Coastal Fertility Medical Center | RSMC Irvine

Medical Director: Lawrence B. Werlin M.D.

Contact Information

Patient

First Name *	Last Name *	Middle Initial	Marital Status

Best Ph # To Reach You *	OK to leave a message?	2nd Best Ph # To Reach You	OK to leave a message?
	☐ Yes ☐ No		☐ Yes ☐ No

Date Of Birth *	E-mail *	Age *	Address *

City *	State *	Zip Code *	DRIVER'S LIC

State	Occupation	Work Hours	Employer

City	State	Zip Code

Do You have Partner?

☐ ☐

Yes No

If yes:

Partner

First Name *	Last Name *	Middle Initial	Marital Status

Best Ph # To Reach You *	OK to leave a message?	2nd Best Ph # To Reach You	OK to leave a message?
	☐ Yes ☐ No		☐ Yes ☐ No

Date Of Birth *	E-mail *	Age *	Address *

City *	State *	Zip Code *	DRIVER'S LIC

State	Occupation	Work Hours	Employer

Referral information

WHOM MAY WE THANK FOR THIS REFERRAL? *

☐ Physician ☐ Friend
☐ Seminar ☐ Internet
☐ Support Group

Name of the referrer:

Insurance information

Patient

PRIMARY INS | Insured's Name | Insurance ID | Type

CLAIMS ADDR | City | State

Zip Code | Phone | Do you have partner?

☐ Yes ☐ No

Emergency contact person (not living with you) | Relationship | Insured's Name

Insured | Do you have document to upload?

☐ Yes ☐ No

Patient's signature * | Date

Partner's signature | Date

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CONTACT INFORMATION

Primary Patient

☐ Has a Uterus ☐ Has a Penis

First Name * | Middle Initial | Last Name * | Age *

Date of Birth (MM/DD/YY) * | Occupation | Home Street Address * | City *

State * | Zip/Postal Code * | Country * | E-mail *

Indicate which number to call or leave messages

Phone (Home) | Phone (Work)

Do you have a spouse/partner?

☐ Yes ☐ No ☐ Divorced ☐ Other

If yes (Spouse/Partner):

First Name * | Last Name * | Age * | Date of Birth (MM/DD/YY) *

Occupation | Home Street Address * | City * | State *

Zip/Postal Code * | Country *

Physician Notes (For office use only)

Who is your Primary Care Physician?

Name * | Phone

Coastal Fertility Medical Center | RSMC Irvine

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Family History Questionnaire

Genetic Family History & Pregnancy Questionnaire

Date of Appointment (mm/dd/yyyy)

Patient Information

Patient's Name	Date Of Birth	Occupation	Address

City	State	Zip	Home Phone

Work Phone	Cell Phone	Referring Physician's Name	Referring Physician's Phone Number

Partner Information

Partner

☐ Yes ☐ No

If yes (Partner):

Partner's name *	Date of Birth (MM/DD/YY) *	Occupation *

The following questions may help your doctor or genetic counselor complete a genetic risk assessment and determine if certain genetic tests are appropriate. If you are unsure about your family history, please speak with family members.

Patient

☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian

☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese

☐ Jewish, French Canadian or Cajun

☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American

☐ Hispanic or Mexican

☐ Caucasian

☐ Other (specify)

Specific

Partner

☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian

☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese

☐ Jewish, French Canadian or Cajun

☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American

☐ Hispanic or Mexican

☐ Caucasian

☐ Other (specify)

Specific

Both

☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian

☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese

☐ Jewish, French Canadian or Cajun

☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American

☐ Hispanic or Mexican

☐ Caucasian

☐ Other (specify)

Specific

Have you, your partner or anyone in your families ever had the following conditions

Down Syndrome		Other Chromosome problems		Mental retardation, autism, or developmental delay		Spina bifida (open spine)	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Anencephaly (opening in head/brain		Blood disorder, such as hemophilia or sickle cell		Muscular dystrophy or neuromuscular disease		Cystic fibrosis	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Neurofibromatosis		Skeletal disorder, like dwarfism		Polycystic kidney disease		Cystic fibrosis	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Heart defect		Cleft lip/cleft palate		Blindness/deafness		Baby who died at birth or within first year	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Stillborn or 2 or more pregnancy losses		Any birth defect not in this list		Any other inherited (genetic) condition		Any other serious medical condition or surgery	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Are you or your partner adopted?		Are you and your partner related to each other (other than by marriage)?		Is there a history of infertility in either you and /or your partner?		Please specify the cause of infertility, if known
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	

Have you and / or your partner had:

Carrier testing for cystic fibrosis?		Carrier testing for any other genetic disorder?		Blood chromosome testing?	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Are you taking the following:

Medications		Recreational Drugs		Alcoholic drinks		Cigarette smoking	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

If yes please list *

Do you have diabetes, PKU (phenylketonuria) or lupus?

☐ Yes ☐ No

Are you considering or have you used:

Egg donor?

☐ Yes ☐ No

Donor sperm?

☐ Yes ☐ No

Preimplantation Genetic Diagnosis (PGD)

☐ Yes ☐ No

Preimplantation Genetic Screening (PGS)?

☐ Yes ☐ No

Intracytoplasmic sperm injection (ICSI)?

☐ Yes ☐ No

☐ I have answered these questions to the best of my knowledge.

Patient Signature

Date (mm/dd/yyyy):

Coastal Fertility Medical Center | RSMC Irvine

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Permission to Contact Insurance Carrier and Agreement of Financial Responsibility AUTHORIZATION FOR COASTAL FERTILITY MEDICAL CENTER / REPRODUCTIVE SPECIALTY LABS TO CONTACT MY INSURANCE CARRIER

☐

I authorize Coastal Fertility Medical Center/Reproductive Specialty Labs to inquire on my behalf, regarding information about my benefits and coverage. I also authorize the release of any medical or other information necessary to process my insurance claim(s)

Patient Signature *

Date (Patient):

AGREEMENT OF FINANCIAL RESPONSIBILITY and AUTHORIZATION TO BILL DESIGNATED INSURANCE CARRIER(S)

☐

I authorize Coastal Fertility Medical Center (CFMC) / Reproductive Specialty Labs (RSL) to bill my insurance carrier(s), and I also authorize benefits to be paid directly to CFMC and RSL. If my insurance carrier, for any reason, will not cover a particular treatment, medication, or procedure, either in full or part, I understand, and agree it is my responsibility to remit payment in full, unless prior written arrangements have been made with the CFMC/RSL billing department

Patient Signature *

Date (Patient):

SIGN BELOW ONLY IF YOU DO NOT WANT US TO CONTACT YOUR INSURANCE CARRIER

DO NOT CONTACT INSURANCE CARRIER

I wish to be a cash account. PLEASE DO NOT CONTACT MY INSURANCE CARRIER FOR ANY REASON, unless I request (in writing) for you to do so.

Patient Signature*

Date (Patient):

Coastal Fertility Medical Center | RSMC Irvine

Medical Director: Lawrence B. Werlin M.D.

Dear Patient: To assist you in understanding your infertility benefits, we ask that you call your insurance company and ask the following questions. This will give you a better understanding of how your insurance may cover your treatment at Coastal Fertility Medical Center.

Does my health plan participate with Lawrence Werlin, M.D. or Coastal Fertility Medical Center?

- Does my health plan participate with Lawrence Werlin, M.D. or Coastal Fertility Medical Center? (TAX I.D.# 33 0870026)
- Do I have infertility benefits? If yes, then ask the following questions.
- Do I have out of network benefits?
- If you have a POS plan, ask the clerk which tier offers the best infertility coverage.
- What services are covered for infertility?
    - Consultation
    - Second Opinion?
    - Diagnostic Testing?
    - Diagnostic or Corrective Surgery?
    - Medications:
        - Oral:
        - Self Injectable:
- Treatment:
    - IUI (artificial insemination) IVF (in-vitro fertilization)
- Do I have any limits on number of attempts?
- Do I have any monetary limit?
- What is my deductible?
- Do I have an out of pocket maximum?
- Do I need pre-certification?

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Email Consent

Patient Name*

Patient E-mail Address:*

RISK OF USING EMAIL

Coastal Fertility Medical Center (CFMC) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect e-mails transmitted through their systems,
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court

CONDITION FOR THE USE OF E-MAIL

CFMC will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, CFMC cannot guarantee the security and confidentiality of e-mail communication and will not e liable for improper disclosure of confidential information that is not caused by Provider’s intentional misconduct. Thus, patients must provude written consent, except as authorized or required by law.

Consent to the use of e-mail for patient information. Consent to the use of E-mail includes agreement with the following conditions:

- All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals,

authorized to access the medical record, such As staff and billing personnel, will have access to those e-mails.

- Your Provider may forward e-mails internally to CFMC staff and agents as necessary for diagnosis, treatment, reimbursement, health care operations, and other handling .Your Provider will not, however forward e-mails to independent third parties without the patient' s prior written Consent, except as authorized or required by law.
- Although CFMC staff will endeavor to read and respond Promptly to an e-mail from the patient, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
- If the patients e-mail requires or invites a response from Provider and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The patient should not use e-mail for communicationregarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental Health, developmental disability, substance abuse.
- The patient is responsible for informing your provider of any type of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above
- The patient is responsible for protecting his/her pass word or other means of access to e-mail. CFMC is not liable for breaches of confidentiality caused by the patient or any third party.
- CFMC Providers shall not engage in e-mail communication that is unlawful, such as unlawful practicing medicine across state lines.
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS

To communicate by e-mail, the patient shall:

- Limit or avoid use of his/her employer’s computer.
- Inform CFMC of changes in his/her e-mail address.
- Put the patient's name in the body if the e-mail.
- Include the category of the communication in the e.mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that all relevant information is provided before sending to your Provider.
- Inform your Provider that the patient received an email from your Provider.
- Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by e-mail or written communication to your Provider.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between CFMC staff and me, and consent to the conditions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient signature *

Date(Patient) *

Thank you for taking the time to make this all. When you come in for your consultation, you will meet with a financial advisor who will compare notes with your research and the verification that took place in our office. If three are any discrepancies, another call will be made by our staff to give us an accurate picture of what your insurance covers.

Coastal Fertility Medical Center | RSMC Irvine

Medical Director: Lawrence B. Werlin M.D.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND ACKNOWLEDGMENT OF MEDICAL BOARD OF CALIFORNIA NOTICE TO CONSUMERS

I acknowledge that I have read the Privacy Notice

Patient or Personal Representative*

Date*

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

Patient's signature*

Date (Patient) *

☐ I HAVE READ AND AGREE TO THE FINANCIAL POLICIES ENCLOSED

Coastal Fertility Medical Center | RSMC Irvine

Medical Director: Lawrence B. Werlin M.D.

Medical Records Request Use or Disclosure Authorization

Patient's Name (print):	Birthdate: S.S.N:
Partner's Name (print):	Birthdate: S.S.N:

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I/We hereby authorize the following provider(s):

Physician's name: _____Tel:_____ **FAX:**_____

Address: _____

***** It's important that we have your doctor's fax #, please call your doctor's office for the fax #.**

To disclose the following protected health information to:

Coastal Fertility Medical Center
15500 Sand Canyon Ave., Suite 100
Irvine, California 92618 Tel: 949-726-0620 **Fax: 949-726-0653**
Attention: Lupe Castaneda

- Medical History, including specific progress notes regarding any problems that would impact my treatments progress or outcome.
- Results of relevant diagnostic or laboratory tests.
- Other _____

This protected health information is being used by the practice for the purpose of preparation treatment at the Coastal Fertility Medical Center. This authorization shall be in force and effect until _____ ***(date)***.

I understand that, as set forth in the Practice's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Coastal Fertility Medical Center, 15500 Sand Canyon, Suite 100, Irvine, California 92618, Attn: Privacy Officer

I understand that a revocation is not effective to the extent that the Practice has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to th is authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that the Practice will not condition my treatment on whether I prov ide authorization for the requested use or disclosure.

I understand that I have the right to:

- ☐ Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- ☐ Refuse to sign this authorization.

_____

Patient's signature Date

_____

Partner's signature Date

_____