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.

FERTILITY CENTER OF SOUTHERN CALIFORNIA

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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: ______________________________

Any previous fertility treatment? (if yes, when and what type) ______________________________

PERSONAL HISTORY

Medical problems: ______________________________

☐ High blood pressure ☐ Diabetes ☐ Thyroid Disease ☐ Seizures

☐ Migraines ☐ Asthma ☐ Blood clots (DVT) ☐ Lupus

Surgeries: ______________________________

Allergies to medications: ______________________________

Medications: ______________________________

Height: _________ Weight: __________ Ethnicity: ______________________

HABITS

Do you exercise? ☐Yes ☐No Type of Exercise: ______________ How often: ____________

How much caffeine do you drink a day? ______________________________

Do you drink? ☐Yes ☐No If yes, how many drinks per week? ______________________

Do you smoke? ☐Yes ☐No If yes, how much ______________How long? ____________

Have you ever smoked? ☐Yes ☐No If yes, how much _________ When did you quit? ______

Any history of drug use? ☐Yes ☐No If yes, when and what? ______________________

GYNECOLOGICAL/OBSTETRICAL HISTORY

Age of Onset of Menses: __________ Date of last menstrual period: ______________

Number of days from beginning of period to first day of next period: ________

Duration of Flow (days): ________ How many pads/tampons per day? ______________

Bleeding between periods? ☐Yes ☐No

Pain with periods? ☐Yes ☐No Pain with sex? ☐Yes ☐No

Date of last Pap Smear ______________ Any previous abnormal Pap smears? ☐Yes ☐No

Have you used birth control in the past? ☐Yes ☐No If yes what type? ________________

Date of last Mammogram (if over 40-years-old) ____________

Have you ever been diagnosed with an STD? ☐Yes ☐No

Number of Pregnancies: _____

Miscarriages: ______ Ectopic Pregnancies: ____ Terminations: ____

Preterm delivery (<37 weeks): ________ Full term delivery (>37 weeks): _________

Type of Birth(s): ☐ vaginal ☐ C-section

PATIENT FAMILY HISTORY

Ovarian cancer ☐Yes ☐No If Yes, who and at what age? ______________________
Colon cancer ☐Yes ☐No If Yes, who and at what age? ______________________
Breast cancer ☐Yes ☐No If Yes, who and at what age? ______________________
Uterine cancer ☐Yes ☐No If Yes, who and at what age? ______________________
Infertility ☐Yes ☐No If Yes, who? ______________________
Miscarriage ☐Yes ☐No If Yes, who? ______________________
Birth defects ☐Yes ☐No If Yes, who? ______________________
Genetic conditions ☐Yes ☐No If Yes, who and what type? ______________________
Autoimmune disease ☐Yes ☐No If Yes, who and what type? ______________________
Bleeding disorders ☐Yes ☐No If Yes, who and what type? ______________________
Blood clots in legs or lungs ☐Yes ☐No If Yes, who? ______________________
Tremor/ataxia ☐Yes ☐No If Yes, who? ______________________
Intellectual delay ☐Yes ☐No If Yes, who? ______________________

SYMPTOM REVIEW

Do you have any of the following?

☐ Fevers	☐ Chest pain	☐ Shortness of breath	☐ Nausea
☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Burning on urination
☐ Dry skin	☐ Brittle nails	☐ Thinning of hair	☐ Heat intolerance
☐ Cold intolerance	☐ Palpitations	☐ Easy bleeding	☐ Blood clots (DVT)
☐ Headache	☐ Vision changes	☐ Nipple discharge	☐ Acne
☐ Excessive thirst	☐ Urinating often	☐ Dark hair on face/body	

MALE PARTNER'S HISTORY (if applicable)

Medical problems: ______________________
Surgeries: ______________________
Medications: ______________________
Allergies to medications: ______________________ Ethnicity: ______________________

Do you exercise? ☐Yes ☐No Type of Exercise:____________ How often: ____________
Do you smoke? ☐Yes ☐No If yes, how much ____________ How long? ____________
Have you ever smoked? ☐Yes ☐No If yes, how much ____________ When did you quit? ______
Do you drink? ☐Yes ☐No If yes, how many drinks per week? ______________________
Any previous drug use? ☐Yes ☐No If yes, when and what? ______________________

Any pregnancies with a previous partner?
If yes, how many? ____________
What was the outcome(s) [delivery, miscarriage, termination]? ______________________

Have you ever been diagnosed with an STD? ☐Yes ☐No

Any history of the following?

☐ Childhood illness ☐ Hernia repair ☐ Testicular trauma ☐ Testicular tumor
☐ Mumps after puberty ☐ Steroid use ☐ Exposure to chemicals or radiation
☐ None of above

Do you have any issues getting or maintaining an erection? ☐Yes ☐No
Do you have problem with ejaculation? ☐Yes ☐No
Do you have normal libido? ☐Yes ☐No
Do you have normal energy? ☐Yes ☐No
Do you spend time with direct heat to the testes (hot tubs, saunas, long bike rides)? ☐Yes ☐No
Have you ever had a semen analysis? ☐Yes ☐No If yes, what was the result? ______________

Family History:

Infertility	☐Yes	☐No	If yes, who? ______________________________
Miscarriage	☐Yes	☐No	If yes, who? ______________________________
Birth defects	☐Yes	☐No	If yes, who? ______________________________
Genetic conditions	☐Yes	☐No	If Yes, who and what type? ____________________
Cancer	☐Yes	☐No	If yes, who and what type? ____________________
Tremor/ataxia	☐Yes	☐No	If Yes, who? ______________________________
Intellectual delay	☐Yes	☐No	If Yes, who? ______________________________

Additional Comments: ____

____

____

____
Patient Signature Today's Date

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.

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

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