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 COUPLES

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 **COUPLES** 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 (female)
  -- Patient Communication Instructions (partner)
  -- Receipt of HIPAA Notice (female)
  -- Receipt of HIPAA Notice (male)
  -- Insurance Coverage for Laboratory or Radiologic Testing
  -- Preconception Carrier Screening
  -- Questionnaire for Women
  -- Questionnaire for Men
- 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.

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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

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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 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 all current and outstanding co-pay, co-insurance, and deductible amounts at each date of service. Failure to pay for treatments rendered and/or any outstanding balances may result in further treatment being postponed or terminated. 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 Explanation of Benefits (EOB) or FFC statement.

If FFC does not participate with your insurance plan, or if services are not covered under your insurance plan, you will be responsible for paying all charges prior to services being rendered by FFC. Discounted fee packages are available for patients with no insurance coverage for treatment; payment plans are not available.

Any unpaid patient balances remaining after 90 days for any reason 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 owed by you.

FFC participates in Northampton County Bad Check Restitution Program. For each check returned due to non-sufficient funds (NSF), a $50 service fee will be charged to you. Failure to pay the amount of NSF check and service fee within 10 days after receiving written notice by FFC will result in a Bad Check Crime Report being filed with the Bad Check program. You will incur additional costs and/or be prosecuted by the District Attorney's office.

We reserve our 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. I/WE ALSO AUTHORIZE FAMILY FERTILITY CENTER TO CHARGE MY/OUR CREDIT CARD, AS MAY BE REQUESTED BY PHONE, FOR ONE-TIME AGREED-UPON PAYMENTS. I/WE UNDERSTAND CREDIT CARD INFORMATION WILL NOT BE SAVED FOR FUTURE TRANSACTIONS.

Patient Signature: _____ **Date**

Partner Signature: _____ **Date**

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YOUR SIGNATURE IS REQUIRED FOR US TO SUBMIT INSURANCE CLAIMS AND RECEIVE PAYMENT

The Non-Medicare Patient: I authorize the release of all medical information pertinent to my medical care which is necessary to process any claims. 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 payment of authorized Medicare benefits for me or on my behalf be made directly to H. CHRISTINA LEE, MD for any services furnished me by that provider and/or its agents. I authorize the release of all medical information pertinent to my medical care to the Health Care Financing Administration and its agents as 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: _____
(Parent, if minor) **Date**

Partner Signature: _____
Date

PLEASE HAVE VALID DRIVER'S LICENSES AND INSURANCE CARDS READY TO PHOTOCOPY. Thank you.

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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: _____

drugVerify.doc

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PATIENT COMMUNICATION INSTRUCTIONS
FOR THE PATIENT

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"

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☐ 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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PATIENT COMMUNICATION INSTRUCTIONS
FOR THE PARTNER

Partner 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"

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FOR THE PATIENT
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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Insurance Coverage for Laboratory or Radiologic Tests

FOR THE PATIENT

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; general health screen 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 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 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 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 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:** _____

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[ ] 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.

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Patient Signature: _____ **Date:** _____

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Preconception Carrier Screening

Modified in part from ACOG: Preconception Carrier Screening
https://www.acog.org/patient-resources/faqs/pregnancy/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 people 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 tests do 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 people 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 reproductive 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, followed 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 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/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/03/carrier-screening-for-genetic-conditions.pdf

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Preconception Carrier Screening

FOR THE PATIENT

Family Fertility Center recommends and offers preconception carrier screening to **all** people of reproductive age planning to have a child with his/her gamete (sperm or egg). Currently we utilize Natera® (www.natera.com) for preconception carrier screening.

Natera® Horizon Carrier Screen tests up to 274 hereditary genetic disorders. https://www.natera.com/womens-health/horizon-advanced-carrier-screening Natera® is in-network with many insurance carriers including Capital Blue Cross, Blue Shield (PPO), St. Luke's Hospital, Cigna, Keystone Central, and some Geisinger and Aetna plans. Natera® will run a personalized estimate and contact you regarding your out-of-pocket expense. The average out of pocket expense is around $250 in 2024. Further information about insurance coverage for Natera Horizon Carrier Screen is available at https://www.natera.com/womens-health/pricing-billing Natera® offers discount for qualified individuals with its compassionate care program. Check online at https://patientportal.natera.com/pricing/about_compassionate_care and see if you qualify. See https://natera.showpad.com/share/M9LjD8QRUNiqabRam8vnU for more details.

If you decide to proceed with preconception carrier screening with Natera®, we will place an online order with Natera® for you. Natera® will send you an email, a text or a phone call regarding your carrier screening test. **You must respond in order to make arrangement to collect a blood sample from you.** Go to https://my.natera.com/services/blood_draw to find a lab near you.

The turnaround time is about 14 to 21 days. Natera® will notify you by email, text or phone call when your result is available. You can check on the patient portal at https://my.natera.com/ for your test results. Natera® will also send a copy of your carrier screen results to us, the ordering physician. If the test is positive, your partner must be tested for carrier screen as well. Natera® offers one free session of genetic counseling with a board-certified genetic counselor regardless of your carrier screen results. Natera® also offers pre-implantation genetic testing on embryos at a discounted price if both partners are tested positive carrier for the same genetic disorder.

PLEASE SIGN BELOW TO INDICATE WHETHER YOU WISH TO DECLINE OR PROCEED WITH PRECONCEPTION CARRIER TESTING:

I have been advised and offered to undergo pre-conception carrier screening. The benefits, risks, limitations and cost of carrier screening have been explained and understood by me. I voluntarily decide to **DECLINE** any preconception carrier screening.	**Signature** **Date**
I have been advised and offered to undergo pre-conception carrier screening. The benefits, risks, limitations and cost of carrier screening have been explained and understood by me. I understand I have the right to undergo my preconception carrier screening at any laboratory of my choice. I agree to **PROCEED** with preconception carrier screening with *Natera®.	**Signature** **Date**

* You are free to choose any genetic laboratory other than Natera® to perform your carrier screening. Family Fertility Center has no financial relationship with, and does not receive any kick back from any company including Natera®. The estimated cost is current as of JAN 10, 2024. **Family Fertility makes no guarantee the cited cost is up-to-date. It is your responsibility to contact Natera® 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 testing not covered by your insurance.** Family Fertility Center reserves the right to change the testing laboratory without further notice.

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Preconception Carrier Screening

FOR THE PARTNER

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If you decide to proceed with preconception carrier screening with Natera®, we will place an online order with Natera® for you. Natera® will send you an email, a text or a phone call regarding your carrier screening test. **You must respond in order to make arrangement to collect a blood sample from you.** Go to https://my.natera.com/services/blood_draw to find a lab near you.

The turnaround time is about 14 to 21 days. Natera® will notify you by email, text or phone call when your result is available. You can check on the patient portal at https://my.natera.com/ for your test results. Natera® will also send a copy of your carrier screen results to us, the ordering physician. If the test is positive, your partner must be tested for carrier screen as well. Natera® offers one free session of genetic counseling with a board-certified genetic counselor regardless of your carrier screen results. Natera® also offers pre-implantation genetic testing on embryos at a discounted price if both partners are tested positive carrier for the same genetic disorder.

PLEASE SIGN BELOW TO INDICATE WHETHER YOU WISH TO DECLINE OR PROCEED WITH PRECONCEPTION CARRIER TESTING:

I have been advised and offered to undergo pre-conception carrier screening. The benefits, risks, limitations and cost of carrier screening have been explained and understood by me. I voluntarily decide to **DECLINE** any preconception carrier screening.	**Signature** **Date**
I have been advised and offered to undergo pre-conception carrier screening. The benefits, risks, limitations and cost of carrier screening have been explained and understood by me. I understand I have the right to undergo my preconception carrier screening at any laboratory of my choice. I agree to **PROCEED** with preconception carrier screening with *Natera®.	**Signature** **Date**

* You are free to choose any genetic laboratory other than Natera® to perform your carrier screening. Family Fertility Center has no financial relationship with, and does not receive any kick back from any company including Natera®. The estimated cost is current as of Jan 10, 2024. **Family Fertility makes no guarantee the cited cost is up-to-date. It is your responsibility to contact Natera® 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 testing not covered by your insurance.** Family Fertility Center reserves the right to change the testing laboratory without further notice.

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Questionnaire for Women

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:

_____ _____ _____ _____

_____ _____ _____ _____

Gynecologic History

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

Usual cycle length _____ days _____
range
(interval from start of one period to start of next)

Usual duration of bleeding _____

Do you have any symptoms at time of ovulation (i.e., pain)?
Yes___ No____ _____

Amount of flow: Light _____ Moderate _____ Heavy_____

Cramping: None____ Minimal ____ Moderate ____ Severe_____

What do you do to relieve menstrual symptoms? _____

_____

Circle symptoms preceding period: None Breast soreness Irritability Cramping Other:_____

History of: Pelvic Pain _____

Endometriosis _____

Gynecologic surgery _____

_____

Last PAP _____ Results _____

History of Abnormal PAP?_____

Last Mammogram _____ Results _____

Have you ever been treated for: Dates

HPV Human Papilloma Virus _____

Syphilis _____

Gonorrhea _____

Chlamydia _____

Genital / anal warts _____

Pelvic inflammatory disease _____

Do you have a history of genital herpes? Yes_____ No_____

Did your mother take any medications while pregnant with you?
Yes _____ No_____ Don't know _____ What?_____

Was DES taken? Yes_____ No_____

Sexual History

Frequency of sexual intercourse per week _____

Use of lubricants ___ yes ___ no _____

Name of lubricants _____

Does husband ejaculate in the vagina during intercourse__ yes__no

Is intercourse painful to you? _____ yes _____no

Is intercourse painful to your partner? _____ yes _____ no

_____

Contraceptive History

Birth control pills _____ yes _____ no # of years taken _____

Date stopped birth control pills _____

Were menses regular before birth control pills ____ yes ____ no

Were menses regular after stopping the pills ____ yes ____ no

How long after stopping the pills did menses start _____

Previous use of IUD (intrauterine device) __ yes __ no __ # years

When was IUD removed (date) _____ reason _____

_____

Circle previous use of:

Diaphragm Condom Foam Rhythm Sponge

Sterilization (date) _____

By Whom: _____

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RECORD ALL PREGNANCIES									
	Year	End in Abortion	End in Miscarriage	Ectopic Pregnancy	Infertility Treatment To Conceive?	How Long to Conceive?	Baby born Alive?	Method of Delivery?	Is current Partner the Father?
1st									
2nd									
3rd									
4th									
5th									

Occupation/Leisure History

	Yes	No	Dates/Comments
Exposed to chemical or x-rays in work or hobby	_____	_____	_____
Please list current or past history:	**Yes**	**No**	**Amounts per day or week**
Caffeine	_____	_____	_____
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Nutritional supplements, herbs, etc.	_____	_____	_____
Drugs (not prescribed)	_____	_____	_____

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	_____	_____	_____

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Is there a family history of: (cont'd)	Yes	No	Comments
Lung disease	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid/endocrine problems	_____	_____	_____
High blood pressure	_____	_____	_____
Any women who have never menstruated	_____	_____	_____
Any men who have never had to shave	_____	_____	_____

Medical/Surgery History	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: _____
_____ _____
_____ _____

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

	Yes	No		Yes	No		Yes	No
Chronic headaches	____	____	Increased thirst	____	____	Excessive Fatigue	____	____
History of head injury	____	____	Increased sweating	____	____	Tremors	____	____
Convulsion history	____	____	Intolerance to heat	____	____	Desire for extra salt	____	____
Visual problems	____	____	Intolerance to cold	____	____	Excess Loss of scalp hair	____	____
Dizziness	____	____	Difficulty swallowing	____	____	Growth of hair on face	____	____
Rapid weight change	____	____	Change in voice or			or body in new places	____	____
Acne	____	____	hoarseness	____	____	Change in size of		
Change of appetite	____	____	Difficulty sleeping	____	____	clitoris	____	____
						Discharge from nipples	____	____

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

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	☐	☐	_____
Anemia or Thalassemia	☐	☐	_____

Previous Infertility Testing

Length of time currently attempting pregnancy _____ Years ___ Months
Length of time not using any method to avoid pregnancy _____

	No	**Yes**	**If yes, give dates/results**
Temperature charts	☐	☐	_____
Hysterosalpingogram (x-ray of tubes and uterus)	☐	☐	_____
Hysteroscopy (looking inside uterus)	☐	☐	_____
Endometrial biopsy	☐	☐	_____

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(taking tissue from inside uterus)
Post-coital test ☐ ☐ _____
(to test sperm in cervical mucus)
_____
Semen Analysis ☐ ☐ _____
_____
Laparoscopy ☐ ☐ _____
_____
_____

Hormone Tests
Day 3 FSH ☐ ☐ _____

Day 3 Estradiol ☐ ☐ _____

Clomid Challenge Test ☐ ☐ _____

Anti-Mullerian Hormone ☐ ☐ _____

Thyroid tests ☐ ☐ _____

Chromosome tests ☐ ☐ _____
Genetic tests ☐ ☐ _____

Previous Infertility Treatment

Treatment with Clomiphene (Clomid, Serophene) ☐ No ☐ Yes

If Yes:
Cycles **without** Intrauterine Insemination (IUI) ☐ No ☐ Yes #Cycles / Dates _____

Cycles **with** Intrauterine Insemination (IUI) ☐ No ☐ Yes #Cycles / Dates _____

Pregnant ☐ No ☐ Yes Dates _____

Treatment with Gonadotropins (e.g., Follistim, Gonal-F, Bravelle, Menopur) ☐ No ☐ Yes

If Yes:
Cycles **without** Intrauterine Insemination (IUI) ☐ No ☐ Yes #Cycles / Dates _____

Cycles **with** Intrauterine Insemination (IUI) ☐ No ☐ Yes #Cycles / Dates _____

Pregnant ☐ No ☐ Yes Dates _____

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Treatment with IVF or other Assisted Reproductive Technologies (ICSI, GIFT, ZIFT)

Cycle #	Stimulation Protocol (if known)	Dose of FSH or LH	Peak Estrogen Level	# Eggs Retrieved	# Eggs Fertilized	# Embryos Transferred	# Embryos Frozen	Outcome: +Preg, -Preg SAB, etc.	Birth Outcome

Other comments on Infertility treatments:

_____
_____
_____
_____
_____
_____

CONSENT:

Infertility is a disease that affects couples. Understanding our individual and joint infertility diagnoses and treatment options may be necessary to make an informed decision. I hereby authorize Dr. Lee, the Family Fertility Center, and its agents to disclose to my partner any specific medical information, test results and/or recommended treatment plans as may be needed.

Patient Signature:_____ **Date:**_____

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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
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 _____

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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	____	____

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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	_____	_____	_____

H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
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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: _____

_____

CONSENT:

Infertility is a disease that affects couples. Understanding our individual and joint infertility diagnoses and treatment options may be necessary to make an informed decision. I hereby authorize Dr. Lee, the Family Fertility Center, and its agents to disclose to my partner any specific medical information, test results and/or recommended treatment plans as may be needed.

Patient Signature: _____ **Date:** _____