FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

WELCOME PACKET FOR A MALE INDIVIDUAL

Thank you for choosing the Family Fertility Center for your fertility care. We take great pride in operating as a team to provide quality health care to all of our patients and, ultimately, to help our patients realize their dream of having a child. Included in this packet for **a MALE INDIVIDUAL** are:

- Directions to the Family Fertility Center

- Forms to be completed and brought with you to your appointment:
  -- New Patient Demographics Form
  -- Your Financial Responsibility Form
  -- Pharmacy Benefit Pre-Verification Form
  -- Patient Communication Instructions
  -- Receipt of HIPAA Notice (male)
  -- Insurance Coverage for Laboratory or Radiologic Testing
  -- Preconception Carrier Screening
  -- Questionnaire for Women

- Other documents required at first visit:
  -- Valid drivers' license or state-issued photo ID for both partners
  -- Health insurance cards for both partners
  -- Prescription cards for both partners
  -- Referrals/pre-authorizations as may be required by your insurance, whether primary or secondary. Call the customer service number on your insurance card for assistance in determining if you will need a special referral.

  NOTE: All patients having **Aetna** insurance -- either primary or secondary -- must call the infertility hotline to enroll in the infertility program and/or obtain a pre-authorization. Please call 1-(800)575-5999 to enroll in Aetna's program.

Please take a few minutes to complete these forms, particularly the medical information forms. It is important that you provide as much detailed history as possible to your doctor during your initial consult.

If you already have undergone a basic infertility workup, or if you have had infertility treatment elsewhere, please request copies of those medical records and bring them along to your initial consult. A **Patient Request for Medical Records** form also is available at this website for your convenience.

If your insurance requires any special referrals or preauthorization for infertility, please bring it with you to your initial consultation. Also confirm if ultrasounds and hormone blood tests can be performed in the specialist's office. If not, what is the name of the specific radiology facility or laboratory you must use?

Directions to Our Office
Go to www.familyfertility.com Home page> Becoming a Patient>Schedule a Consultation >Directions to the Family Fertility Center.

H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Keeping your appointment

Last minute delays or schedule conflicts happen. Our team will greatly appreciate a courtesy call to keep us informed. We will give our best effort to accommodate reasonable delays or we will be glad to reschedule your consultation at another mutually convenient time.

Your First Visit

At your first visit, a careful review of the woman's medical history including past and current health condition will be undertaken. This can include:

- A review of the pattern of menstrual cycle and bleeding to help determine if ovulation is occurring and if other problems such as diminished reserve (aging) of the ovary or uterine defects (fibroids or polyps) are present.
- A review of past pregnancies and outcome.
- Collection of information which might suggest an anatomic problem with the tubes, such as questions about past history of sexually transmitted infections, painful periods or intercourse, and/or a previous abdominal surgery.
- Questions about prior freezing or surgery to the cervix for abnormal pap smears.
- A general review of systems to ascertain symptoms suggestive of other endocrine abnormalities which might be contributing to infertility.
- A careful social history to evaluate for any environmental exposures or social habits (such as smoking, drinking alcohol, drug usage or extreme exercise) which could contribute to the infertility.
- A detailed family history to identify possible familial diseases such as uterine fibroid, diabetes, thyroid disease, ovarian cancer and breast cancer.

A physical examination, a pelvic ultrasound, and/or hormone blood tests may be performed at your first visit to evaluate the pelvic organs and assess potential hormonal problems. In some cases, your insurance may require you to have these tests performed at an outside facility. Also please check with your insurance to determine if any special referrals or authorizations are required if these tests are performed in our office.

Any medical records you may have related to previous infertility evaluation or treatment will be reviewed to define the cause of your infertility, evaluate the effectiveness of past treatment and, assess how that information may impact your future treatment options.

We look forward to meeting you. Should you have any questions in the meantime, please feel free to call our office at (610)868-8600.

Thank you.
The Healthcare Team at Family Fertility Center

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

NEW PATIENT DEMOGRAPHICS

Date:

	PATIENT	PARTNER
Name		
Street Address		
City, State, Zip		
Social Security #		
Date of Birth		
Home Phone#		
Cell Phone #		
Work Phone #		
Email Address		
Occupation		
Employer		
Primary Insurer		
Subscriber Name		
Policy #		
Group #		
Secondary Insurer		
Subscriber Name		
Policy #		
Group #		
Emergency Contact		
Relationship		
Contact Phone#		
Referring Doctor		
Phone #		
OB/GYN Doctor		
Phone #		
Family Doctor		
Phone #		

frmNPdemographic.doc

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

YOUR FINANCIAL RESPONSIBILITY

Having insurance is not a substitute for payment. Family Fertility Center (FFC) cannot guarantee payment of claims by your insurance company. At all times, patients are responsible to advise FFC of any and all changes in insurance coverage. You are responsible for knowing the terms of your benefit plan and making sure all action is taken by you in order to ensure optimal reimbursement, including, but not limited to, obtaining referrals and/or pre-authorizations, appealing denials, etc. If FFC participates with your insurance plan, claims for covered services will be submitted directly to your insurance. You are responsible for paying co-pay, co-insurance, and deductibles at the time of service. It is the patient's sole responsibility to appeal any denied charges. Payment for any denied charges, regardless of rejection reason or appeal status, is due within 30 days of receiving your insurance (EOB) Explanation of Benefits or FFC statement. If FFC does not participate with your insurance plan, or if services are not eligible under your insurance plan, you will be responsible for paying all charges prior to services being rendered by FFC or, if credit is extended, within 30 days of receipt of your insurance EOB or FFC invoice. Any unpaid patient balances remaining after 90 days will be forwarded to an outside agency for collection and/or may be reported to the Credit Bureau as a bad debt without further notice to you. Any and all costs incurred (attorney fees, collection expenses of 33.3%, etc.) to collect any unpaid balances will be payable by you. All terms and payment agreements are subject to credit approval, and a credit report may be retrieved without further notice to you. While we do reserve the right to waive payment in the event of financial hardships or based on individual consideration, any payment waiver and/or reduction will be made at our sole discretion and is not to be construed as an agreement or contract to reduce/waive any or all fees.

I/WE, THE UNDERSIGNED, HAVE READ THIS INFORMATION, UNDERSTAND IT, AND AGREE TO BE FINANCIALLY RESPONSIBLE IN ACCORDANCE WITH THE TERMS SET ABOVE.

SS #: ____________________ **SS#:** ____________________

Patient Signature: ______________________________ **Date** ____________________

FFC Financial Policy given to patient by: ____________________ Date ____________________

==

YOUR SIGNATURE IS NECESSARY FOR US TO SUBMIT ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT IS RECEIVED FOR SERVICES RENDERED:

The Non-Medicare Patient:
I authorize the release of all medical information that is necessary to process any claims and is pertinent to my medical care. I assign all medical and/or surgical benefits to which I and/or my partner are entitled to H. CHRISTINA LEE, MD. This assignment will remain in effect until revoked by me or my partner in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient:
I request that payment of authorized Medicare benefits be made to me or on my behalf to H. CHRISTINA LEE, MD for any services furnished me by that provider and/or its agents. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I/WE AUTHORIZE THE RELEASE OF MEDICAL INFORMATION AS INDICATED ABOVE AND THE PAYMENT OF MEDICAL BENEFITS TO H. CHRISTINA LEE, MD d/b/a FAMILY FERTILITY CENTER, ON MY/OUR BEHALF.

Patient Signature: ______________________________ **Date** ____________________
(Parent, if minor)

PLEASE HAVE A VALID DRIVER'S LICENSE AND INSURANCE CARD READY FOR PHOTOCOPY. Thank you.

Updated20171130

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

PHARMACY BENEFIT PRE-VERIFICATION FORM

Family Fertility Center works with certain specialty drug pharmacies that offer complimentary insurance pre-verification of your fertility medication coverage so that you can maximize prescription benefits available to you. All specialty pharmacies are HIPAA compliant and any personal information provided to them will be kept strictly confidential. **If you would like a preliminary investigation of your prescription drug benefits, please complete and sign this form.**

First Name:________________________ MI ____ Last Name: ___________________________________
Home Address: ____
City: ____________________________ State: ______ Zip: _____________ SSN: ____________________
Date of Birth: _____________Home Phone #: ___________________ Cell Phone #:__________________
Email: ____ Cycle Type: ____________________________
Spouse's Name: _____________________________________Spouse Date of Birth: __________________
Spouse SSN:________________Spouse Date of Birth:________________Phone #:____________________

Please include a copy of all medical & prescription insurance cards – front & back.

Primary Medical Insurance Coverage

Plan Name: ___________________________________ Employer: _________________________________
ID#: ______________________Group/Policy#:________________ Phone #:________________________
BIN#:____________ PCN#:___________________Policy Holder: _________________________________

Primary Prescription Drug Insurance Coverage

Plan Name: ___________________________________ Employer: _________________________________
ID#: ______________________Group/Policy#:__________________ Phone #:______________________
BIN#:____________ PCN#:___________________Policy Holder: _________________________________

Secondary Medical Insurance Coverage

Plan Name: ___________________________________ Employer: _________________________________
ID#: ______________________Group/Policy#:__________________ Phone #:______________________
BIN#:____________ PCN#:___________________Policy Holder: _________________________________

Secondary Prescription Drug Insurance Coverage

Plan Name: ___________________________________ Employer: _________________________________
ID#: ______________________Group/Policy#:__________________ Phone #:______________________
BIN#:____________ PCN#:___________________Policy Holder: _________________________________

Patient Signature: ____________________________________ Date: ____________________________

drugVerify.doc

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

PATIENT COMMUNICATION INSTRUCTIONS

Patient Name: ___________________________________ Date of Birth: _____________________

I hereby give my consent for Dr. Lee and the staff at the Family Fertility Center to contact me at the following phone number(s).

Phone # 1_______________________________ □ home □ work □ cell □ other _____________________

☐ yes ☐ no, do not leave a message such as "Please call Dr. Lee's office"

☐ yes ☐ no, do not leave on the voice mail or answering machine full details regarding my personal health information including but not limited to test results, medications, and other instructions.

☐ yes ☐ no, do not leave full details regarding my personal health information including but not limited to test results, medications, and other instructions with the following individual(s)

(name(s) of person and relationship) ____

****

Phone # 2_______________________________ □ home □ work □ cell □ other _____________________

☐ yes ☐ no, do not leave a message such as "Please call Dr. Lee's office"

☐ yes ☐ no, do not leave on the voice mail or answering machine full details regarding my personal health information including but not limited to test results, medications, and other instructions.

☐ yes ☐ no, do not leave full details regarding my personal health information including but not limited to test results, medications, and other instructions with the following individual(s)

(name(s) of person and relationship) ____

****

Phone # 3_______________________________ □ home □ work □ cell □ other _____________________

☐ yes ☐ no, do not leave a message such as "Please call Dr. Lee's office"

☐ yes ☐ no, do not leave on the voice mail or answering machine full details regarding my personal health information including but not limited to test results, medications, and other instructions.

☐ yes ☐ no, do not leave full details regarding my personal health information including but not limited to test results, medications, and other instructions with the following individual(s)

(name(s) of person and relationship) ____

****

Other Special Communication Instructions ____

____

Patient Signature: ____ **Date:** ________________

H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Family Fertility Center to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Family Fertility Center has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendment. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Official:

Mail: Family Fertility Center, Attention: Privacy Official
95 Highland Avenue, Suite #100, Bethlehem, PA 18017
Telephone:(610) 868-8600 Facsimile:(610) 868-8700

Acknowledgement and Consent

I, ______________________________, (name of patient) have received the Notice of Privacy Practices for the Family Fertility Center. I authorize the Family Fertility Center to use and disclose health information about myself for treatment, payment, and health care operations purposes consistent with its Notice of Privacy Practices.

______________________________ ______________________________
Signature of patient or personal representative Date

______________________________ ______________________________
Name of personal representative (if applicable) Relationship to patient (or other authority)

****

FOR PRACTICE USE ONLY:

I provided the above named______________patient OR ____________________ personal representative with the Notice of Privacy Practices for the Family Fertility Center on ______________________________ (date).

Describe how notice was provided:
_____Offered copy and individual refused to accept delivery
_____Offered copy and individual accepted delivery
_____Other ______________________________

Describe efforts to obtain signature on acknowledgement of notice form:
_____Patient/personal representative was asked to sign form and refused.

_____Other ______________________________

____
Signature of staff Print Name Date

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Insurance Coverage for Laboratory or Radiologic Tests

What are laboratory or radiologic tests?
Laboratory tests typically involve blood test, urine analysis or test on tissue biopsy. Most common radiologic tests are X-ray, ultrasound, CAT scan or MRI.

Why are laboratory or radiologic tests necessary?
Laboratory and radiologic tests are necessary to screen you for certain disorders you are at risk for, to find out why you have certain symptoms, and to evaluate if you respond well to a particular treatment.

What tests are ordered for me?
Family Fertility Center follows prevailing standards of care regarding what tests are medically indicated for males planning to have a child using donor eggs. These include but are not limited to screening for general health such as complete blood count, thyroid hormone, blood glucose, sexually transmitted diseases, STD, including HIV; preconception carrier screening for cystic fibrosis and other genetic diseases; and genetic disease testing and chromosomal analysis for certain medical conditions.

Does my health insurance cover the cost of laboratory or radiologic tests?
Even though a test is medically indicated and recommended by prevailing standards of care, it may or may not be covered by your insurance. Family Fertility Center makes no guarantee that your insurance will cover any test.

Can Family Fertility Center find out for me if a laboratory or radiologic test is covered by my insurance?
Your health insurance is a contract between you and your insurance company. It is your responsibility to contact your insurance company to find out whether a particular test is covered by your policy and how much you should expect to pay.

What should I do if I am concerned the test is not covered by my health insurance?
You must voice your concern to the staff at the Family Fertility Center and request to opt out any or all of the medically indicated tests **BEFORE** the test is performed.

PLEASE SIGN BELOW TO INDICATE WHETHER YOU WISH TO PROCEED WITH OR OPT OUT OF ANY OR ALL LABORATORY OR RADIOLOGIC TESTING

[ ] I agree to **PROCEED** with laboratory and radiologic testing as indicated by prevailing standards of care*. I understand I am responsible to contact my insurance company to find out if a particular test is covered by my insurance policy and my expected out of pocket expense.

[ ] I wish to **OPT-OUT OF ALL** medically indicated laboratory and radiologic testing until further notice. I understand by declining laboratory and radiologic testing, my medical care is compromised because such tests are necessary to screen for certain diseases I am at risk for, to find out why I have certain symptoms and/or to evaluate if I am responding well to a particular treatment.

[ ] I wish to **OPT-OUT OF ONLY THE TEST WRITTEN BELOW** until further notice. I understand by declining laboratory and radiologic testing, my medical care is compromised because such test is necessary to screen for certain diseases I am at risk for, to find out why I have certain symptoms and/or to evaluate if I am responding well to a particular treatment.

Name of laboratory or radiologic test opting out ______________________________

*Family Fertility Center makes no guarantee any or all of the laboratory or radiologic testing is covered by your insurance company in spite of prevailing standards of care. **It is your responsibility to contact your insurance company to find out whether a particular test is covered and your expected out of pocket expense. You are responsible for the cost of any or all of the laboratory or radiologic testing not covered by your insurance.**

Patient Signature: ______________________________ **Date:** ____________________

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Preconception Carrier Screening

Modified in part from ACOG: Preconception Carrier Screening
https://www.acog.org/Patients/FAQs/Carrier-Screening

What is preconception carrier screening?

Preconception carrier screening is a type of genetic test you can have before pregnancy that can tell whether you carry a gene for certain genetic disorders. It allows you to find out the chances of having a child with a genetic disorder.

What is a carrier?

For some genetic disorders, it takes two genes for a person to have the disorder. A carrier is a person who has only one gene for the disorder. Carriers have no or mild symptoms but can pass on the gene for that disorder to his or her child.

Who should have carrier screening?

All women who are thinking about becoming pregnant are offered carrier screening for cystic fibrosis, thalassemia, hemoglobinopathies, and spinal musclar atrophy. You can have screening for additional disorders as well. There are two approaches to carrier screening for additional disorders: 1) targeted screening and 2) expanded carrier screening.

What is targeted carrier screening?

In targeted carrier screening, you are tested for disorders based on your ethnicity or family history. If you belong to an ethnic group or race that has a high rate of carriers for a specific genetic disorder, carrier screening for these disorders may be recommended. This also is called ethnic-based carrier screening. If you have a family history of a specific disorder, screening for that disorder may be recommended, regardless of your race or ethnicity.

What is expanded carrier screening?

In expanded carrier screening, many disorders are screened for using a single sample. This type of screening is done without regard to race or ethnicity. Companies that offer expanded carrier screening create their own lists of disorders that they test for. This list is called a screening panel. Some panels tests for more than 100 different disorders. Screening panels usually focus on severe disorders that affect a person's quality of life from an early age.

Is one approach better than the other?

As of 2017, the American College of Obstetricians and Gynecologists (ACOG) recommends either approach is acceptable. But for individuals with a specific family history or ethnicity for certain genetic disorder, a targeted carrier screening would be more appropriate.

Do I have to have carrier screening?

Carrier screening is a voluntary decision. You can choose to have carrier screening or not. There are no right or wrong choices.

How is carrier screening done?

Carrier screening involves testing a sample or blood or saliva. The sample is sent to a laboratory for testing. Often the partner who is most likely to have a defective gene is tested first. If test results show that the first parnter is not a carrier, then no additional testing is needed. If test results show that the first partner is a carrier, the other partner is tested.

Does preconception carrier screening test for all genetic disorders? What carrier screening tests are available?

Carrier screening test does not detect all genetic disorder. Carrier tests are available for a limited number of diseases, including cystic fibrosis, fragile X syndrome, sickle cell disease, and Tay-Sachs disease. As of 2017, the American College of Obstetricians and Gynecologists (ACOG) recommends carrier screening for cystic fibrosis, spinal muscular atrophy, thalassemia and hemoglobinopathies be offered to all women who are considering pregnancy or are already pregnant regardless of ethnicity.

Does a normal test guarantee my child will not have a genetic disorder?

Screening can reduce, but not eliminate, the chance for some genetic disorder. Because test results can be wrong, it is possible for you to have a child with a genetic disorder even if your and your partner's test results are negative. A false-postivie test results when a person tests positive for being a carrier but does not actually have the gene. A false-negative test result is when a person tests negative for being a crrier but actually does have the gene.

What can the results of a carrier screening test tell me?

If both you and your partner are carriers for the same disease, there is a 1 in 4 (25%) chance that the child will get the abnormal gene from each parent and will have the disorder. There is a 50% chance that the child will be a carrier of the disorder, just like the carrier parent.
If only one parent is a carrier, there is a 50% chance that the child will be a carrier of the disorder and a 0% chance that the child will have the disorder.

What decisions do I need to make if I am a carrier?

If you and your partner are both carriers of a genetic disorder, you have several options. You may choose to proceed with becoming pregnant, with the option of considering prenatal diagnosis. You may choose to use in vitro fertilization to create fertilized eggs in the laboratory, follow by preimplantation genetic diagnosis on each of the embryos for the genetic disorder before implanting the embryo into the uterus to achieve a pregnancy. You may also use donor sperm or donor egg to achieve pregnancy. You may also choose not to become pregnant.

Who should I speak to if I have more questions about preconcpeption carrier screening?

If you have questions about preconception carrier screening or genetic disorders in general, and especially if there is a family history of a genetic disorder, genetic counseling with a board-certified geneticist is strongly recommended.

References

Carrier Screening for Genetic Conditions
https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Genetics/Carrier-Screening-for-Genetic-Conditions

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Preconception Carrier Screening

Family Fertility Center offers preconception carrier screening to **all** women of reproductive age. Currently we utilize the following genetic laboratories for preconception carrier screening:

Counsyl's Foresight® Carrier Screen screens for 175 genetic disorders, including cystic fibrosis, fragile X, and spinal muscular atrophy. Counsyl is in-network with most insurance carriers. Some plans cover the cost of this test 100% so there is no cost to you. Some plans may have an out-of-pocket cost due to deductibles and/or copays with the average out-of-pocket cost is $75 to $160. Counsyl would notify you by email or text prior to performing the test to advise of your out-of-pocket cost; and you would have an opportunity to decline the testing or elect to pay for the test out-of-network at a fee of $349. https://www.counsyl.com/access/

Progenity's Preparent Standard or Global Panel Screen tests 29 to 200+ hereditary genetic disorders respectively but is **out-of-network for all insurance carriers.** Your insurance company would be billed but, in the event you incur any out-of-pocket expense, you can call Progenity and request your bill be reduced to a self-pay price of $99. If the female partner is tested positive for one or more of the genetic disorders, Progenity offers testing of the male partner free of charge. https://www.progenity.com/tests/preparent/preparent-global

Natera's Horizon Carrier Screen tests up to 274 + hereditary genetic disorders. Natera is in-network with most insurance carriers. Most patients pay less than $200, many pay zero out of pocket. Natera will run a personalized estimate for in-network patients, those who owe more than $200 will receive a call and will be offered a pay discount. https://www.natera.com/in-network-plans Out of network patients whose coverage is denied in full will pay no more than $200. Natera also offers pre-implantation genetic testing on embryos for $99 if both partners are tested positive carrier for the same genetic disorder. Call or email Wally Zebi: wzebi@natera.com (973)816-3720 for additional questions.
.

PLEASE SIGN BELOW TO DESIGNATE WHETHER YOU WISH TO PROCEED WITH PRECONCEPTION CARRIER TESTING OR DECLINE TO UNDERGO SUCH SCREENING:

Initials	I wish to **PROCEED with preconception carrier screening** with the genetic test laboratory. Initial to the left and check one genetic laboratory you elect to use.	
	Counsyl*	I understand I shall have 48 hours to decline testing after I have been advised of any costs.
	Progenity*	I understand Progenity will bill my insurance company even though it is out of network; and that I can request my cost be reduced to $99 whether or not my insurance company makes payment.
	Natera*	I understand Natera will bill my insurance company even though it is out of network; and that my cost can be reduced to $200 whether or not my insurance company makes payment.
Initials	I wish to **DECLINE** preconception carrier screening despite being advised of its benefits	

*Family Fertility Center has no financial relationship with and does not receive any kick back from any testing company. You have the right to undergo your preconception carrier screening at any laboratory of your choice. The estimated cost is current as of October of 2017. Family Fertility makes no guarantee the cited cost is up-to-date. **It is your responsibility to contact the particular testing company for an exact quote and to find out from your health insurance company your expected out of pocket expense. You are responsible for the cost of any or all of the laboratory or radiologic testing not covered by your insurance.** Family Fertility Center reserves the right to change the testing laboratory without further notice.

Patient Signature: ____________________________ **Date:**________________

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100
Bethlehem, PA 18017
Telephone (610) 868-8600
Fax (610) 868-8700

Questionnaire for Men

General Information

Referred by: Dr.___ ________________ Word of mouth [ ] Web Search [ ] Insurance [ ] Other [ ]

Name ____ **Today's Date** ____________________

Address

____

____

Telephone: Home: ______________________ Work: __________________________ Cell: ____________________

Birth date ____________________ Age __________ Ethnic Background ______________________________

Height _______________ Weight _______________ Highest Education ______________________________

Partner's Name ______________________________ How long in this relationship? ______________________

Work History: Please list all recent employment, titles, brief description, and years employed:

____________________ ____________________ ____

____________________ ____________________ ____

Infertility History

Have you ever fathered a pregnancy? ____ yes ____ no

If yes: Year of Birth? Same Partner?

______________ ______________

______________ ______________

______________ ______________

Have you ever been told you are infertile? ____ yes ____ no

If yes, when and by whom? ______________________

Length of time attempting pregnancy: ____ Years ____ Months

Length of time not using any contraceptives:

____ Years ____ Months

Did your mother take DES or other medications while pregnant with you?

_____ yes _____ no ______ don't know

If yes, list: ______________________________

____

____

Sexual History

Has there been any change in your libido or sexual drive? ___ yes ___ no

Is there any difficulty in maintaining an erection? ____ yes ____ no

If yes, are you taking any medication? (Name, dose)

____

Do you ejaculate into the vagina without difficulty? ____ yes ____ no

Do you have any pain or burning with urination or ejaculation? ___ yes ___ no

Have you ever had any discharge from the penis? ____ yes ____ no

Frequency of sexual intercourse per week? ______

Have you ever been treated for: Dates

	Dates
Genital/anal warts	_______
Syphilis	_______
Gonorrhea	_______
Chlamydia (non-specific urethritis)	_______
Prostatitis (infection of the prostate)	_______
Infection of the testicles	_______
Infection of the seminal vesicles	_______

Do you have a history of genital herpes ______yes ______no

Urologic History (if Yes, when and by whom)

Vasectomy ____

Vasectomy Reversal ________________________________

Surgery to Correct Undescended Testicle(s) ____________________

____

Varicocele Repair __________________________________

Hernia Repair ____________________________________

H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Medical/Surgery History (Past or Present)	Yes	No	Dates/Comments
Mumps			
Measles			
Chicken Pox			
Rubella (German Measles)			
Rheumatic fever			
Elevated Blood pressure			
Heart murmur			
Heart disease			
Diabetes			
Lung disease			
Liver or gall bladder disease			
Jaundice			
Kidney infections			
Hepatitis			
Kidney stones			
Gout			
Urinary tract abnormalities			
Thyroid disease			
Arthritis			
Auto immune diseases (lupus, rheumatoid arthritis, etc.)			

Other serious or chronic diseases
____

Any surgery (list type and year)
____
____
____

Do you have any adverse reactions to food/medications/other: Yes ______ No ______ If yes, name and type of reaction:.
____
____

Please list any medications you are now taking or have taken in the past. Current: ________________ Past: ________________

Any history of therapeutic x-ray treatment or anti-cancer drugs? Current: ________________ Past: ________________

Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches			Increased thirst			Fatigue		
History of head injury			Increased sweating			Tremors		
Convulsion history			Intolerance to heat			Desire for extra salt		
Visual problems			Intolerance to cold			Rapid weight change		
Dizziness			Difficulty sleeping			Change of appetite		

FAMILY FERTILITY CENTER www.familyfertility.com
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. Medical and Laboratory Director
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Please include any other information which you believe may be pertinent to your infertility problem ________________________
____

Occupation/Leisure History	**Yes**	**No**	**Dates/Comments**
Have you ever been employed in an occupation with sustained high temperature?	_____	_____	________________________
Do you drive long distances as part of your employment?	_____	_____	________________________
Do you use hot tubs, saunas, etc.?	_____	_____	________________________
Exposed to chemical or x-rays in work or hobby	_____	_____	________________________
Please list current or past history:	**Yes**	**No**	**Amount per day or week**
Caffeine	_____	_____	________________________
Smoking	_____	_____	________________________
Alcohol	_____	_____	________________________
Marijuana	_____	_____	________________________
Drugs (not prescribed), list	_____	_____	________________________
Herbs/supplements	_____	_____	________________________
Performance-enhancing drugs	_____	_____	________________________

Please describe recreational/sports activities (frequency, length of time, etc.) ________________________
____

Family History

Father's age if alive _____ If no longer living, cause of death and age ________________________
Medical problems: ________________________ # of biologic children: ___________
Mother's age if alive _____ If no longer living, cause of death and age ________________ ________________
Medical problems: ________________________ # of biologic children: ___________
Sister(s): Age: __________ Medical problems: ________________________
Age: __________ Medical problems: ________________________
Age: __________ Medical problems: ________________________
Brother(s): Age: __________ Medical problems: ________________________
Age: __________ Medical problems: ________________________
Age: __________ Medical problems: ________________________

Is there a family history of:	**Yes**	**No**	**Comments**
Birth defect	_____	_____	________________________
Mental Retardation	_____	_____	________________________
Genetic diseases	_____	_____	________________________
Infertility	_____	_____	________________________
Hormone problems	_____	_____	________________________
Miscarriages/stillbirths	_____	_____	________________________
Pregnancy problems	_____	_____	________________________
Cancer: Breast Prostate Ovarian Colon	_____	_____	________________________
Stroke	_____	_____	________________________
Heart disease	_____	_____	________________________
Lung disease	_____	_____	________________________
Diabetes	_____	_____	________________________
Thyroid/endocrine problems	_____	_____	________________________
High blood pressure	_____	_____	________________________
Any women who have never menstruated	_____	_____	________________________
Any men who have never had to shave	_____	_____	________________________

FAMILY FERTILITY CENTER www.familyfertility.com
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. Medical and Laboratory Director
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Any additional comments you would like to make that you feel may be pertinent and have not already been addressed:

____

____

Pre-conceptual Health Screening

Have you ever been tested for:	Yes	No	If yes, give dates/results
Hepatitis B	☐	☐	____________________
HIV (AIDS)	☐	☐	____________________
Rubella	☐	☐	____________________
TB (Tuberculosis)	☐	☐	____________________
Blood Type	☐	☐	____________________
Tay-Sachs	☐	☐	____________________
Gaucher Disease	☐	☐	____________________
Canavan Disease	☐	☐	____________________
Cystic Fibrosis	☐	☐	____________________
Sickle cell	☐	☐	____________________
Diabetes	☐	☐	____________________
Thalassemia	☐	☐	____________________

Previous Infertility Testing

Previous urological exam? ☐ yes ☐ no

Results: ____

Previous semen analysis? ☐ yes ☐ no

Results:	Date	Count (million/cc)	Motility (% moving)	Morphology (% normal shape)
	________	____________	____________	____________
	________	____________	____________	____________
	________	____________	____________	____________
	________	____________	____________	____________

Specialized sperm testing? ☐ yes ☐ no
(Acrosome reaction, sperm penetrating assay, antibody testing)

Results (which tests): ____

Specific treatment for Male Infertility? ☐ yes ☐ no

Details: ____

____

Patient Signature: ____ **Date:** ______________