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

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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

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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: _____

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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

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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:**_____

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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 our gynecologic patients as well as patients with infertility. These tests include but are not limited to screening for cervical cancer such as Pap smear and HPV testing; screening for sexually transmitted diseases, STD, including HIV; pre-conception screening for cystic fibrosis and other genetic diseases for all reproductive age women; genetic disease testing and chromosomal analysis for certain medical conditions; and ovarian reserve testing such as anti-Mullerian hormone, AMH.

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 and 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 of 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 <u>ALL</u>** 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 <u>TEST WRITTEN BELOW</u>** 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. **<u>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.</u>**

Patient Signature: _____ **Date:** _____

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Gynecology Health History

ID No.: _____
Today's Date: ____ / ____ / ____

PATIENT IDENTIFICATION *(Please print)*

Patient's Name: _____
Address: _____
_____
Home Telephone No: ( ) _____
Work Telephone No: ( ) _____
Reason for Seeing Doctor _____

Date of Birth: ____/____/____ Age: _____ Religion: _____
Marital Status: ❑ S ❑ M ❑ D ❑ SEP ❑ W Race: _____
Education: _____ years Occupation: _____
Employer: _____
Type of Insurance: _____ Policy #: _____
Referring Physician: _____
Primary Physician: _____

1. MEDICATION ALLERGY / SENSITIVITY

List all medications allergic to: ❑ None

_____
_____
_____

MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:	You	Your Family
2. High Cholesterol	❑	❑
3. Heart Disease	❑	❑
4. Rheumatic Fever	❑	
5. High Blood Pressure	❑	❑
6. Asthma	❑	
7. Tuberculosis	❑	
8. Diabetes	❑	❑
9. Thyroid Problems	❑	❑
10. Liver Disease	❑	
11. Stomach, Bowel or Gall Bladder Problems	❑	
12. Kidney or Bladder Problems	❑	
13. AIDS (HIV)	❑	❑
14. Hepatitis (type___)	❑	❑
15. Anemia or Blood Disorder	❑	❑
16. Blood Transfusion	❑	
17. Allergies	❑	
18. Breast Problems	❑	❑
19. Cancer	❑	❑
20. Infertility	❑	
21. Female or Sexual Problems	❑	
22. Chlamydia	❑	
23. Gonorrhea	❑	
24. Herpes (HSV)	❑	
25. Syphilis	❑	
26. Birth Defects or Inherited Diseases	❑	❑
27. Sexual Abuse or Domestic Violence	❑	❑
28. Other Medical Problems	❑	❑
29. **No Known Medical Problems**	❑	❑

30. HOSPITALIZATIONS

List those operations/serious illnesses that have required hospitalization. If more than six, check this box. ❑ *Do not include pregnancies here.*

Month/Year	Illness or Operation	Complications No	Yes
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑

SUBSTANCE USE *(Check only those you use)*

31. Alcohol ❑
Type _____
Amt/day _____

32. Tobacco ❑
Type _____
Amt/day _____

33. Caffeine ❑
Type _____
Amt/day _____

34. Non-Prescribed Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

35. Street Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

36. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term=40 Wks)	Hours In Labor	Type Of Delivery	Type of Anesthesia	Complications Yes	No
1	/		lbs. oz.					❑	❑
2	/		lbs. oz.					❑	❑
3	/		lbs. oz.					❑	❑
4	/		lbs. oz.					❑	❑
5	/		lbs. oz.					❑	❑

37. MENSTRUAL HISTORY

First Day of Last Menstrual Period ____ / ____ / ____

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
years	days	days

Abnormalities: ❑ Excessive Bleeding ❑ Discharge ❑ Pain ❑ None

38. CONTRACEPTIVE HISTORY

Type	Dates Used
Oral Contraceptive ❑	
Type(s) _____	_____
_____	_____
IUD ❑	_____
Diaphragm ❑	_____
Norplant ❑	_____
Sponge ❑	_____
Spermicide ❑	_____
Condoms ❑	_____
Other _____ ❑	_____

Sterilization ❑ Male ❑ Female

LIFESTYLE

	Yes	No
39. Did your mother take DES or any other hormones when pregnant with you?	❑	❑
40. Have you ever had a Pap test?	❑	❑
If Yes: Date of your last Pap Test? ____ / ____ / ____		
Have you ever had abnormal Pap test results?	❑	❑
41. Are you sexually active?	❑	❑
42. Do you have one partner or many partners?	❑ one	❑ many
43. Is intercourse painful for you?	❑	❑
44. Do you do a monthly self breast exam?	❑	❑
45. Have you ever had a mammogram?	❑	❑
If Yes: Date of last mammogram? ____ / ____ / ____		
46. Do you exercise on a regular basis?	❑	❑
If Yes: Type of exercise _____ Hours per week exercise _____		

Check and detail positive findings below. Use reference numbers.

Signature: _____

To Order: Call 1-800-243-5546

2229 1-94

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Patient's Name: _____
ID No.: _____

Initial Gynecology Profile

INITIAL PHYSICAL EXAM			
1. Height _____			
2. Weight _____			
3. Blood Pressure ____ / ____			
Pelvic Exam	Normal	Abn.	N.E.
4. Ext. genitalia			
5. Vagina			
6. Cervix			
7. Uterus (describe)			
8. Adnexa			
9. Rectum			
10. Other			
General Physical	Normal	Abn.	N.E.
11. Skin			
12. HEENT			
13. Neck			
14. Chest			
15. Breasts			
16. Heart			
17. Lungs			
18. Abdomen			
19. Musculoskeletal			
20. Extremities			
21. Neurological			

N.E. = Not Evaluated

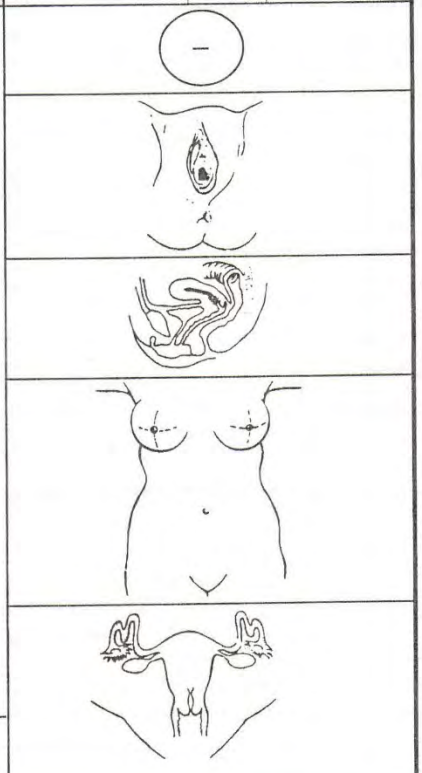
Nutritional Assessment

22. Not performed ..... ❑
23. Apparently adequate ..... ❑
24. Apparently inadequate ..... ❑
25. Excessive caloric intake ..... ❑

Check and detail all positive findings below.
Use system numbers.

LABORATORY PROCEDURES		
Test	Date	Result
26. Hgb	/	
27. Hct	/	
28. WBC	/	
29. Differential	/	
30. Pregnancy Test	/	
31. Urinalysis	/	
32. HIV	/	
33. Gonorrhea	/	
34. Chlamydia	/	
35. HSV	/	
36. VDRL Serology	/	
37. Hepatitis __	/	
38. Pap Test	/	
39. Wet Mount	/	
40. Culture	/	
41. Stool Occult Blood	/	
42. Blood Glucose	/	
43. Cholesterol	/	
44. Thyroid Screen	/	
45. Biopsy	/	
46. Mammogram	/	
47.	/	
48.	/	
49.	/	
50.	/	

Diagnosis and Treatment Plans



Next Appointment: ____/____/____ Signature: _____