FERTILITY CENTER OF SOUTHERN CALIFORNIA

4980 BARRANCA PARKWAY, SUITE 200 IRVINE, CA 92604

TEL 949-955-0072 FAX 949-955-0077

ILENE E. HATCH, M.D. CATHERINE E. GORDON, M.D.

Dear Patient,

Welcome to our office! We are pleased that you have chosen us for your fertility care. We are looking forward to providing you with the highest quality of care.

Your appointment will be on _____ at _____ am/pm.

In preparation for your first visit we have attached for the following forms for you to fill out. We prefer that you send them back to us prior to your visit via mail or fax or email, although you may choose to bring them with you to your appointment.

- ☐ **New patient information**
- ☐ **Patient Health Questionnaire**
- ☐ **Financial Policy:** Please read and initial
- ☐ **Medical Records Release Request:** Please forward this release to any physician that has records that pertain to your fertility.
- ☐ **Benefit Guideline Questionnaire:** This will help guide you when you call your insurance company for infertility benefits.
  (This is not necessary if you have an out of network insurance in which you are unable to use at our office.)

The fee for your new patient consultation will be $600. We will be glad to bill this amount to your insurance or if you are an out-of –pocket patient, the quoted day of service discounted rate will be due at the time of service.

If you have any questions regarding the paperwork or medical records that we need, please feel free to call our office at (949)955-0072.

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WHOM MAY WE THANK FOR THIS REFERRAL?

PATIENT FULL LEGAL NAME			DOB
HOME TELEPHONE	WORK TELEPHONE	CELL OR ALTERNATE TELEPHONE	
ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	MARITAL STATUS	DRIVER'S LICENSE	
OCCUPATION	EMPLOYER	EMAIL ADDRESS	
WORK ADDRESS	CITY	STATE ZIP	Preferred Pharmacy Number

PARTNER INFORMATION

PARTNER FULL LEGAL NAME			DOB
HOME TELEPHONE	WORK TELEPHONE	CELL OR ALTERNATE TELEPHONE	
ADDRESS	CITY	STATE ZIP	
SOCIAL SECURITY NUMBER		DRIVER'S LICENSE	
OCCUPATION	EMPLOYER	EMAIL ADDRESS	
WORK ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		CIRCLE ONE: HMO PPO POS
SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE	MEMBER ID:
EMPLOYER / GROUP NAME / GROUP NUMBER		CUSTOMER SERVICE / PROVIDER PHONE NUMBER

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE NAME		CIRCLE ONE: HMO PPO POS
SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE	MEMBER ID:
EMPLOYER / GROUP NAME / GROUP NUMBER		CUSTOMER SERVICE / PROVIDER PHONE NUMBER

EMERGENCY CONTACT NAME	RELATIONSHIP	TELEPHONE NUMBER

FERTILITY CENTER OF SOUTHERN CALIFORNIA WILL SUBMIT CLAIMS TO YOUR PRIMARY INSURANCE IF WE ARE CONTRACTED PROVIDERS, ONCE INSURANCE VERIFICATION OF INFERTILITY COVERAGE HAS BEEN DETERMINED. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS BE MADE DIRECTLY TO THE PROVIDER FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF MY MEDICAL INFORMATION TO INSURANCE COMPANIES FOR PAYMENT OF MY MEDICAL CLAIMS. I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR ANY BALANCE ON MY ACCOUNT FOR ALL OUTSTANDING SERVICES RENDERED.

PATIENT'S SIGNATURE DATE

PARTNER'S SIGNATURE DATE

FERTILITY CENTER OF SOUTHERN CALIFORNIA

Ilene E. Hatch, M.D. Catherine E. Gordon, M.D.

PATIENT HEALTH QUESTIONNAIRE

Referring M.D.: _____
Patient Name: _____ Date of Birth: _____
Occupation: _____
Partner's Name: _____ Date of Birth: _____
Occupation: _____
Reason for your visit: _____

GYNECOLOGICAL/OBSTETRICAL HISTORY

Age of Onset of Menses: _____ Interval from beginning of period to next period: _____
Duration of Flow: _____ Bleeding between periods: _____ Cramps with menstrual flow: ___
Pelvic Pain during cycle: _____ Date of Last Mentrual period: _____

Number of Pregnancies: _____ Abortions:_____ Miscarriages: _____ Tubal Pregnancies:_____
Children: _____ Type of Births: _____

PERSONAL HISTORY

Vaginal Discharge: ☐No ☐Yes Color: _____Irritation: ☐No ☐Yes Odor: ☐No ☐Yes
Appetite: ☐ Good ☐ Poor Weight: ☐ Steady ☐ Gaining ☐Losing
Skin Problems: _____ Excess Hair growth: ☐No ☐Yes Hair Loss: ☐No ☐Yes
Surgeries: _____
_____
Weight:_____ Height:_____ Ethnicity:_____
Allergies: _____
Medications: _____

MEDICAL HISTORY

☐ Breast discharge	☐ Diabetes	☐ Thyroid Disease	☐ Seizures
☐ Tuberculosis	☐ Migraines	☐ Asthma	☐ Hepatitis
☐ High Blood Pressure	☐ Heart Murmurs	☐ Mitral Valve Prolapse	☐ Lupus

HABITS

Do you exercise? ☐No ☐Yes Type of Exercise:_____ How often: _____
Do you smoke? ☐No ☐Yes If yes, how much _____How long? _____
Do you drink? ☐No ☐Yes If yes, how much _____ Per week? _____

PATIENT FAMILY HISTORY

Parents Alive and Well : _____
Siblings: _____ ☐ Brothers: _____ Alive & Well: _____ ☐ Sisters: _____ Alive & Well: _____
Family History of infertility: _____
Family History of miscarriages: _____
Family History of birth defects: _____

☐ Lupus	☐ Rhuematoid Arthritis	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ High Blood Pressure
☐ Hepatitis	☐ Heart Disease	☐ Colon Cancer
☐ Ovarian Cancer	☐ Breast Cancer	☐ Uterine Cancer

PARTNER'S HISTORY

Ethnicity: _____
Surgeries: _____
Allergies: _____
Medications: _____
Medical History

☐ Diabetes	☐ Thyroid Disease	☐ Seizures
☐ Tuberculosis	☐ Migraines	☐ Asthma
☐ High Blood Pressure	☐ Hepatitis	☐ Heart Murmurs

☐ Mitral Valve Prolapse ☐ Impotence ☐ Prostatitis ☐ Decreased libido

Do you exercise? ☐ No ☐ Yes Type of Exercise: _____ How often: _____
Do you smoke? ☐ No ☐ Yes If yes, how much _____ How long? _____
Do you drink? ☐ No ☐ Yes If yes, how much _____ Per week? _____

Pregnancies and Outcome: _____
Family History of infertility: _____
Family History of miscarriages: _____
Family History of birth defects: _____

Additional Comments: _____

_____

_____

_____

Patient Signature Today's Date

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION:

I hereby authorize:

Physician Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, and/or diagnosis or prognosis.

To: **Fertility Center of Southern California**
Ilene E. Hatch, M.D. and Catherine E. Gordon, M.D.
4980 Barranca Parkway, Suite 200
Irvine, CA 92604
Phone (949) 955-0072
Fax (949) 955-0077

The medical information/records will be used for the following purpose: _____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also ***initial*** to consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ HIV Diagnosis/Treatment _____
Psychiatric/Mental Health _____ Genetic Information _____
Test for Antibodies to HIV _____

DURATION This authorization shall be effective immediately and remain in effect until _____ Date

RESTRICTIONS Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative Date

_____ _____
Patient's Name (Print) Patient's Date of Birth

_____
Patient's Social Security Number

FERTILITY CENTER OF SOUTHERN CALIFORNIA

FINANCIAL POLICIES

Our continuing goal at Fertility Center of Southern California is to provide you with the quality healthcare you deserve. We have developed the following list to clarify our billing policies for you. *Please read and initial each item* as your understanding and acceptance of our financial policies.

NON INSURED-Payment is due at the time of service. You will be expected to pay on the day that services are rendered.

PPO INSURED: If you have insurance, please verify your infertility benefits. Once we have verified your infertility benefits, the information is kept in your chart and available to determine the amount due from you at each visit. If we are contracted with your insurance, we will submit claims to your insurance company.

HMO INSURED: A referral from your OB/GYN or Primary Care Physician (PCP) – depending on your medical group – is required. It is your responsibility to obtain this referral prior to your appointment. We do not see patients for office visits without a referral. If a referral has not been received in our office prior to your appointment, you will be asked to reschedule. If you have a Point Of Service (POS) plan in conjunction with your HMO through your medical group, and you did not obtain a referral, then your PPO benefits may be in effect but your out-of-pocket expenses will be greater. Many times infertility benefits are not covered at this level. Be sure to check!

VERIFICATION OF COVERAGE: is required before any insurance billing is done. If we do not have a current copy of your insurance card, you will be responsible for payment. If your insurance has changed during the course of your treatment, we will need to have the updated insurance information.

COPAYMENT, DEDUCTABLES AND NON-COVERED SERVICES: It is very important that you understand your infertility coverage. We have a very specific benefits questionnaire that is used when verifying your coverage with your insurance company. You are responsible for payment for all copays and non covered services at the time of service.

PRE-AUTHORIZATIONS: PPO and HMO insurances may require a pre-authorization for certain procedures. You should be aware of what your insurance plan "rules" are by calling and receiving your benefits. Typically pre-authorizations take 7-10 working days to receive. If an authorization is not obtained, your insurance benefit may be lowered or jeopardized.

CHANGE TO YOUR INFORMATION: It is your responsibility to notify our staff if your name, address, phone number or insurance changes. Please notify us in writing.

I have read and understand the above information _____ _____
Signature Date

If you have any questions regarding these policies, please feel free to contact our office at 949-955-0072. We will be happy to answer any questions.

FERTILITY CENTER OF SOUTHERN CALIFORNIA

Benefit Guideline Questionnaire

Date: _____

Insurance company _____
Claims Address _____
_____

Insured ID # _____ Precert phone # _____
Group # _____
Insured Name _____

Representative you are speaking with: _____

Reference # for phone call: _____

Questions to ask:

1. Do I have infertility benefits? Yes No
   a. If no, payment will be expected at time of service.
   b. If yes, continue with questions

2. Is a consultation covered? Yes No

3. What is my coverage for?

   1. Ultrasounds? _____
   2. Labwork? _____If yes, what lab is contracted with you? _____
   3. Infertility oral and injectable medications? _____

4. Is infertility diagnostic testing covered? Yes No

5. Is artificial insemination (IUI) covered? Yes No
   Is in-vitro fertilization (IVF)? Yes No
   Is zygote intrafallopian transfer (ZIFT)? Yes No
   Is egg donor or sperm donor covered? Yes No

   If yes, are there any limits to the number of attempts? _____

6. What is my out of pocket expense?
   a. Deductible: _____
   b. Coinsurance: _____
   c. Maximum Co-pay: _____
   d. Infertility Lifetime Max: _____

7. Is preauthorization required? Yes No
   If yes, for which services? _____

8. Do I have medical and pregnancy benefits? Yes No
9.
    a. What is my office visit copay? _____
    b. What is my co-insurance? _____
    c. Do I have a deductable? If so, how much has been met? _____
    d. Do I have a maximum out of pocket? If so, how much has been met? _____

10. Please send me a written copy of the information you have provided for me.

Fertility Center of Southern California believes that if you have insurance coverage your insurance company will require pre-certification or pre-authorization for the services provided here. If no authorization is obtained because inadequate information was given, you will be responsible for payment.

I understand that I am responsible for providing my medical benefits information to Fertility Center of Southern California. I agree that if I do not provide the necessary information, I will be responsible for payment.

_____ _____

Patient Signature Date