5455 Wilshire Blvd. Suite 1904, Los Angeles, CA 90036, Tel 323-525-3377 Fax 323-525-3376 chaivf.com

First Name		**Last Name**			
Date of birth		**Phone Number**			
Address					
City		**State**		**Zip Code**	
Spouse/Partner First Name		**Spouse/Partner Last Name**			
Spouse/Partner Date of birth		**Spouse/Partner Phone Number**			

Authorization to Release Medical Information

<u>Contact via Voicemail/Email Authorization</u>

During the course of your treatment, we will need to contact you periodically with test results, embryo status reports, appointment dates/times and other pertinent information. In an effort to respect your privacy, please indicate your preferences from the selections below.

☐ **Yes, leave a voicemail message on my home phone, mobile phone, or send an email.**

Home phone # ____________ Mobile phone # ____________

Send me an email at ____________

☐ **No, I do not authorize any voicemails or emails. I will call the office for my results.**

<u>Consent to Share Information</u>

Infertility involves treatments with both male and female partners, please select and authorize your preference.

☐ **Yes, I authorize CHA Fertility Center to leave confidential information such as test results, embryo status reports, and/or treatment and appointment information directly with my spouse/partner or on my spouse/partner's voicemail whenever I am not available unless I request otherwise.**

☐ **No, I do not authorize any information whatsoever regarding my personal medical treatment and/or any results to my partner.**

I understand that my treatment medical records will be maintained jointly with my spouse/partner throughout my infertility care at CHA Fertility Center. ______ (Initial)

Print First and Last Name **Signature** **Date**

Print First and Last Name (spouse/partner) **Signature** **Date**

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NEW PATIENT CONSULTATION
CLINICAL QUESTIONNAIRE

Please complete this questionnaire and bring to your appointment. Feel free to retain a copy for your records. Please let us know if you have any questions or require translation assistance. Thank you!

I confirm that I will read and complete this questionnaire in its entirety and will provide information truthfully and accurately to the best of my knowledge.

Patient's Full Name: ____________________

Patient's Signature: ____________________ Date: __________

Your Partner's Full Name: ____________________

Reason for Visit:

☐ Infertility Evaluation ☐ Male Infertility
☐ Egg Freezing/Fertility Preservation ☐ Gender Selection
☐ Gynecology Evaluation ☐ Other ____________________

Your Ob/Gyn's Name: ____________________ Phone: (   ) __________

Address: ____________________

When was the last time you visited your Ob/Gyn? ____________________

Your Primary Care Physician's Name: ____________________ Phone: (   ) __________

Address: ____________________

When was the last time you visited your Primary Care Physician? ____________________

Have you attended one of our Fertility Seminars? ☐ Yes ☐ No

How did you first hear about CHA Fertility Center - Los Angeles?

☐ My doctor. Name and location of doctor: ____________________
☐ My family/relative. Specify relation: ____________________
☐ Friends/Colleagues/Patients. Full Name (optional): ____________________
☐ Donor/Surrogacy Agency. Specify name of agent or agency: ____________________
☐ Internet Search. Please mark all that apply:

☐ Google ☐ Healthgrades.com ☐ YouTube
☐ Yelp ☐ Vitals.com ☐ Twitter
☐ Facebook ☐ Zocdoc ☐ Other. Specify: __________

☐ Newspaper/Magazine. Specify name of publication / language: ____________________
☐ Television. Specify TV program name / language: ____________________
☐ Radio. Specify radio channel / language: ____________________
☐ Other. Specify: ____________________

What is your ancestry / ethnic background? ____________________

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FEMALE - GYNECOLOGIC HISTORY

Are you currently trying to have a baby? ☐ Yes ☐ No

How long have you been trying to have a baby? ______________________________

When was the first day of your last period? ___________________________

How old were you when you started your period? _________________________

Are your periods regular or irregular? ☐ Regular ☐ Irregular

How often do you get your periods? ____________________________

How many days of bleeding do you experience? ________________________

Have there been recent changes in your menstrual patterns? ☐ Yes ☐ No

Do you have pain with menstruation? ☐ Yes ☐ No

Do you experience pain with sexual intercourse? ☐ Yes ☐ No

Do you experience pain with ovulation? ☐ Yes ☐ No

Have you experienced abnormal hair growth on your face, chin, chest or abdomen? ☐Yes ☐No

Date of your last Pap smear? ______________

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No If yes, when? _____________

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No If yes, when? ____________

Have you ever had Pelvic Inflammatory Disease (PID)? ☐ Yes ☐ No If yes, when? _________

Have you ever used an IUD? ☐ Yes ☐ No

Have you ever used Oral Contraceptive Pills? ☐ Yes ☐ No

What type / brand? _______________________________________

Did you have any side effects / reactions? ☐ Yes ☐ No

How many years? ___________________

When did you last use the pills? ______________

Date of last Mammogram? ______________

Result: ____

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PREVIOUS FERTILITY WORKUP AND TREATMENT

Please specify if you have had any of the following tests before.

Female Assessment	Date	Result
Vaginal Ultrasound		
HSG Hysterosalpingogram (Dye test)		
Fluid Ultrasound/Sonohysterogram		
Day 3 FSH		
Anti-Mullerian Hormone		
Other Blood Tests		

Has your partner ever had a semen analysis? ☐ Yes ☐ No If yes, when? __________

Results:

Count (cell/ml) __________ Motility (%) _________ Morphology (% normal) __________

Have you ever received fertility treatments before? ☐ Yes ☐ No

If yes, please specify types of treatments and other information:

Treatment	Date	# of attempts	Outcome
Clomid and Intercourse			
Clomid and IUI			
Gonadotropins injections and intercourse			
Gonadotropin Injections and IUI			
Other			

Have you had an IVF cycle in the past? ☐ Yes ☐ No

If yes, please provide the following:

Date of IVF Cycle	# of Eggs	# of Embryos	Outcome

Did you ever use an egg donor? ☐ Yes ☐ No

Did you ever use a sperm donor? ☐ Yes ☐ No

Did you ever use a gestational surrogate? ☐ Yes ☐ No

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MEDICAL HISTORY

Please indicate if you and/or your partner have or have had any of the following conditions:

Condition	Yes	No	Comments
Anemia			
Bleeding disorders			
Blood clots in lungs or veins			
Thalassemia			
Asthma			
Pneumonia / Lung Disease			
Liver Disease / Hepatitis			
Acid Reflux / Heartburn			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Migraines / Headaches			
Multiple Births			
Birth Defects			
Inherited / Genetic Disease			
Carrier of a Genetic Disease			
Fragile X Syndrome / Pre-mutation			
Diabetes			
Thyroid Disease			
Other Hormonal Conditions			
Lupus			
Rheumatoid Arthritis			
Uterine Cancer			
Cystic Fibrosis			
Tay Sachs			
Breast Cancer			
Other Cancer			
Fibroids			
Infertility			
Endometriosis			
Ovarian Cysts			
Familial Mediterranean Fever			
Other			

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CURRENT MEDICATIONS

Please list any medications that you are currently taking.

Medication	Dose	Frequency

Are you allergic to any medications? ☐ Yes ☐ No Please list.

Medication	Reaction to the Medication

PREVIOUS SURGERIES

Procedure	Date	Outcome / Complications

Have you ever had any complications related to anesthesia? ☐ Yes ☐ No If yes, please explain:

____

OBSTETRICAL HISTORY

Have you ever been pregnant before? ☐ Yes ☐ No

Date	Current/ Prior Partner	Live Birth Y/N	Miscarriage/ Abortion/ Ectopic	Wks	Fetal Heart Y/N	D&C Y/N	Natural or C-Section	Boy or Girl	Weight

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FAMILY HISTORY

Please state if any of your family members have any of the following conditions.

Condition	Yes	No	Comments
Diabetes			
Heart Disease			
High Blood Pressure			
Stroke			
Kidney Disease			
Liver Disease / Hepatitis			
Multiple Births			
Birth Defects			
Mental Retardation			
Fragile X Syndrome / Pre-mutation			
Autism			
Inherited / Genetic Diseases			
Thyroid Disease			
Lupus			
Bleeding disorders			
Blood Clots in Lungs or Legs			
Cystic fibrosis			
Tay Sachs			
Breast Cancer			
Ovarian Cancer			
Uterine cancer			
Other Cancer			
Infertility			
Recurrent Miscarriage			
Early Menopause			
Sickle Cell Disease			
Rheumatoid Arthritis			
Thalassemia			
Familial Mediterranean Fever			
Other			

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SOCIAL HISTORY

Do you use tobacco? ☐ Yes ☐ No # of packs per day ________
Have you ever used tobacco before? ☐ Yes ☐ No # of years________

Do you use alcohol? ☐ Yes ☐ No # of drinks per week ________

Do you use recreational / street drugs? ☐ Yes ☐ No

If yes, what type and how often? ____

Do you use caffeine? ☐ Yes ☐ No

What type? ________________________ # drinks per day ________

Do you exercise regularly? ☐ Yes ☐ No

What type of exercise do you do? ____

Have you gained /lost weight in the last several years? ☐ Yes ☐ No

Gained ________ lbs Lost ________ lbs

What is your occupation?____

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to your job:

Circle a number: 1 2 3 4 5 6 7 8 9 10

Are you married? ☐ Yes ☐ No If yes, for how long? ________

How frequently do you have intercourse? ________ times per wk / mo

Do you use lubricant? ☐ Yes ☐ No

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility:

Circle a number: 1 2 3 4 5 6 7 8 9 10

Do you see a counselor? ☐ Yes ☐ No

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MALE HISTORY

Please indicate if you have had any of the following conditions or procedures in the past:

Conditions / Procedure	Date	Outcome
Orchitis / Infection of the testes		
Undescended testes		
Trauma to the groin		
Condition requiring Chemotherapy / Radiation		
Vasectomy		
Vasectomy reversal		
Hernia repair		
Varicocele ligation		
Cystic fibrosis		
Other		

Please list any medications that you are currently taking.

Medication	Dose	Frequency

Are you allergic to any medications? ☐ Yes ☐ No Please list.

Medication	Reaction to the Medication

Do you use tobacco? ☐ Yes ☐ No # of packs per day _________
Have you ever used tobacco before? ☐ Yes ☐ No # of years_________

Do you use alcohol? ☐ Yes ☐ No # of drinks per week _________

Do you use recreational / street drugs? ☐ Yes ☐ No
If yes, what type and how often? ____

What is your occupation?____ ______________________

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to your job:

Circle a number: 1 2 3 4 5 6 7 8 9 10

Do you use a hot tub? ☐ Yes ☐ No If yes, how many times per week? _______

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Are there any other aspects of your medical, surgical, family and/or social history that you think your doctor should know?

____

____

____

____

____

____

COMMENTS

____

____

____

____

____

Thank you for taking the time to complete our questionnaire. Your doctor will review this questionnaire with you.

As a part of your initial evaluation your doctor may perform a focused physical exam and a pelvic ultrasound that is directed to assess reproductive health. This exam is in no way a replacement for a comprehensive routine physical exam that you should receive annually or more frequently as indicated by your age and medical history.

I authorize CHA Fertility Center to (a) share my information with the companies and associates of CHA Fertility Center and CHA Health Systems and (b) aggregate and de-identify my patient information and use and share such aggregated and de-identified information for research and marketing purposes. My information shall not be shared outside of said parties without my written consent. I confirm that I have read this questionnaire entirely and have provided the information above truthfully and accurately.

Patient Signature: ____ Date: ____________

Partner Signature: ____ Date: ____________

I confirm that I have reviewed the information above.

Physician Signature: ______________________________________ Date: ____________

Ver.02.08.2017

CHA FERTILITY CENTER
PATIENT ACKNOWLEDGEMENT

*** Disclosure of Ownership: Your Physician <u>may</u>** have a financial interest in this facility.

PATIENT'S RIGHTS:

- Patients are treated with respect, consideration, dignity and provided appropriate personal privacy.
- Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse the release, except when release is required by law.
- Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Patients have the right to the facility's rules and regulations as they apply to their conduct, responsibilities and participation as a patient.
- The patient has the right to change their provider if other qualified providers are available.
- Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care, and related fees for services rendered.
- Be informed of charges, fees for service, payment policies, receive an explanation of your bill and receive counseling on the availability of known financial resources for health care services.
- Be informed of your right to refuse to participate in experimental research if applicable.
- Know that this facility does not honor advance directives; however, any advance directive will be noted in the patient medical record and will be communicated to other medical facilities, if a transfer is needed.
- The patient has the right to receive enough information from the physician so that he/she can understand the services being rendered in order to sign the informed consent.
- The patient may leave this facility, even against the advice of his or her physicians.
- Reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.
- Be free from all forms of abuse, discrimination, harassment or reprisal. Receives access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion, or sources of payment for care.
- Know that your physician may have financial interests or ownership in this facility.
- Know the name and role of your caregiver (e.g., doctor, nurse, technician, etc.). You have a right to request information, malpractice insurance coverage and/or credentials about the physician providing your care.
- Report any comments or voice any grievances concerning the quality of services provided to the patient during the time spent at the facility without being subjected to discrimination or reprisal and receive timely, fair follow-up on your comments.
- Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

PATIENT'S RESPONSIBILITIES:

- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours. If required by his/her provider.
- Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Be respectful of all the health care providers and staff, as well as other patients.
- Respect the privacy of other patients.
- To work with your health care team and to follow all safety rules.
- To tell your doctor about any changes in your health after you leave our facility.
- To keep, or cancel in a timely manner, your scheduled appointments for your health care.
- To tell your health care team if you wish to change any of your decisions.
- To ask for clarification if you do not understand any information or instructions given to you by your health care team.
    - **IF YOU HAVE CONCERNS:**
    - If you wish to obtain more information regarding the Privacy Notice/HIPPA Policy in our facility, please contact our receptionist to receive the CHA Fertility Center Notice of Privacy Practices or if you have any questions or concerns about your responsibilities, you can contact our administrator.

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how this facility may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to obtain payment for your health care bills, to support the operation of the physician's practice, and any other use require by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physical therapist or rehabilitation therapist that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. For example, we would send electronic communication to your physician, which included your PHI and lab results, if needed. We do this by one or more of the following: e-mail, texting, calling, and faxing.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for physical therapy may require that your relevant protected health information be disclosed to the health plan to obtain approval for therapy.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk were you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations may include, but are not limited to: as Require By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when require by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken and action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not necessarily have access to the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask this facility not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints/You have the right to file a complaint directly to the Office of Civil Rights
Complaints should be made in writing to this facility and/or the entities listed below if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer or Administrator. **We will not retaliate against you for filing a complaint.**

- **U.S. Dept. of Health & Human Services, 200 Independence Ave, Washington, D.C. 20201 (877) 696-6775**

- **State Department of Health Services- Los Angeles County**
  5555 Ferguson Drive, Suite 320, Commerce, CA 90022 (323) 890-8500

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our office manager, in person or by phone at our Main Phone Number.

Acknowledgement of Receipt

- I acknowledge that I have received a copy of the Privacy Notice/HIPAA Policy.
- I acknowledge that prior to my surgery date, I have received verbally and in writing, the following information:
  - Patient Rights and Responsibilities
  - Disclosure of Ownership

I am also aware that if I have further questions or need assistance with obtaining more information regarding these issues, I may call CHA Fertility Center at 323-525-3377.

____
Print Name Patient/Patient Representative

____
Signature Patient/Patient Representative

____
Date

____
Print Name Patient Partner/Patient Partner Representative

____
Signature Patient Partner/Patient Partner Representative

____
Date