FERTILITY CENTER of OREGON

The Fertility Center of Oregon
590 Country Club Parkway, Suite A
Eugene, OR 97401
541-683-1559 • Fax 541-683-1709
Reproductive Endocrinology•Infertility
Douglas J. Austin, MD
B. Esty Stein, CNM
C. Camille McGregor, WHNP

Dear New Patient,

A new *infertility* patient deposit in the amount of $638.00 is required at the time of your appointment and will be applied to the cost of your visit. Any additional testing done during this consultation visit will be an additional charge.

If you have questions, please don't hesitate to call me prior to your appointment.

Thank you.

Patient Financial Coordinator
541-868-9759

Thank you for taking the time to fill out this new patient packet. We ask that you fully complete and sign each form *before we will schedule your appointment*. In order to serve you best, we will request records for all the previous treatment you have received that are relevant to your condition.

Once we receive the completed forms, we will contact you to schedule your appointment. All new patient appointments will be scheduled on a first-come first-serve basis *after* receiving the information requested. We will do our best to see you as soon as we can and we appreciate your patience.

Table of Contents Checklist

- □ Patient Profile
- □ Financial Agreement
    - o If you write down insurance information our financial coordinator will call prior to your appointment to discuss benefits.
    - o New Patient Consults are $638.00 if not covered by insurance.
- □ HIPAA Policy
- □ Release of Information
    - o This is the form we use to request records from your previous providers.
    - o Please make sure to sign, date, and INITIAL all appropriate spaces.
    - o If this form is not filled out and signed, we will return the packet to be completed.
    - o If you have not seen any providers in the last 2 years please write that on the form, you don't need to fill it out.
- □ Oregon Genetics Privacy and Research
    - o State of Oregon mandated program, fill out the form entirely.
    - o If you would like to opt out make sure the check box to decline is selected
- □ Authorization to Share Health/Treatment Information with Another Person
    - o This form allows you to elect up to two people who can call in and discuss your health information.
    - o We cannot share any of your medical information with anyone without this consent signed.
    - o This form is optional.
- □ Medical History Questionnaire
    - o This form allows Dr. Austin to review your health history prior to your initial consult.
    - o Please fill out as completely as you are able. It's ok to leave blank if you are unsure or it does not apply to you.

If you would like an email confirmation that we received your new patient packet please list your email here:

_____

If you do not provide your email, we will not confirm receipt of receiving your packet, but you will receive a call when we are ready to schedule your consult.

FERTILITY CENTER of OREGON

Female Profile
Patient Information

Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Note: Please use your full legal name.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Street Address *(if different from mailing address)*: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred phone: _____

Date of Birth: _____ SSN: _____ Sex: _____ Marital Status: _____

Employer/School: _____ Occupation/Retired/Student: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance Information

Insurance Company Name: _____ Insurance Company Phone: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Relationship to Patient: _____ ☐ Male ☐ Female

Insured Party Date of Birth: _____ Insured Party Employer: _____ Insurance Effective Date: _____

Secondary Insurance Information

Insurance Company Name: _____ Insurance Company Phone: _____

Identification Number: _____ Group Number: _____

Name of Insured Party: _____ Relationship to Patient: _____ ☐ Male ☐ Female

Insured Party Date of Birth: _____ Insured Party Employer: _____ Insurance Effective Date: _____

Guarantor

Who is the guarantor? ☐ Same as patient. ☐ Other If other, please list name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Street Address *(if different from mailing address)*: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Emergency Contact

Name: _____ Phone Number _____ Relationship: _____

Authorization

I authorize the Fertility Center of Oregon to bill the above insurance on my behalf, and assign any insurance benefits payable directly to the Fertility Center of Oregon. I understand that I am financially responsible for all non-covered services.

Date: _____ Signature Field: _____

FERTILITY CENTER of OREGON

The Fertility Center of Oregon
590 Country Club Pkwy, Suite A
Eugene, Oregon 97401
(541) 683-1559
www.fertilitycenteroforegon.com

REPRODUCTIVE ENDOCRINOLOGY
INFERTILITY
FEMALE QUESTIONNAIRE

Full Legal Name: _____ Prefered Name: _____

Primary Care Physician: _____ OB/GYN Physician: _____

Date of Birth: _____ Age: _____ Today's Date: _____ Who referred you to us for care? _____

Have you consulted another doctor about infertility? ☐ No ☐ Yes If yes, please list doctor's name, dates of treatment, and diagnosis: _____

In your own words, please state the main reason for your visit.

_____

INFERTILITY

Have you been trying to get pregnant? ☐ No *(please go to Section II)* ☐ Yes

Unprotected intercourse for _____ _____ Please write years or months.

Have you done Basal body temperature charting? ☐ Yes ☐ No Biphasic temperature? ☐ Yes ☐ No

Have you done LH monitoring? ☐ Yes ☐ No

Did you have a positive (+) test? ☐ Yes ☐ No If yes, what day of your cycle? _____

Please explain how you have timed intercourse? _____

Have you had any of these tests? (*check if yes*)

☐ Hysterosalpingogram (*X-ray of uterus and tubes*)
Where? _____
Date: _____ Result: _____

☐ Laparoscopy (*visual examination of pelvic organs through an instrument placed through the abdominal wall*)
Where? _____
Date: _____ Result: _____

☐ Endometrial biopsy (*removal of samples of uterine lining*)
Where? _____
Date: _____ Result: _____

☐ Endocrine hormone laboratories
Where? _____
Date: _____ Result: _____

Have you had previous infertility treatments? *(Check if yes)*

☐ Infertility surgery

Date: _____ Procedure: _____

Where? _____

Date: _____ Procedure: _____

Where? _____

☐ Artificial inseminations Date: _____ Date: _____ Date: _____ Date: _____

Where? _____

☐ Medication Therapy Doctor: _____

☐ Metformin/Glucophage Date started: _____ # Months _____ Dose _____

Outcome: _____

☐ Clomid Date started: _____ # Months _____ Dose _____

Outcome: _____

☐ Letrozole Date started: _____ # Months _____ Dose _____

Outcome: _____

☐ *Gonadotropin Date started: _____ # Months _____ Dose _____

** aka Pergonal, Repronex, Follistim, Poravella, Menopur*

Outcome: _____

☐ IVF (*In Vitro Fertilization*) Doctor: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

Have you and your partner considered adoption? ☐ No ☐ Yes Have you consulted an adoption agency? ☐ No ☐ Yes

If yes, which agency? _____

How long have you been with your present partner? _____ _____ Please choose months or years

Have you attempted pregnancy with past partners? ☐ No *If no, please go to next section* ☐ Yes

Any pregnancy? ☐ No ☐ Yes *list in chart*

Do you use contraception? ☐ No ☐ Yes If yes, years used _____ to _____ Type _____

GYNECOLOGICAL HISTORY

When was the first day of your last normal menstrual period? _____

How old were you when your menstrual period started? _____ Have you ever had irregular cycles? ☐ No ☐ yes

What is the usual number of days from the start of one period to the start of the next? _____

How many days do you flow? _____

Flow is usually: ☐ Light ☐ Moderate ☐ Heavy

Do you have any discomfort during your period (menstrual cramps)?

☐ Never ☐ Rarely ☐ Usually *If you checked "never", please skip the next question.*

Onset: _____ years old

Severity: ☐ severe *(have to stop usual activities)*
☐ moderate
☐ mild

Changes: ☐ getting worse
☐ about the same
☐ getting better

Location: ☐ midline lower abdomen
☐ both sides of abdomen
☐ one side of abdomen

Timing: ☐ starts before flow
☐ starts on first day
☐ starts on subsequent day

Have you ever had any of the following? (*Check if yes*)

☐ Bleeding , staining, or spotting between periods
☐ Bleeding or spotting after intercourse
☐ Heavy bleeding, gushing, large clots (*blood runs down leg, requires two pads at once*)
☐ Recent change in periods? *(Please describe)* _____

Do you have PMS Symptoms which generally interfere with normal activities? ☐ No ☐ Yes

What symptoms do you experience? _____

Have you ever had a Pap smear? ☐ No ☐ Yes If yes, date: _____ Doctor: _____

Do you have a history of abnormal pap smears? ☐ No ☐ Yes If yes, please give date, treatment, and doctor below:

Date: _____ Doctor: _____ Treatment: _____

Have you ever had a mammogram? ☐ No ☐ Yes If yes, date: _____ Doctor: _____

Do you have a history of abnormal mammogram? ☐ No ☐ Yes

Current method of birth control: _____

Have you ever had any of the following? (*Please check below and tell us when*)

☐ Chlamydia When? _____
☐ Gonorrhea (clap, GC) When? _____
☐ Infected tubes or ovaries When? _____
☐ Vaginal infections When? _____
☐ Blood in urine When? _____
☐ Infection of bladder or kidney When? _____
☐ Trouble starting to urinate When? _____
☐ Loss of urine with cough or sneeze When? _____
☐ Any other problems with female organs? Please describe: _____

Intercourse and Contraception

Have you ever had sexual intercourse? ☐ No (*If no, please skip to "Hair and Skin" section*) ☐ Yes (*Please continue this section*)

How often do you have sexual intercourse? _____ times per _____

Do you have orgasms (climax)? ☐ No ☐ Yes If yes, how often? _____

Do you have any discomfort or pain with intercourse? ☐ No ☐ Yes Describe: _____

Circumstance: _____ Severity: _____ Change: _____

Do you have a happy sex life? _____ Do you use lubricant? ☐ No ☐ Yes If yes, which one? _____

Have you ever had any problems with any methods of contraception? ☐ No ☐ Yes

If yes, please explain: _____

Hair and Skin

Are you troubled by excessive hair growth? ☐ No ☐ Yes

If yes, please describe: _____

Have you noticed hair loss from your scalp? ☐ No ☐ Yes

If yes, please describe: _____

Do you have acne? ☐ No ☐ Yes

PREGNANCY

Have you ever been pregnant? ☐ Yes ☐ No *(If no, please skip to the next section; medical history)*

Fill in the number of the following:

Term deliveries *(baby weighted over 5.5 pounds at birth and was born at least 37 weeks of pregnancy)* _____

Premature deliveries *(over 5 months pregnancy but baby weighed under 5.5 pounds)* _____

Miscarriages *(before 5 months)* _____

Abortions _____

Ectopic pregnancies _____

Children now living _____

Multiple gestations _____

If you have had any TERM or PREMATURE deliveries, please fill in this section. If you need room for additional deliveries, hit add item.

* Your due date was 40 weeks. If you delivered one week late, write 41. If you delivered three weeks early, write 37, and so on.

Delivery date: _____ * Weeks of pregnancy: _____ Length of labor: _____ Type of anesthesia: _____

Delivery type: _____ Hospital: _____

Boy or Girl? _____ Weight (pounds, ounces): _____

Delivery date: _____ * Weeks of pregnancy: _____ Length of labor: _____ Type of anesthesia: _____

Boy or Girl? _____ Weight (pounds, ounces): _____

If you have had any Abortions or Miscarriages, please fill in this section. If you need additional room hit add item.

Month/Year _____ ** Weeks of pregnancy: _____ Doctor's Name: _____

Were you hospitalized? ☐ yes ☐ No ☐ Miscarriage ☐ D & C (*scrape uterus*)

** Please give the number of weeks between last normal menstrual period and termination or miscarriage of pregnancy.

Please list any additional pregnancies on the last page, or attach an additional page.

MEDICAL HISTORY

Current medical problems: _____

Have you ever had any serious illnesses, injuries, or hospitalizations other than listed above? ☐ Yes ☐ No

Date: _____ Problem: _____

Treatment: _____

Date: _____ Problem: _____

Treatment: _____

SURGERIES - Please list any surgeries below.

Date: _____ Procedure: _____

Date: _____ Procedure: _____

MEDICATIONS - Please list any medications you take below.

Medication: _____ Dose: _____ Prescriber: _____

Medication: _____ Dose: _____ Prescriber: _____

ALLERGIES - Please list and allergies you may have.

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

SOCIAL HISTORY & HEALTH MAINTENANCE

Occupation: _____ Are you satisfied with your work? _____

Please check

☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced

Partner's name: _____ Years with current partner? _____

Do you smoke tobacco? ☐ No ☐ Yes *(If yes, please answer the following)* If yes, how many packs per day? _____

For how many years? _____ Previous tobacco use - Start date: _____ Quit date: _____ Packs per day _____

Do you use any other tobacco products? ☐ No ☐ Yes Are you currently, or have you in the past lived or worked in an environment where you were exposed to second-hand smoke? ☐ Yes ☐ No ☐ Currently ☐ Previously

Do you drink alcohol? ☐ No ☐ Yes *(If yes, please answer the following)*

Oz. of Liquor _____ per _____ 12 oz glass(es) of beer _____ per _____ 6 oz. glass(es) of wine _____ per _____

Have you ever used any non-prescription drugs such as: *(If yes, please indicate last date used)*

☐ Marijuana Last used: _____ ☐ LSD, STP, etc. Last used: _____

☐ Heroin, etc. Last used: _____ ☐ Morphine, Demerol, etc. Last used: _____

☐ Barbiturates Last used: _____ ☐ Injected drug of any kind Last used: _____

Have you ever been treated or diagnosed for anorexia or bulimia? ☐ No ☐ Yes If yes, when? _____

Have you ever been the victim of sexual, physical, or emotional abuse? ☐ No ☐ Yes

How many days a week do you exercise? _____ Type of exercise? _____

Calcium intake: How many servings of dairy per day? _____ Calcium supplements: How many mg per day? _____

Caffeine use: What is the average number of drinks per day (*coffee, soda, tea, etc.*)? _____

What percentage of time do you wear a seatbelt? _____ How often are you out in the sun? _____

Hobbies/Activities? _____

FAMILY HISTORY

Please list any members of your family who have had significant medical problems (*such as diabetes, high blood pressure, heart attack, cancer)*:

RELATIONSHIP MEDICAL PROBLEM(S)

- [ ] Maternal grandmother _____
- [ ] Maternal grandfather _____
- [ ] Paternal grandmother _____
- [ ] Paternal grandfather _____
- [ ] Mother _____
- [ ] Father _____

SIBLINGS

- [ ] Brother _____
- [ ] Sister _____
- [ ] _____
- [ ] Children _____
- [ ] Children _____

Has anyone in your immediate family or among grandparents, aunts, uncles, and first cousins had any of the following diseases or problems?

- [ ] congenital abnormalities - i.e., any defects present at birth or any disorders which "run in the family"
- [ ] Infertility - i.e., difficulty getting pregnant for any reason
- [ ] Delayed puberty - i.e., didn't shave, didn't menstruate or develop breasts
- [ ] Breast, ovarian, or endometrial cancer
- [ ] Frequent miscarriages

REVIEW OF SYSTEMS

Please check off any issues you have now or have had in the last year.

Constitutional

- [ ] Chills
- [ ] Fever
- [ ] Feeling poorly
- [ ] Tired
- [ ] Weight gain
- [ ] Weight loss

Eyes

- [ ] Blurred vision
- [ ] Double vision
- [ ] Painful eyes
- [ ] Itchy eyes
- [ ] Change in vision
- [ ] Wear glasses

Mental Health

- [ ] Depression
- [ ] Anxiety
- [ ] PTSD
- [ ] Suicidal thoughts
- [ ] Bipolar
- [ ] Excessive anger

Ear, Nose, Throat

- [ ] Ear ache
- [ ] Loss of hearing
- [ ] Nosebleeds
- [ ] Ringing in ears
- [ ] Sore throat

Genitourinary

- [ ] Painful urination
- [ ] Leaking urine
- [ ] Blood in urine
- [ ] Vaginal discharge

Endocrine

- [ ] Always hot
- [ ] Always cold
- [ ] Tired/sluggish
- [ ] Excessive thirst
- [ ] Excessive hunger

Cardiovascular

- [ ] Chest pain
- [ ] Palpitations
- [ ] Fast pulse
- [ ] Slow pulse
- [ ] Leg pain w/exercise
- [ ] Ankle/feet swelling
- [ ] Varicose veins

Musculoskeletal

- [ ] Joint pain
- [ ] Muscle pain
- [ ] Muscle cramps
- [ ] Neck pain
- [ ] Low back pain
- [ ] Joint swelling
- [ ] Joint stiffness

Neurological

- [ ] Numbness
- [ ] Tingling
- [ ] Weakness
- [ ] Dizziness
- [ ] Tremors
- [ ] Confusion
- [ ] Headaches

Skin

- [ ] Skin Lesions
- [ ] Rash
- [ ] Itching
- [ ] Change in a mole
- [ ] Boils/cysts
- [ ] Unusual growth
- [ ] Acne/breakouts
- [ ] Unwanted hair growth

Respiratory

- [ ] Cough
- [ ] Wheezing
- [ ] Shortness of breath
- [ ] Snoring

Blood and Lymph

- [ ] Easy bleeding
- [ ] Easy bruising
- [ ] Swollen glands
- [ ] Blood Clots
- [ ] Anemia

Gastrointestinal

- [ ] Abdominal pain
- [ ] Nausea
- [ ] Vomiting
- [ ] Constipation
- [ ] Diarrhea
- [ ] Heartburn
- [ ] Blood in stool
- [ ] Hemorrhoids

Other

- [ ] Sleep too much
- [ ] Sleep too little
- [ ] Can't fall asleep
- [ ] Can't stay asleep
- [ ] Breast lump
- [ ] Breast tenderness
- [ ] Period Cramps
- [ ] Painful Sex

Please describe below any symptoms and/or problems we didn't ask you about that you feel are important.

Thank you for taking the time to complete our questionnaire. Please save your completed form to your computer and then send as an attachment via email to The Fertility Center of Oregon at FCONP@womenscare.com

Race/Ethnicity	**Preferred Language**	
☐ American Indian/ Alaska Native	☐ Arabic	☐ Chinese
☐ Asian	☐ English	☐ French
☐ Black/African American	☐ German	☐ Hindi
☐ Caucasian	☐ Italian	☐ Japanese
☐ Hispanic or Latin/o/a/x	☐ Korean	☐ Mandarin
☐ Native Hawaiian or Pacific Islander	☐ Polish	☐ Portuguese
☐ Decline	☐ Spanish	☐ Thai
☐ Other	☐ Vietnamese	☐ Other
		☐ Declined

The Federal Offices of the Centers for Medicare and Medicaid Services is asking health care providers to submit data on race and ethnicity in their effort to end disparities in health care.

Your participation is entirely voluntary and answers are confidential.

Women's Care OBSTETRICS, GYNECOLOGY & MIDWIFERY CENTER

FERTILITY CENTER of OREGON

Patient			
Preferred Name/Maiden Name/Other			
Date of Birth (MM/DD/YYYY)		Phone number	
Street Address or PO Box			
City	State	Zip Code	

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize the use and disclosure of a copy of the specific health and medical information as described below:

To: The Fertility Center of Oregon — 541-683-1559
Individual or Facility — Phone Number

590 Country Club Parkway, Ste A, Eugene OR, 97401 — 541-683-1709
Mailing Address, City/State, Zip — Fax Number

From: _____ _____
Individual or Facility — Phone Number

_____ _____
Mailing Address, City/State, Zip — Fax Number

The purpose of this request is:
- ☐ Referred Medical Care
- ☐ Transferring Primary Care
- ☐ Relocation
- ☐ Personal Preference
- ☐ Clinical Research
- ☐ Billing Purposes
- ☐ Personal Request
- ☐ Legal Matter
- ☐ Other: _____

The purpose of this request is at the request of the individual

Please INITIAL all types of Information to be released:

- ☐ *All Medical Records (Last 2 years)
- ☐ Hospital Records/Consultations
- ☐ Imaging Reports
- ☐ Physician Notes
- ☐ Immunization Records
- ☐ Other: _____
- ☐ Lab/Pathology Reports
- ☐ Billing Information

*All Medical Records includes Physician Notes, Lab/Pathology reports, Hospital Records/Consultations and Immunization Records for the last 2 years unless otherwise specified

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I **place my initials** in the applicable space next to each type of information:

- ____ Drug/Alcohol diagnosis, treatment or referral information
- ____ Mental Health information – including provider notes
- ____ HIV/AIDS information
- ____ Genetic testing Information

Copy Format: Electronic Paper Fax

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. I specifically give authorization to fax or electronically provide my medical information. I understand that risk is involved in electronically transmitting records and confidentiality at the receiving end cannot always be guaranteed. All disclosed information will contain a confidentiality statement and instructions for returning misdirected information. ____ (INITIALS)

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that, you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to: *Women's Care HIPAA Compliance Officer, P.O. Box 70368 Springfield Oregon 97475* that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. Records will be released within 30 days of receipt of this authorization.

This Authorization will expire on the earlier of _____ (date), 365 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

_____ Date: _____
Signature of Individual or Personal Representative

_____ _____
Description of Representative's Authority — (For internal use - Center for Genetics Patient)

FERTILITY CENTER of OREGON

Financial Agreement

Thank you for trusting The Fertility Center of Oregon to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Date:_____ Printed Full Legal Name: _____

Patient Signature: _____

Date:_____ Printed Full Legal Name: _____

Parent/Guardian Signature:_____

Insurance

Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits.

As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

Medicare

We participate in the Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered. We may ask you to sign an Advanced Beneficiary Notice, which lists our fee and notifies you of your financial responsibility for certain medical services.

Managed Care

Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations, it is important that we have your current insurance information. Depending on individual policies, your provided care may not have a covered benefit. **It is your responsibility to check for optimal coverage by your insurance company. Please contact your insurance company with questions regarding your coverage.**

Patient Responsibility for Payment:

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your visit. Patient due balances noted on your monthly statement are due within 30 days of receipt.

Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.

OB Care and Delivery

OB patients will meet with our business office representatives to discuss insurance coverage and payment options. Automatic payments from your bank account are available for your convenience.

Deposits:

New patients without insurance, or if insurance co-payment cannot be verified, are required to pay a deposit on or before the first date of service. If insurance payment results in a credit balance, it will be refunded to you.

Payment Options:

We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our Business Office at (541) 868-9759 to make payment arrangements.

We offer uninsured patients a 20% discount for payment by cash, check or credit card received on the date of service or as soon as charges are available for the service. Discount does not apply to infertility services, lab, or supply charges.

Non-Payment:

Failure to pay may result in your account being referred to a collection agency, which may affect your credit. Please contact our business staff to discuss payment arrangements. Referral to a collection agency, or naming The Fertility Center of Oregon in a bankruptcy filing, may result in dismissal from our practice.

If we refer your account for legal action, you will be charged a processing fee and any applicable legal fees.

FERTILITY CENTER of OREGON

ACKNOWLEDGEMENT AND CONSENT

Full Legal Name: _____ Date of Birth: _____

I understand that The Fertility Center of Oregon, (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area and online at www.fertilitycenteroforegon.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices and The Fertility Center of Oregon will honor that request if approved.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Date: _____ By: _____
(Patient signature)

OR

Patient representative's full legal name: _____

Description of Representative's Authority: _____

Date: _____ By: _____
(Patient representative signature)

Fact Sheet for Health Care Consumers
Genetic Privacy & Research

Oregon's first genetic privacy laws were passed in 1995 with a goal of trying to help protect your genetic information and prevent possible employment or insurance discrimination to health care consumers like yourself.

In 2005, a few changes were made in Oregon laws about when results of a genetic test, specimens collected (such as blood or tissue), or health care information may be available for certain types of genetic research. You will be asked to make decisions about this starting in 2006.

What is the same?

- If genetic test results, specimens collected or health care information can be linked to you (for example if it includes your name or address or birth date) the researcher must still get your permission before using this information for genetic research.

What is new?

- If genetic test results, specimens collected or other health care information does not include any information that can be linked to you (or there is only a code and the key to the code is kept separately) the new law allows researchers to access these and ask permission of an independent review board (called an IRB) to use the test results, specimens collected or health care information for what is called “anonymous” or “coded” genetic research.
- The new law requires you to make a decision regarding use of your health information in anonymous or coded genetic research.
- As a result, starting July 1, 2006, the new law requires that your doctor or health care provider give you notice and asks you to complete a form at least once and mark if you DO NOT want any of your specimens or health care information available for anonymous or coded genetic research. This is often called an “opt-out” form.

Why was the change made?

- Many people want to keep their health care information, including their genetic information, private. Many people also recognize that medical and genetic research can help develop new information that allows both patients and doctors to learn more about diseases, make good health care decisions, and discover new treatments.
- The new law tries to balance the interests of those who want to keep their genetic information private by allowing them to make a decision to "opt-out" while allowing researchers to do genetic research needed to make good health care decisions by you and your health care providers.

What do I need to do?

- You will need to make a personal decision on whether your genetic test results, specimens collected or health care information will be available for anonymous or coded genetic research.
- If you DO NOT want your results of a genetic test, specimens collected or health care information available for anonymous or coded genetic research you must mark that place on the form provided by your doctor or health care provider
- If you DO want the results of a genetic test, specimens collected, or your health care information available for anonymous or coded genetic research, you don't need to do anything.
- In either case, your health care provider is responsible for providing a notice and form for you to mark. This only needs to happen once, not at every visit.
- If you change your mind in the future, it is YOUR responsibility to inform your health care provider and it would only affect results of genetic tests, specimens collected or health care information from that date forward.

Where can I get more information?

Talk to your doctor or health care provider.
The Oregon Genetics Program - (971) 673-0271 or
www.healthoregon.org/genetics

The Fertility Center of Oregon

Notice of your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect the genetic privacy of individuals. These laws give you the right to refuse to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a review board reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants. With the exception of anonymous or coded research, use of your health information or biological samples for genetic research requires your specific written consent.

In anonymous research, personal information that could be used to identify you, like your name or medical record number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, **you don't have to do anything**. If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

If you decline to have your health information and biological sample available for anonymous or coded genetic research, **you must tell your health care provider** by:

- Completing this form and giving it to your health care provider.

Your decision is effective on the date you sign this form. No matter what you decide now, you can always change your mind later. If you change your mind, inform us of your decision in writing. The new decision will apply only to health information or biological samples collected after we receive this completed form.

If you have any questions or concerns about this notice, please contact our laboratory manager at 541-683-1559.

☐ **By checking this box and signing below I decline to have my health information and biological samples available for anonymous and/or coded genetic research.**

Date: _____

Patient's printed full legal name: _____

By: _____
(Patient signature)

OR

Patient representative's printed full legal name: _____

Description of representative's authority: _____

By: _____
(Patient representative signature)