Home Phone:(_____) _____ Work Phone:(_____) _____ Cell Phone:(_____) _____

With which of the following racial/ethnic groups do you, the **female** patient, most identify (check all that apply)?

- American Indian
- Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian
- Other Pacific Islander
- White

Occupation: _____ Employer: _____

Spouse: _____ / _____ / _____ Birthdate: _____ Age: _____

Address (if different from above): _____

Social Security #: _____ - _____ - _____ Work Phone #:(_____) _____

Occupation: _____ Employer: _____

With which of the following racial/ethnic groups do you, the **male** patient, most identify (check all that apply)?

- American Indian
- Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian
- Other Pacific Islander
- White

Nearest relative not living with you: _____

Relationship: _____ Home Phone #:(_____) _____

How did you hear about our practice? _____

Address: _____

City/State/Zip: _____

Would you like a courtesy letter sent to your OB/GYN? (circle one) Yes No

INSURANCE INFORMATION

WIFE INSURANCE: _____ Ins. Phone #:(_____) _____

Claims Address: _____

City/State/Zip: _____

Employee Name: _____ Group/Policy #: _____

VERY IMPORTANT * Is HUSBAND also covered under this insurance plan (check one)? YES NO**

HUSBAND INSURANCE: _____ Ins. Phone #:(_____) _____

Claims Address: _____

City/State/Zip: _____

Employee Name: _____ Group/Policy #: _____

VERY IMPORTANT * Is WIFE also covered under this insurance plan (check one)? YES NO**

Driver's License (Patient): _____ Spouse: _____

Pharmacy Name: _____ Pharmacy Phone #:(_____) _____

- PLEASE REVIEW AND SIGN FOLLOWING PAGE -

Insurance and Payment Responsibilities: Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. *There is no guarantee that your insurance will reimburse you for fees paid; many insurance companies do not allow treatment for infertility. It is your responsibility to pay any deductible, co-payment or any other balance for services not covered by your insurance. It is also your responsibility to know the terms and limitations of your coverage. YOUR SIGNATURE BELOW IS ACKNOWLEDGMENT THAT YOU ARE RESPONSIBLE FOR ANY AND ALL NON-COVERED OR NON-REIMBURSABLE EXPENSES.*

I understand that if I am a CHAMPUS/TRICARE subscriber, I will be responsible for 115% of the Tricare allowed amount for any covered procedure. This is the amount I will be billed after Tricare has processed the claim(s).

I understand that I am financially responsible for all charges whether or not paid by said insurance. ***I ALSO UNDERSTAND THAT IF I AM A MEDICARE SUBSCRIBER, I WILL BE REQUIRED TO PAY FOR ALL CHARGES INCURRED, WHETHER COVERED BY MEDICARE OR NOT.***

IN AN EFFORT TO CONTROL THE COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR THE OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. IF YOU ARE INSURED BY A PPO OR HMO PLAN IN WHICH WE ARE PARTICIPATING, PAYMENT OF YOUR DEDUCTIBLE OR CO-PAYMENT AT THE CONCLUSION OF EACH VISIT IS REQUIRED. If this account is assigned to a third party for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of this medical record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to:

**Center for Reproductive Medicine, or;
Gary W. DeVane, M.D., Randall A. Loy, M.D., Sharon B. Jaffe, M.D., or Sejal D. Patel, M.D.**

I authorize said assignee to release all information necessary to secure any insurance payment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Routine GYN Care: *I also understand that I will continue all routine gynecologic and primary medical care, including but not limited to breast evaluation and PAP smear screening, by my primary care physician, internist or gynecologist and not the physicians or other clinical staff of the Center for Reproductive Medicine. This does not apply to patients seeing our nurse practitioner, Linda Jones, RNC, ARNP.*

Copies of Medical Records: I understand that if wish to obtain a copy of my medical records generated from my treatment at the Center for Reproductive Medicine, I must make such a request in writing. I also understand that I will be charged for these medical records according to the fee schedule set forth in the Florida Statute 455.241: \$1.00 per page for the first 25 pages and \$0.25 per page for each page thereafter (reference also Florida Administrative Rule 59 Section 10.003).

Patient: _____ Date: _____

There is no expiration for this authorization unless said authorization is revoked, in writing, by me, the patient, or my legal representative.

Guarantor (if other than patient): _____ Date: _____

There is no expiration for this authorization unless said authorization is revoked, in writing, by me, the patient, or my legal representative.

Acknowledgments:

I have received a copy of the Center for Reproductive Medicine's HIPAA Notice of Privacy Practices, the CRM practice brochure that provides information about the physicians at the Center and their qualifications and the "Office-based Surgery Patients' Bill of Rights."

Signature: _____ Date: _____

PLEASE MAIL OR FAX REGISTRATION AND HISTORY FORMS TO THE OFFICE PRIOR TO YOUR VISIT.



CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909
Orlando, FL Celebration, FL Lake Mary, FL

LABORATORY DISCLAIMER

Effective October 13, 2008, the Center for Reproductive Medicine (CRM), will be exclusively utilizing Laboratory Corporation of America (Labcorp) for all referral/send-out lab work. Labwork will include any blood tests that can not be performed in our office, surgical pathology from in-office procedures, as well as routine cytology (paps).

Please contact your insurance carrier and ask if Labcorp is an approved provider for your insurance. If Labcorp is not an approved provider, it is your responsibility to inform CRM and we will attempt to make the necessary arrangements to send your lab work elsewhere.

Please initial the section below to indicate that you are aware that your lab work may be sent to Labcorp. If your lab work needs to be sent elsewhere, please indicate the name of your approved lab.

_____ I acknowledge that I have checked with my insurance carrier and Labcorp **IS** an approved laboratory.

Insurance Name: _____

_____ I acknowledge that I have checked with my insurance carrier and Labcorp **IS NOT** an approved laboratory.

Insurance Name: _____

Please send my lab work to: _____.

If your insurance changes, please ask a CRM staff member for new form, so we can document your new insurance.

Thank you for your cooperation during this transition period.

Patient Printed Name

Date

Patient Signature

Date of Birth



FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date: Reason for visit: Name: Partner's Name: Allergic to any medications? If yes, please specify:

II. MEDICAL HISTORY

Have you gained or lost greater than 15 pounds of weight in the last year? Have you ever had any surgery? If yes, specify date and type

Do you have or have you ever had (check all that apply): Gonorrhea, Chlamydia, Pelvic Infection, Herpes, Syphilis, Milky Breast Discharge, Breast Soreness, Endometriosis, Excess Hair Growth, Ovarian Cysts, Condyloma/Vaginal warts, Vaginitis, Thyroid Problems, Uterine Fibroids, Blood Transfusions

III..... MENSTRUAL AND PREGNANCY HISTORY

Age at first period? First day of your last period? Are your periods regular? If yes, what is the usual number of days between periods? Do you have pain or cramps with your period? What is the usual duration of your period? Use: Tampons Pads Do you bleed or spot between periods? Do you have pain when you ovulate? Last Pap smear? Do you have a history of abnormal paps? Please list any premenstrual symptoms you experience:

Table with 10 columns: Year?, End in Abortion?, End In Miscarriage?, Ectopic Pregnancy?, Inf. treatment req. to Conceive?, How long to conceive?, Vaginal or C-section?, Baby born alive?, Current partner the father? and 3 rows: 1st Pregnancy, 2nd Pregnancy, 3rd Pregnancy

III..... MENSTRUAL AND PREGNANCY HISTORY (continued)

Were there any complications during or after your pregnancies?
If yes, please specify: _____
How long have you been trying to get pregnant? _____
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?

IV..... CONTRACEPTIVE/SEXUAL HISTORY

What form of contraception do you use now or have you used in the past? Check all that apply.
 Pills (Name) _____ IUD (Name) _____
 Diaphragm..... Withdrawal Foams/Jellies.. Condom Rhythm None
 Other _____
If you've ever been on oral contraceptives (pills), were your periods regular **YES** **NO**
after stopping the pills?.....
Do you use lubricants for intercourse?
If yes, which one? _____
Do you douche before or after intercourse?.....
Do you have pain with intercourse?
If yes, please specify when and type: _____
How many times per week do you and your partner have sexual intercourse? _____
How many times do you have sexual intercourse around ovulation? _____

V. FAMILY HISTORY

Is there a family history of infertility or endometriosis or uterine fibroids?
If yes, please specify, including family relationship: _____

VI..... SOCIAL HISTORY..... Self..... Partner

Yes..... No..... Yes..... No
Do you drink alcoholic beverages?
If yes, please specify type and number per week: _____
Do you smoke cigarettes (or use tobacco in other forms)?
If yes, please specify # of cigarettes (or other) per day: _____
Do you use other drugs (illicit or recreational)?
If yes, please specify type and amount of usage: _____
Do you exercise on a regular basis?
If yes, please specify type and frequency: _____

VII. HISTORY OF FERTILITY THERAPY

Duration of current infertility: _____
Have you been treated for infertility before?
Have you been through IVF treatment before?
Have you had any of the following tests (check all that apply):
 BBT Ovulation predictor kits Endometrial Biopsy Post Coital Test HSG
 Blood/Hormone studies, please specify: _____
Who was your physician? _____

VIII..... PARTNER HISTORY

Previous surgery: _____
Medical Problems: _____
Last S/A date and results: _____
Previous Marriage? _____ Number of Children: _____

This form must be signed to be complete:

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____

FAMILY HISTORY AND GENETIC QUESTIONNAIRE

Patient Name: _____ .. Partner Name: _____ ...Date: _____

Please answer the following medical history questions about yourself, your partner and your relatives. Please consider all family members related to you or your partner by blood, including parents, grandparents, siblings, half-siblings, nieces, nephews, aunts, uncles, cousins and any children you have had together and/or with previous partners.

| Have any of the following conditions occurred in your family? Check “yes” if the condition has occurred in you, your partner and/or any of your relatives. Please specify how the person is related to you or your partner (i.e., grandmother, aunt, son, etc.) and any details you know about the condition. Additional space is provided below. | Female and her family members | | Male and his family members | |
|--|-------------------------------|---------------------------|-----------------------------|---------------------------|
| | Yes ✓ | Specify who in the family | Yes ✓ | Specify who in the family |
| Open spine defect (e.g. spina bifida, anencephaly) | | | | |
| Heart defect | | | | |
| Cleft lip and/or palate | | | | |
| Other birth defects | | | | |
| Chromosome condition (e.g. translocation carrier, Down syndrome) | | | | |
| Blood disorder (e.g. sickle cell anemia, thalassemia, hemochromatosis) | | | | |
| Bleeding disorder (e.g. hemophilia) | | | | |
| Neuromuscular disease (e.g. muscular dystrophy) | | | | |
| Cystic fibrosis | | | | |
| Adult onset neurological disorder (e.g. Huntington disease) | | | | |
| Fragile X syndrome | | | | |
| Other inherited or genetic condition | | | | |
| Mental retardation | | | | |
| Development delay, autism or learning difficulties | | | | |
| Relative who died suddenly before age 50 years (not from accident) | | | | |
| Kidney disease at a young age (before age 40 years) | | | | |
| Cancer (before age 50 years) | | | | |
| Three or more miscarriages | | | | |
| A still born baby or a baby that died within the first year | | | | |
| Premature menopause (before age 40 years) | | | | |
| Infertility | | | | |
| Any other family history that is of concern? Please specify below. | | | | |

For any of the above answered “yes”, please specify the condition. List who has the condition (you, your partner or how they are related to you or your partner), the approximate age that the condition was diagnosed, and any details about the condition that you know: _____

Are you and your partner related by blood? (Circle)..... Yes No.....Unsure

If yes, how are you related? _____

Some genetic conditions occur more commonly in certain racial or ethnic groups. Please answer the following questions about you and your partner's ethnic background and any genetic testing or carrier screening either of you have had.

Ancestry: Female Partner

| Are you or any of your blood relatives... (Check all that apply) | Yes | Have you had carrier testing for... | No | Yes | Unsure | If you have had testing, when and what were the results? | |
|---|-----|-------------------------------------|----|-----|--------|--|--------|
| | | | | | | Date | Result |
| Caucasian? | | Cystic Fibrosis? | | | | | |
| From Italy, Greece, India or the Middle East? | | Thalassemia? | | | | | |
| From Southeast Asia, Taiwan, China or the Philippines? | | Thalassemia? | | | | | |
| African/African American or Hispanic? | | Sickle-cell trait? | | | | | |
| French Canadian? | | Cystic Fibrosis? | | | | | |
| | | Tay-Sachs disease? | | | | | |
| Ashkenazi Jewish? | | Cystic Fibrosis? | | | | | |
| | | Canavan disease? | | | | | |
| | | Tay-Sachs disease? | | | | | |

Ancestry: Male Partner

| Are you or any of your blood relatives... (Check all that apply) | Yes | Have you had carrier testing for... | No | Yes | Unsure | If you have had testing, when and what were the results? | |
|---|-----|-------------------------------------|----|-----|--------|--|--------|
| | | | | | | Date | Result |
| Caucasian? | | Cystic Fibrosis? | | | | | |
| From Italy, Greece, India or the Middle East? | | Thalassemia? | | | | | |
| From Southeast Asia, Taiwan, China or the Philippines? | | Thalassemia? | | | | | |
| African/African American or Hispanic? | | Sickle-cell trait? | | | | | |
| French Canadian? | | Cystic Fibrosis? | | | | | |
| | | Tay-Sachs disease? | | | | | |
| Ashkenazi Jewish? | | Cystic Fibrosis? | | | | | |
| | | Canavan disease? | | | | | |
| | | Tay-Sachs disease? | | | | | |

Have you or your partner had any genetic testing not listed above? (Circle)..... YesNo.....Unsure

If yes, please specify who had the testing, what the test was for and the result: _____

Patient Signature: _____ Physician Signature: _____ Date: _____

PLEASE SEND THIS PAGE TO YOUR REFERRING PHYSICIAN.

CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909

Gary W. DeVane, M.D., Randall A. Loy, M.D., Sharon B. Jaffe, M.D., Sejal Dharia Patel, M.D.

Orlando, FL Celebration, FL Lake Mary, FL

Appointment Date and Time: _____

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

I, _____ (patient) hereby authorize

(Name of Facility or Physician)

to (check one): **release copies** **allow review** **obtain records**

of the medical record of: _____

(Print complete patient name)

for the purpose of (check one): **continuing medical care** **personal records**

other: _____

including dates of service _____ through _____

to: **Center for Reproductive Medicine**
3435 Pinehurst Avenue, Orlando, FL 32804
Phone 407-740-0909; Fax 407-740-7262

Requested Records (please initial all that apply):

- _____ Consultation Reports
- _____ All Operative Reports and Other Procedure Reports
- _____ Lab, Diagnostic Test Results (including HIV, Hepatitis and Semen Analysis), X-Ray (Hysterosalpingogram) Reports and Actual Films (if available)
- _____ History and Physical
- _____ Physician's and Nurses' Progress Notes
- _____ Other _____

I understand that this consent may be withdrawn at any time and shall expire ninety (90) days after the date indicated below. I further agree that a photocopy or facsimile copy of this authorization shall be as effective as the original.

Patient Full Name (please include any alternate names you may have used as a patient):

Patient Signature: _____ Date: _____

Patient Birth date: _____ Social Security Number: _____

PLEASE RETURN A COPY OF THIS FORM WITH RECORDS



CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909

Orlando, FL Celebration, FL Lake Mary, FL

Billing Policies

Thank you for choosing the Center for Reproductive Medicine. These guidelines are written to provide you with a better understanding of our billing policies.

1. **For all Self Pay patients** (including patients without insurance and patients with insurance that does not cover any infertility treatment):

Payment will be required at time of service. Should you need to make special arrangements, please contact our billing office, in advance of services, at (407) 740-0909. A current listing of fees is available for your review so that you may better plan your out-of-pocket expenses.

2. **For patients with insurance:**

Payment of your co-payment amount will be required at time of service. Your insurance claim will be filed for you. You will receive a statement in the mail within 30 days showing that your claim has been filed and what the current balance is on your account. If you have any questions about this statement, please call the billing office at (407) 740-0909.

If your claim for your visit remains unpaid by the insurance company after 60 days, we will place a follow-up phone call to the insurance company. If there is no response from the insurance company within 14 days, the remaining charge will be your responsibility and you will be billed accordingly. Payment from you will be expected within 14 days.

If your payment is not received within 14 days of this notification, we will contact you by telephone to review your balance. If we have no further payment or contact from you after this time, your account will be reviewed for referral to our collection agency.

We hope this information is helpful and will enable you to better plan your out-of-pocket expenses. As always, if we may be of service to you, please contact our billing office at (407) 740-0909.



CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909

Orlando, FL Celebration, FL Lake Mary, FL

TO ALL PROSPECTIVE INFERTILITY PATIENTS

We feel that all women trying to conceive should have antibodies against Rubella--also called the German measles. If a woman is not immune to Rubella and she develops the disease while pregnant, it can cause severe malformations and deformities to the developing fetus.

We recommend that you ask your gynecologist or family physician to perform a Rubella titer to determine if antibodies against Rubella are present. Please bring documentation of your immunity to Rubella when you come for your visit. If you are unsure about your immunity or have not been tested, we can perform a Rubella titer at our office.

If antibodies are not detected, please arrange to receive the Rubella vaccine through your physician's office. Once vaccinated, contraception is advised for one (1) month from the date of the injection as the vaccine contains a small amount of the live virus. In other words, if pregnancy should occur during this waiting period, it can have the same effects as having German measles while pregnant. At the conclusion of the three month waiting period, a repeat titer should be drawn to verify that antibodies are present.



CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909
Orlando, FL Celebration, FL Lake Mary, FL

OFFICE-BASED SURGERY PATIENTS' BILL OF RIGHTS

The patient has the right to high-quality care delivered in a safe, timely, efficient and cost-effective manner and the right to be assured that the expected results can be reasonable anticipated.

The patient has the right to dignity, respect and consideration of legitimate concerns.

The patient has the right to privacy and confidentiality.

Patients are involved in all aspects of care. Informed consent, following a discussion of risks, benefits and alternatives, should be obtained. The patient has the right to information about the current diagnosis, treatment and prognosis. If it is not advisable to give such information to the patient for health reasons, the information should be available to a person designated by the patient or a legally authorized person.

The patient has the right to be advised of all reasonable options/alternatives for care and treatment and the potential advantages/disadvantages of each. Included in this should be a discussion of the advantages/disadvantages and alternatives to having the procedure performed in the office.

The patient has the right to refuse any diagnostic procedure or treatment, and to be advised of the likely medical consequences of such refusal.

The patient has the right to education to address his or her needs. The educational process should consider the patient's values, abilities, readiness to learn and patient and family responsibilities in the care process.

The patient has the right to know who will be delivering the care and the qualification for such individuals. In the case of student personnel (including residents/fellows), the patient has the right to know the extent to which the student personnel will be involved.

The patient has the right to change the practitioner if other qualified practitioners are available.

The patient has the right to inspect and obtain a copy of her or his medical records. In addition, the patient has the right to expect a reasonable and timely transfer of information from one practitioner to another when required. Charges for copies of medical records should not exceed the charges provided for by Section 17 of the Public Law.

The patient has the right to request and receive information concerning the bill for services regardless of the source of payment.

The patient has the right to request and receive information about alternate sources of appropriate care.

The patient has the right to know about the expectations of the office-based practice with regard to her or his behavior and the consequences of failure to comply with these expectations.



CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909

Orlando, FL Celebration, FL Lake Mary, FL

INTERNET RESOURCES

| | |
|--|--|
| Center for Infertility and Reproductive Medicine | www.ivforlando.com |
| American Society for Reproductive Medicine | www.asrm.org |
| American College of Obstetricians and Gynecologists | www.acog.org |
| American Infertility Association | www.americaninfertility.org |
| American Medical Association | www.ama-assn.org |
| American Society for Andrology | www.andrologysociety.com |
| National Center for Health Statistics | www.cdc.gov/nchs |
| Center for Mental Health Services | www.mentalhealth.org |
| fertileHOPE (infertility after cancer therapy) | www.fertilehope.org |
| Health Finder | www.healthfinder.gov |
| Infertility Federation of Fertility Societies | www.mnet.fr/iffs |
| National Institute of Health | www.nih.gov |
| National Library of Medicine | www.nlm.nih.gov |
| PCOS Association | www.pcosupport.org |
| Premature Ovarian Failure Support | www.pofsupport.org |
| RESOLVE | www.resolve.org |
| Society for Assisted Reproductive Technology | www.sart.org |
| Society for Male Reproduction and Urology | www.smru.org |
| Society for Reproductive Endocrinology and Infertility | www.socrei.org |
| Women's Health Research | www.womens-health.org |
| The Fertility Network | www.fertilitynetwork.com |
| The Fertility Neighborhood | www.fertilityneighborhood.com |

Mail Order Pharmacies

| | |
|--|--|
| Freedom Drugs (mail order pharmacy) | www.freedomdrug.com |
| IVPcare (mail order pharmacy) | www.ivpcare.com |
| Portland Professional Pharmacy (mail order pharmacy) | www.portlandpharmacy.com |

Healthbanks (requires physician-specific User ID and password at right) www.healthbanks.com

Dr. DeVane User ID:7

740090901

Dr. Loy User ID:

740090902

Dr. Jaffe User ID:

740090903

Password for all: cirm407



CRM

CENTER FOR REPRODUCTIVE MEDICINE (407) 740-0909

Orlando, FL Celebration, FL Lake Mary, FL

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- * How we may use and disclose your IIHI
- * Your privacy rights in your IIHI
- * Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

HIPAA Compliance Officer, 407-740-0909

C.....WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer

will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- * maintaining vital records, such as births and deaths
- * reporting child abuse or neglect
- * preventing or controlling disease, injury or disability
- * notifying a person regarding potential exposure to a communicable disease
- * notifying a person regarding a potential risk for spreading or contracting a disease or condition
- * reporting reactions to drugs or problems with products or devices
- * notifying individuals if a product or device they may be using has been recalled
- * notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- * notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- * Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- * Concerning a death we believe has resulted from criminal conduct
- * Regarding criminal conduct at our offices
- * In response to a warrant, summons, court order, subpoena or similar legal process
- * To identify/locate a suspect, material witness, fugitive or missing person
- * In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

6. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to your practitioner's nurse, 407-740-0909 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Medical Records Clerk, 407-740-0909. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Medical Records Clerk, 407-740-0909 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the HIPAA Compliance Officer, 407-740-0909. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the Medical Records Clerk, 407-740-0909. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the HIPAA Compliance Officer, 407-740-0909.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the HIPAA Compliance Officer, 407-740-0909. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the HIPAA Compliance Officer, 407-740-0909.