



ART FERTILITY PROGRAM OF ALABAMA

2006 Brookwood Medical Center Drive

Suite 508

Birmingham, AL 35209

205-870-9784; 1-800-476-9784

Fax: 205-870-0698

NEW PATIENT AGENDA

Welcome to the ART Fertility Program of Alabama. We would like to provide you with an outline of what you can expect on your initial visit. Your visit will include the following:

1. A meeting with the physician to discuss:
 - Detailed patient history
 - Treatment plan
 - Risk and benefits
 - Statistics

2. Physical exam performed by the physician or the nurse practitioner. Exam includes:
 - Pap smear
 - Cervical Cultures
 - Blood work

3. A meeting with the nurse to include:
 - Details of your treatment plan
 - Office policies
 - Prescriptions/medications

4. A meeting with the financial counselor will include:
 - a. Costs associated with your treatment plan
 - b. Review of insurance coverage

5. The partner will have a semen analysis and blood drawn for required screening.



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New Patient Checklist

The following is a checklist of paperwork that you must have completed and returned before your initial visit with the physician. We request that you either send the signed and completed paperwork to Angie Champion at Honea, Houserman, Long and Allemand, PC, 2006 Brookwood Medical Center Drive, Suite 508, Birmingham, Alabama 35209 OR fax the signed and completed paperwork to Angie Champion at (205) 803-1980.

It is extremely important that we receive this paperwork as early as possible prior to your appointment. Your visit may be delayed if these forms are not completed and received prior to your arrival.

Please do Immediately

- Medical Release Form (mail to your current physician[s])

Please Complete and Sign and Return

- General Information
- Designation of Partnership
- Assignment and Instructions
- Female Patient History
- Male Patient History
- Preconception Questionnaire
- Answering Machine Consent
- Release of Results
- HIPAA Privacy Notice (send only signed pages 5 and 6, both partners must sign)

Please bring to your appointment

- Insurance Card (Patient and Partner) (we would prefer you send copies of front and back of all cards along with your paperwork)
- Driver's License (Patient and Partner)
- Information regarding your last three menstrual cycles, if applicable

Please Remember

- Discontinue smoking
- Limit/decrease your caffeine intake to one cup (coffee, tea, cola, etc.) per day
- Begin a multi-vitamin, which contains at least 0.4 mg folic acid (females)
- Abstain from intercourse 2-3 days prior to your initial appointment

Our weekend patients come from all locations to the Birmingham office for their care. Generally, the patients are scheduled at approximately 9:00 am for IUI. The IUI procedure will then be performed based on completion of the sperm prep; therefore, the time in the office may range from 1-2 hours for the patient receiving the IUI. Please be aware and plan your schedule accordingly.



ART FERTILITY PROGRAM OF ALABAMA

Kathryn L. Honea, M.D.
Virginia L. Houserman, M.D.
Cecil A. Long, M.D.
M. Chris Allemand, M.D.

MEDICAL RELEASE FORM

Date of Initial Appointment: _____

Patient Name: _____

Patient DOB: _____ Patient SS#: _____

Referring Physician: _____

Address: _____

I hereby authorize the physician listed above to disclose my health information to:

Honea, Houserman, Long and Allemand, P.C.
2006 Brookwood Medical Center Drive, Suite 508
Birmingham, Alabama 35209
Fax: 205-870-0698

Please send the following information:

- Dates of service : From _____ to _____
- Specific Records : _____
- Entire OB/GYN and pertinent medical history records related to infertility care.

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying the referring physician listed above in writing, but if I do, it will not have any effect on uses or disclosure prior to the receipt of the revocation.
4. I understand that this Authorization will expire on ____/____/____(DD/MM/YR). Date must be entered!

Signature of Patient

Date

After completing this release, please forward to your physician(s) for your medical records to be sent to our office prior to your appointment.

ART FERTILITY PROGRAM OF ALABAMA -- HONEA, HOUSERMAN, LONG & ALLEMAND
GENERAL INFORMATION

(Please Print)

Date of Appointment: _____

Patient:

Name: _____ Preferred Name: _____

Email: _____ SS# _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: () _____ Cell: () _____

DOB: _____ Age: _____ Sex: M F Race: _____ Marital Status: M D S W Other: _____

Employer: _____ Phone: () _____

Address: _____ Occupation: _____

Partner:

Name: _____ Preferred Name: _____

Email: _____ SS# _____ Cell Phone: () _____

Date of Birth: _____ Age: _____ Sex: M F Race: _____

Employer: _____ Phone: () _____

Address: _____ Occupation: _____

General:

Contact person for emergency (other than spouse): _____

Relationship to patient: _____ Phone Number(s): _____

Who is your current OB/GYN? _____

May we send an update regarding your treatment to your current physician? Yes No

What other doctor(s) would you like Honea, Houserman, Long & Allemand to update regarding your treatment plans?

1. _____ 2: _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Company: _____ Phone: () _____

Address: _____

Name of Insured: _____ Contract #: _____ Group #: _____

Secondary Insurance:

Insurance Company: _____ Phone: () _____

Address: _____

Name of Insured: _____ Contract #: _____ Group #: _____

The above information is complete and accurate to the best of my knowledge.

Patient's Signature

Date

Exhibit A

1. In vitro fertilization. This involves "in glass" fertilization and is the process of placing sperm and eggs together in the laboratory to facilitate fertilization. Services, which may be routinely covered by health insurance, may be non-covered services when rendered as part of IVF treatment. Estimated charges range from \$7200.00 to \$10,000.00. The following is included in this estimate:
 - a. Ultrasounds.
 - b. Nursing services.
 - c. Ultrasound retrieval.
 - d. Egg identification.
 - e. Semen analysis.
 - f. Semen prep for insemination.
 - g. Lab monitoring embryo development.
 - h. Embryo assessment and prep for transfer.
 - i. Ultrasound for transfer.
 - i. Embryo transfer.
 - j. Procedure room cost.
 - k. Physician services.
 - l. Blood work.
2. Inseminations. Artificial insemination is insemination of a woman using sperm from her partner or donor performed in the office setting. Estimated charge is \$375.00. Charges for donor semen samples and shipping are additional and depend on the source of samples. The following is included in this price:
 - a. Semen preparation \$160.
 - b. Insemination \$215.
 - c. Services related to the insemination procedure, such as ovulation inducement, diagnostic tests to determine ovulatory status, and office visits may not be covered. These non-covered charges can range from \$500-\$2000.
3. Cryopreservation. Estimated charge is \$770. Cryopreservation is the method used to preserve excess embryos for a future cycle.
 - a. Lab monitoring of embryos for cryopreservation.
 - b. Preparation and storage of embryos cryopreserved.

A separate \$890.00 charge is incurred for embryo thawing, embryo assessment and preparation for transfer.

The following procedures and services may also be considered non-covered under certain insurance contracts. I (we) hereby agree to pay for all charges for such services if determined to be not covered by my (our) insurance or Blue Cross and Blue Shield Preferred Care contract, which may include, but not be limited to, the following services:

- | | | | | |
|----|--|-------------------|-------|-------|
| 1. | Initial consultation | \$237 | HBcAB | \$105 |
| | Follow-up consultation | \$ 90 | HBsAG | \$ 53 |
| | Comprehensive history and physical | \$155 | HIV | \$110 |
| | Ultrasounds | \$184-240 each. | HCV | \$ 60 |
| 2. | Endocrine assays | \$1315 | | |
| | BhCG, estradiol, LH, progesterone, may include screening evaluation, FSH, prolactin, DHEAS (depending on patient). | | | |
| 3. | Medications | \$3,000 - \$6,000 | | |

I understand that prices are subject to change without notice.

Patient Date

Responsible Party Date

Partner Date

FEMALE PATIENT HISTORY -- CONFIDENTIAL - FOR OFFICE USE ONLY

Administrative Information

Social Security #: _____ Date: _____
Full Name: _____ Your Age: _____
Address: _____ Date of Birth: _____ Blood Type: _____
Country: _____ Race: _____
Marital Status: M S D W Other: _____
Telephone: (H) _____ (W) _____ (C) _____
Partner's Full Name: _____ DOB: _____ Sex: M F Social Security #: _____

Reproductive and Gynecologic History

Reproductive:

Total # of pregnancies you have achieved _____
Full term pregnancies _____ Pre-term pregnancies _____ Miscarriages _____ Therapeutic Abortions _____
living children _____ # adopted children _____

Please complete the following information regarding your pregnancies beginning with most recent:

Preg #	Date	Ectopic (Y/N)	Abortion / Miscarriage (Y/N)	Liveborn (Y/N)	Stillborn (Y/N)	Term (Y/N)	IVF Pregnancy (Y/N)
1)	_____	_____	_____	_____	_____	_____	_____
2)	_____	_____	_____	_____	_____	_____	_____
3)	_____	_____	_____	_____	_____	_____	_____

Age at first pregnancy: _____ # pregnancies with current partner: _____
deliveries by C-Section: _____ # infant deaths (past live birth): _____

Please mark "Y" or "N" in the following blanks regarding past pregnancies:

Exposure to Rubella	_____	Radiation Exposure	_____
Toxemia	_____	Prolapsed Cord	_____
Pregnancy Diabetes	_____	Uterine Dysfunction	_____
Incompetent Cervix	_____	Vaginal Bleeding	_____
Placenta Over Cervix	_____	Infection	_____
Increased Amniotic Fluid	_____	Placenta Separation	_____
Premature Labor	_____	Water Broke Prematurely	_____

Congenital Abnormalities
Specify: _____

Has anyone in your family had an infant with a congenital abnormality? _____
Specify: _____

Chromosomal Abnormalities? _____
Specify: _____

Do any chromosomal abnormalities run in your family? _____
Specify: _____

Gynecologic:

Have you ever had an abnormal Pap Smear? _____

If yes, give treatment: _____

Contraception:

	Y/N	1 st year use	Last use	Duration (years)
Birth Control Pills	_____	_____	_____	_____
IUD	_____	_____	_____	_____
Spermicide	_____	_____	_____	_____
Tubal Ligation	_____	_____	_____	_____

Please mark a "Y" in the space provided if you have been diagnosed with any of the following:

- DES Exposure _____ (Did your mother take DES while pregnant with you?)
- Primary Infertility _____ (Always infertile?)
- Secondary Infertility _____ (Infertile past previously achieving pregnancy?)
- Unexplained Infertility _____
- Ovarian Cyst _____
- Abnormal Shaped Uterus _____
- Luteal Phase Defect _____ (Abnormal progesterone level in late cycle?)
- Abnormal Uterine Bleeding _____
- Recurrent Miscarriage _____

Have you had an artificial insemination? _____ If so, how many? _____

If you have taken any of the following medications, please list the number of months in which you took them:

Clomid/Serophene	_____	HCG/Pregnyl/Profasi	_____
Danazol/Danocrine	_____	Progesterone	_____
Pergonal/Repronex/Humgon	_____	Lupron	_____
Metrodin/Fertinex/Follistim/Gonal-F	_____	Parlodel	_____

Any other medications in past or currently? Yes No

If yes, please list medication and number of months taken:

Age at first menstrual period? _____

days from beginning of period to beginning of next period? _____

Are your periods regular? _____

Duration of menstrual flow? _____

Do you experience menstrual cramping? _____

Do you bleed or spot between periods? _____

Do you use lubricants for intercourse? _____ If so, what? _____

Do you douche before or after intercourse? _____

Do you experience pain with intercourse? _____

How long have you tried to conceive? _____

Have you ever had a mammogram? _____ Results? _____

III. Medical and Surgical History

Height: _____ Weight: _____ Blood Type: _____

Are you allergic to any medications? _____

Current medications or supplements: _____

Current herbal or homeopathic therapies: _____

Hospitalizations:

	Date	Reason	Surgery	Type Surgery
1)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
2)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
3)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
4)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Have you lost or gained 20 or more pounds in the past year? _____

If yes, explain: _____

Have you ever had anorexia or bulimia? _____

Serious/Chronic Illness:

Please mark "Y" or "N" in the following blanks:

Heart Attack	_____	Endometriosis	_____	Rheumatic Fever	_____	Asthma	_____
Blood Clots	_____	Breast Soreness	_____	High Blood Pressure	_____	Neurologic Problems	_____
Stroke	_____	Breast Discharge	_____	Gallbladder Disease	_____	Pneumonia	_____
Valve Disease	_____	Hirsutism	_____	Liver Disease	_____	Anemia	_____
Depression	_____	Thyroid Problems	_____	Ulcers	_____	German Measles	_____
Anxiety	_____	Kidney Disease	_____	Diabetes	_____	Regular Measles	_____
Psychosis	_____	Bladder Infection	_____	Arthritis	_____	Blood Transfusion	_____
Hepatitis	_____	Scarlet Fever	_____	Seizures	_____	Tuberculosis	_____
Bronchitis	_____	Changes in cognition, speech, gait	_____	Exposure to tissues suspected of harboring transmissible spongiform encephalopathies:	_____	(yourself)	_____
Cancer	_____					(family member)	_____
Type:	_____	Chemotherapy?	_____	Radiation?	_____	Surgery?	_____

Please mark "Y" or "N" in the following blanks:

Gonorrhea	_____	Treatment:	_____
Syphilis	_____	Treatment:	_____
Chlamydia	_____	Treatment:	_____
Mycoplasma	_____	Treatment:	_____
Herpes	_____	Treatment:	_____
AIDS	_____	Treatment:	_____
Other	_____	Treatment:	_____

Explain _____

If you have any other serious illnesses we should know about, please list below:

Social History/Habits

Occupation _____

Are you exposed to any hazards in your job (i.e., chemicals, toxic fumes, radiation?)

Yes No

Exercise Habits: Type _____

hours per week _____

Have you ever been physically or sexually abused?

Yes No

<u>HABITS</u>	Usage*	Amt/Week	Years	Years Since Stopping
Tobacco	_____	_____	_____	_____
Reg. Coffee (cups)	_____	_____	_____	_____
Decaf. Coffee (cups)	_____	_____	_____	_____
Tea (cups)	_____	_____	_____	_____
<u>SOFT DRINKS</u>				
Regular (glass) Caffeinated	_____	_____	_____	_____
Decaffeinated	_____	_____	_____	_____
Diet (glass) Caffeinated	_____	_____	_____	_____
Decaffeinated	_____	_____	_____	_____
Art Sweeteners (# pkts)	_____	_____	_____	_____
Beer (glass)	_____	_____	_____	_____
Wine (glass)	_____	_____	_____	_____
Liquor (drinks)	_____	_____	_____	_____
<u>RECREATIONAL DRUGS</u>				
Marijuana	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
Others	_____	_____	_____	_____

* Usage = C-Current; P-Past

Family History:

<u>Reproductive:</u>	Relation*	Description	Psychiatric:	Relation*	Description
Congenital Defects	_____	_____	Depression	_____	_____
Chromosomal Abnor.	_____	_____	Anxiety	_____	_____
Uterus Abnormalities	_____	_____	Psychosis	_____	_____
Infertility	_____	_____	Other	_____	_____
<u>Other</u>			Other Illnesses:		
Cardiovascular:	_____	_____	Cancer (type)	_____	_____
Heart Attack	_____	_____	Diabetes	_____	_____
Blood Clots	_____	_____	Liver Disease	_____	_____
Stroke	_____	_____	Kidney Disease	_____	_____
Valve Disease	_____	_____	AIDS	_____	_____
High Blood Pressure	_____	_____	Other	_____	_____

** Relation = M-Mother; F-Father; B-Brother; S-Sister; C-Child; O-Other; PGM-Paternal Grandmother; PGF-Paternal Grandfather; MGM-Maternal Grandmother; MGF-Maternal Grandfather

MALE PATIENT HISTORY

CONFIDENTIAL - FOR OFFICE USE ONLY

Administrative Information

Social Security #: _____ Date: _____
 Full Name: _____ Your Age: _____
 Address: _____ Date of Birth: _____ Blood Type: _____
 _____ Race: _____
 Country: _____ Marital Status: M S D W Other: _____
 Telephone: (H) _____ (W) _____ (C) _____
 Partner's Full Name: _____ DOB: _____ Sex: M F Social Security #: _____

Male Reproductive History

Have you had a vasectomy? _____ What year? _____
 Was this reversed? _____ What year? _____

Have you ever been diagnosed with any of the following (Y or N):

Exposure to DES	_____	Hypospadias	_____
Testicular Cancer	_____	Chromosome Abnormalities	_____
Testicular Surgery	_____	AIDS	_____
Exposure to Chemotherapy	_____	Prostatitis	_____
Exposure to Radiation	_____	Testes Injury	_____
Exposure to Excessive Heat	_____	Testes Tumor	_____
Endocrine Disorders	_____	Testes Infection	_____
Mumps	_____	Bladder Infection	_____
Venereal Disease	_____	Gonorrhea	_____
Infection	_____	Syphilis	_____
Varicocele	_____	Herpes	_____
Ductal Obstruction	_____	Mycoplasma	_____
Ejaculatory Disorders	_____	Chlamydia	_____
Other Disorders	_____	Explain:	_____

Are there any hereditary/genetic illnesses that run in the family? _____
 If yes, explain: _____
 Has anyone in your family had a child with a congenital abnormality? _____
 If yes, explain: _____
 Does anyone in your family have a history of infertility? _____
 If yes, explain: _____
 Have you undergone previous treatment, surgery, or taken medication to improve the quality of your semen? _____
 If yes, please describe: _____
 Have you previously obtained a pregnancy with another partner? _____
 If yes, outcome of pregnancy: _____
 Have you ever had a discharge from your penis or a urinary tract infection? _____
 If yes, when? _____
 Name of personal physician: _____

Medical History -- MALE

Height: _____ Weight: _____ Blood Type: _____

Do you have or have you ever had (check all that apply):

Heart Disease _____	Tuberculosis _____	Measles (German) _____	Emotional Disorders _____
Hypertension _____	Colitis _____	Measles (Regular) _____	Blood Transfusion _____
Gallbladder Disease _____	Diabetes _____	Neurologic Problems _____	Hepatitis _____
Liver Disease _____	Anemia _____	Ulcers _____	Arthritis _____
Kidney Disease _____	Thyroid Problems _____	Epilepsy _____	Other _____

Have you lost or gained 20 or more pounds in the past year? _____

If yes, explain: _____

Are you taking any medications (over the counter or prescription) on a regular basis? _____

If yes, please list: _____

Allergies to medicine: _____

Current supplements: _____

Current herbal or homeopathic therapies: _____

Hospitalizations:

	Date	Reason	Surgery	Type Surgery
1)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
2)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
3)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Social History/Habits

Occupation: _____

of years: _____

Are you exposed to any hazards in your job (i.e., chemicals, toxic fumes, radiation?) Yes No

If so, please list: _____

Do you use tobacco? _____ If so, how many cigarettes per week? _____

Do you drink alcohol? _____ If so, how many glasses per week? _____

Do you use recreational drugs such as marijuana or cocaine? _____

If yes, please list: _____

Do you use saunas or hot tubs? _____ How often? _____

Exercise habits: Type: _____ Hours per week? _____

Family History

Do any members of your family have:

High Blood Pressure _____	Cancer _____
Heart Disease _____	Diabetes _____
Kidney Disease _____	Seizures _____
Other Serious Illness _____	

PRECONCEPTION GENETIC SCREENING QUESTIONNAIRE

Patient's Name: _____ DOB: _____

Partner's Name: _____ DOB: _____

Doctor/Clinic: _____ Today's Date: _____

In the event you become pregnant while in our Program, the following questionnaire will help evaluate the potential risks for your unborn baby. Your answers may indicate that certain tests would be appropriate. Please answer all questions as completely as possible. All information will be kept confidential.

				<u>ORDERS</u>
1. Are you 35 or older?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A, if male	Your due date is ___/___/___	____ CVS ____ Amnio ____ AFP, hCG, UE3
2. Are you OR your partner from any of these ethnic backgrounds?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Southern Chinese, Asian Indian, Taiwanese, Filipino or Southeast Asian Italian, Greek, Middle Eastern or Spanish	If yes, have you or your partner been tested to see if you are a carrier of thalassemia or other hemoglobin abnormality? <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If yes, who was tested and what were the results? _____	____ CBC and HgbElectrophoresis
3. Have you or your partner or any relative had a neural tube defect (such as open spine, spina bifida, anencephaly)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby's father? _____	____ Folic Acid 4 mg
4. Have you or your partner or anyone in your families been born with a heart defect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the defect. How is this person related to you or your partner? _____	____ Fetal Echocardiogram 18-20 weeks
5. Have you or your partner or anyone in your families had a pregnancy or a child diagnosed with Down syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this person related to you or your partner? _____	____ CVS ____ Amnio ____ AFP, hCG, UE3
6. Are you or your partner Jewish?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes or don't know, have either you or your partner been tested to see if you are carriers of Tay-Sachs disease, cystic fibrosis, or Canavan disease? <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If yes, who was tested and what were the results? _____	If no, check for: ____ AshKenazi Jewish Carrier Testing and Gaucher Disease
7. Are you or your partner French Canadian?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes or don't know, have either you or your partner been tested to see if you are carriers of Tay-Sachs disease? <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If yes, who was tested and what were the results? _____	If no, check for: ____ Tay-Sachs
8. Are you or your partner African American or of African descent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes or don't know, have either you or your partner been tested to see if you have sickle cell trait (are a carrier of sickle cell anemia or Thalassemia)? <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If yes, who was tested and what were the results? _____ If no, check for: _____	____ CBC and HgbElectrophoresis

				<u>ORDERS</u>
9. Do you or your partner or anyone in your families have hemophilia or another bleeding disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the disorder. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling
10. Do you or your partner or anyone in your families have a neuromuscular disease or muscular dystrophy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the disease. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling
11. Do you or your partner or anyone in your families have cystic fibrosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this person related to you or your partner? _____	____ CF Screen
12. Do you or your partner or anyone in your families have Huntington's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this person related to you or your partner? _____	____ Preconception Genetic Counseling
13. Do you or your partner or anyone in your families have autism or mental retardation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the problem. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling (FragileX, inherited chromosome rearrangement)
14. Do you or your partner or anyone in your families have an inherited disorder or chromosome abnormality not listed above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the problem. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling
15. Do you or your partner have insulin dependent diabetes, PKU, lupus, or another chronic condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis : _____	____ Preconception Genetic Counseling
16. Do you or your partner or anyone in your families have a birth defect not listed above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the defect. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling
17. Have you or your partner had a stillborn child or two or more pregnancy losses in this or any other relationship?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe: _____	____ POC ____ Chromosomes ____ Peripheral Blood Chromosomes ____ CVS or Amnio
18. Have you or your partner taken any medications, recreational drugs, or had any alcoholic drinks since your last menstrual period, or had any rashes or infectious diseases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe: _____	____ Counseling re: Teratogenic Exposure ____ CVS or Amnio
19. Did you or your partner or anyone in your families have any other serious medical condition in infancy or childhood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling

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

Patient Signature

For office use only: Reviewed by: _____ Date: _____



ART FERTILITY PROGRAM OF ALABAMA

Kathryn L. Honea, M.D.
Virginia L. Houserman, M.D.
Cecil A. Long, M.D.
M. Chris Allemand, M.D.

RELEASE OF RESULTS

I, _____, DOB _____, the undersigned patient, authorize Honea, Houserman, Long and Allemand, P.C., and/or any of the employees or staff of Honea, Houserman, Long and Allemand, P.C., to release laboratory test results and procedure results and to share treatment plans with my partner, _____, DOB _____, or _____, DOB _____ (i.e., mother, sister, etc.). Hepatitis and HIV screening results are excluded from this release. The consent for release of Hepatitis and HIV results is a separate consent.

Patient's Signature

Date



ART FERTILITY PROGRAM OF ALABAMA

**Kathryn L. Honea, M.D.
Virginia L. Houserman, M.D.
Cecil A. Long, M.D.
M. Chris Allemand, M.D.**

RELEASE OF RESULTS

I, _____, DOB _____, the undersigned patient, authorize Honea, Houserman, Long and Allemand, P.C., and/or any of the employees or staff of Honea, Houserman, Long and Allemand, P.C., to release laboratory test results and procedure results and to share treatment plans with my partner, _____, DOB _____, or _____, DOB _____ (i.e., mother, sister, etc.). Hepatitis and HIV screening results are excluded from this release. The consent for release of Hepatitis and HIV results is a separate consent.

Patient's Signature

Date

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Honea, Houserman, Long and Allemand, P.C.
Suite 508, 2006 Brookwood Medical Center Drive
Birmingham, Alabama 35209
(205) 870-9784**

We are required under the federal health care privacy rules (the "Privacy Rules"), to protect the privacy of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history (collectively, "Health Information"). We are also required to provide you with this Privacy Notice regarding our legal duties, policies and procedures to protect and maintain the privacy of your Health Information. We are required to follow the terms of this Privacy Notice unless (and until) it is revised. We reserve the right to change the terms of this Privacy Notice and to make the new notice provisions effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of this Privacy Notice change, we will make a revised copy of the notice available to you. Revised Privacy Notices will be available at our office for individuals to take with them and we will post a copy of revised Privacy Notices in a prominent location in our office. Privacy Notices will also be posted and available electronically on our web site.

PERMITTED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION.

General Uses and Disclosures. ***Under the Privacy Rules, we are permitted to use and disclose your Health Information for the following purposes, without obtaining your permission or Authorization:***

- ▶ **Treatment.** We are permitted to use and disclose your Health Information in the provision and coordination of your health care. For example, we may disclose your Health Information to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment.
- ▶ **Payment.** We are permitted to use and disclose your Health Information for the purposes of determining coverage, billing, and reimbursement. This information may be released to an insurance company, third party payor, or other authorized entity or person involved in the payment of your medical bills and may include copies or portions of your medical record which are necessary for payment of your bill. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.
- ▶ **Health Care Operations.** We are permitted to use and disclose your Health Information during our health care operations, including, but not limited to: quality assurance, auditing, licensing or credentialing activities, and for educational purposes. For example, we can use your Health Information to internally assess our quality of care provided to patients.
- ▶ **Uses and Disclosures Required by Law.** We may use and disclose your Health Information when required to do so by law, including, but not limited to: reporting abuse, neglect and domestic violence; in response to judicial and administrative proceedings; in responding to a law enforcement request for information; or in order to alert law enforcement to criminal conduct on our premises or of a death that may be the result of criminal conduct.
- ▶ **Public Health Activities.** We may disclose your Health Information for public health reporting, including, but not limited to: child abuse and neglect; reporting communicable diseases and vital statistics; product recalls and adverse events; or notifying person(s) who may have been exposed to a disease or are at risk of contracting or spreading a disease or condition.
- ▶ **Abuse and Neglect.** We may disclose your Health Information to a local, state, or federal government authority, if we have a reasonable belief of abuse, neglect or domestic violence.
- ▶ **Regulatory Agencies.** We may disclose your Health Information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs, and compliance with civil rights.
- ▶ **Judicial and Administrative Proceedings.** We may disclose your Health Information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.

- ▶ **Law Enforcement Purposes.** We may disclose your Health Information to law enforcement officials when required to do so by law.
- ▶ **Coroners, Medical Examiners, Funeral Directors.** We may disclose your Health Information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.
- ▶ **Research.** Under certain circumstances, we may disclose your Health Information to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your Health Information.
- ▶ **Threats to Health and Safety.** We may use or disclose your Health Information if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.
- ▶ **Specialized Government Functions.** If you are a member of the U.S. Armed Forces, we may disclose your Health Information as required by military command authorities. We may also disclose your Health Information to authorized federal officials for national security reasons and the Department of State for medical suitability determinations.
- ▶ **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your Health Information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety, or the health or safety of others; or for the safety and security of the correctional institution.
- ▶ **Workers' Compensation.** We may disclose your Health Information to your employer to the extent necessary to comply with Alabama laws relating to workers' compensation or other similar programs.
- ▶ **Fundraising.** We may use or disclose your Health Information to make a fundraising communication to you, for the purpose of raising funds for our own benefit. Included in such fundraising communications will be instructions describing how you may ask not to receive future communications.
- ▶ **Marketing.** We may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.
- ▶ **Appointment Reminders/Treatment Alternatives.** We may use and disclose your Health Information to remind you of an appointment for treatment and medical care at our office or to provide you with information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
- ▶ **Business Associates.** We may disclose your Health Information to business associates who provide services to us. Our business associates are required to protect the confidentiality of your Health Information.
- ▶ **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by the Privacy Rules.

Uses and Disclosures Which Require Patient Opportunity to Verbally Agree or Object. *Under the Privacy Rules, we are permitted to use and disclose your Health Information: (i) for the creation of facility directories, (ii) to disaster relief agencies, and (iii) to family members, close personal friends or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. Except in emergency situations, you will be notified in advance and have the opportunity to verbally agree or object to this use and disclosure of your Health Information.*

Uses and Disclosures Which Require Written Authorization. *As required by the Privacy Rules, all other uses and disclosures of your Health Information (not described above) will be made only with your written **Authorization**. For example, in order to disclose your Health Information to a company for marketing purposes, we must obtain your Authorization. Under the Privacy Rules, you may revoke your Authorization at any time. The revocation of your Authorization will be effective immediately, except to the extent that: we have relied upon it previously for the use and disclosure of your Health Information; if the Authorization was obtained as a condition of obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself; or where your Health Information was obtained as part of a research study and is necessary to maintain the integrity of the study.*

PATIENT RIGHTS.

You have the following rights concerning your Health Information:

Right to Inspect and Copy Your Health Information. Upon written request, you have the right to inspect and copy your own Health Information contained in a designated record set, maintained by or for us. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you. However, we are not required to provide you access to all the Health Information that we maintain. For example, this right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding. Where permitted by the Privacy Rules, you may request that certain denials to inspect and copy your Health Information be reviewed. If you request a copy or summary of explanation of your Health Information, we may charge you a reasonable fee for copying costs, including the cost of supplies and labor, postage, and any other associated costs in preparing the summary or explanation.

Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your Health Information for treatment, payment and health care operations, as well as disclosures to persons involved in your care or payment for your care, such as family members or close friends. We will consider, but do not have to agree to, such requests.

Right to Request an Amendment of Your Health Information. You have the right to request an amendment of your Health Information. We may deny your request if we determine that you have asked us to amend information that: was not created by us, unless the person or entity that created the information is no longer available; is not Health Information maintained by or for us; is Health Information that you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement, and a description of how you may file a complaint.

Right to an Accounting of Disclosures of Your Health Information. You have the right to receive an accounting of disclosures of your Health Information made by us within six (6) years prior to the date of your request. The accounting will not include: disclosures related to treatment, payment or health care operations; disclosures to you; disclosures based on your Authorization; disclosures that are part of a Limited Data Set; incidental disclosures; disclosures to persons involved in your care or payment for your care; disclosures to correctional institutions or law enforcement officials; disclosures for facility directories; or disclosures that occurred prior to April 14, 2003.

Right to Alternative Communications. You have the right to receive confidential communications of your Health Information by a different means or at a different location than currently provided. For example, you may request that we only contact you at home or by mail.

Right to Receive a Paper Copy of this Privacy Notice. You have the right to receive a paper copy of this Privacy Notice upon request, even if you have agreed to receive this Privacy Notice electronically.

If you want to exercise any of these rights, please contact our Privacy Officer. All requests must be submitted to us in writing on a designated form (which we will provide to you), and returned to the attention of our Privacy Officer at the address below.

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION.

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Address:	2006 Brookwood Medical Center Dr., Suite 508 Birmingham, Alabama 35209 Attn: Privacy Officer
Telephone:	(205) 870-9784
Fax:	(205) 870-0698

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The Effective Date of this Privacy Notice is February 1, 2003.



ART FERTILITY PROGRAM OF ALABAMA
2006 Brookwood Medical Center Drive
Suite 508
Birmingham, AL 35209
205-870-9784; 1-800-476-9784
Fax: 205-870-0698

CONSENT TO UTILIZE AUTOMATED VOICE MAIL SYSTEMS
OR ANSWERING MACHINES

Due to your activities, lifestyle and work schedules, as well as our patient visits and clinics, it is often difficult for the nursing staff to be readily accessible for all patient phone calls. Therefore, it may be necessary or convenient to utilize your answering machine, voice mail system or any other automated system to leave results, instructions and responses to your telephone calls. This consent form outlines how we will most effectively communicate with you.

I, _____, understand the necessity of being in (constant) contact with the nursing staff at the ART Fertility Program of Alabama, Honea, Houserman, Long and Allemand, P.C.

In order to facilitate communication between the nursing staff and myself, I give permission for the nurses to leave detailed messages of a personal and confidential nature on my voice mail, answering system or any other automated system at _____. I will have a greeting that confirms this telephone number is my message system. Messages from the ART Fertility Program may include lab results and cycle instructions. I agree that I will be responsible for picking up these messages daily.

I also understand that I must call during office hours if I need clarification of the message. Current office hours are Monday-Thursday, 8:00 a.m. - 4:00 p.m.; Friday, 8:00 a.m. - 2:00 p.m., Central Time.

I understand if I page the on-call nurse after office hours, she will not have access to my chart and may not be able to answer questions regarding the messages that were left.

Signature

Date

I, _____, do not want detailed messages left on my answering machine.

Signature

Date



ART FERTILITY PROGRAM OF ALABAMA

Kathryn L. Honea, M.D.
Virginia L. Houserman, M.D.
Cecil A. Long, M.D.
M. Chris Allemand, M.D.

HUNTSVILLE OFFICE OVERVIEW OF SERVICES

The ART Fertility Program of Alabama is pleased to be part of the Northeast Alabama community with a permanent office in Huntsville, Alabama. The office is located at 401 Lowell Drive, Suite 24, Huntsville.

The Huntsville office is limited in its scope of services. Monday through Friday the office is open from 7:00 a.m. to noon. The Huntsville office is not available for weekend and holiday services. The Birmingham office; however, is open on weekends and certain holidays to accommodate patient care.

New patient visits as well as return visits are performed by a physician in the Huntsville office.

Additionally, Nancy Scott, CRNP, provides services in Huntsville such as physical exams, cultures, ultrasounds, etc. Ms. Scott is a Certified Registered Nurse Practitioner (CRNP) and lives in the Huntsville area. She has received infertility training at our Birmingham clinic and is the primary nurse practitioner for the Huntsville office. Ms. Scott is in constant communication with the Birmingham office and the physicians. Ms. Scott works under physician direction to provide services such as monitoring, ultrasounds, intrauterine inseminations (IUI) with non-frozen sperm, injection instructions, counseling and venipuncture. Medications and supplies are also available for purchase in Huntsville.

We can provide "same-day results" for estradiol, progesterone and BhCG tests for Huntsville patients in our care. Patients who have blood drawn and prepared before the courier picks up (10:00 a.m.) will have results available between 4:00 and 5:00 p.m. on the same day. Patients expecting "same-day results" should call their personal voice mailbox (1-800-338-0765) for results and instructions. There will still be certain situations in a treatment cycle when Huntsville-area patients will have to travel to Birmingham for their services.

We also offer on-site Andrology services, which include semen analysis and semen prep for inseminations. A separate collection area is available in the Huntsville office.

For patient convenience, the Birmingham office is the primary communication channel for the ART Fertility Program's offices. All inquiries, appointments, requests for the physicians or nurses and LH surges, including those for the Huntsville office, are to be scheduled through the Birmingham office. Questions about treatment and lab results, including after-hours calls to our answering service, are to be handled through the Birmingham office.

We request that all payments for services be paid by personal check or credit card. Cash cannot be accepted at the Huntsville office.

Please call our toll free number 1-800-476-9784 with all questions and concerns. Thank you for your continued support.



ART FERTILITY PROGRAM OF ALABAMA

Kathryn L. Honea, M.D.
Virginia L. Houserman, M.D.
Cecil A. Long, M.D.
M. Chris Allemand, M.D.

MONTGOMERY OFFICE OVERVIEW OF SERVICES

The ART Fertility Program of Alabama is pleased to be part of the South Alabama community with a permanent office in Montgomery, Alabama. The office is located at 7209 Copperfield Drive, Montgomery.

The Montgomery office is limited in its scope of services. Monday through Friday the office is open from 7:00 a.m. to 2:00 p.m. The Montgomery office is not available for weekend and holiday services. The Birmingham office; however, is open on weekends and certain holidays to accommodate patient care.

New patient visits as well as return visits are performed by a physician in the Montgomery office.

Additionally, Sarah Shoemaker, CRNP, provides services in Montgomery such as physical exams, cultures, ultrasounds, etc. Ms. Shoemaker is a Certified Registered Nurse Practitioner (CRNP) and lives in the Wetumpka area. She has received infertility training at our Birmingham clinic and is the primary nurse practitioner for the Montgomery office. Ms. Shoemaker is in constant communication with the Birmingham office and the physicians, and works under physician direction to provide services such as monitoring, ultrasounds, intrauterine inseminations (IUI) with non-frozen sperm, injection instructions, counseling and venipuncture. Medications and supplies are also available for purchase in Montgomery.

We can provide "same-day results" for estradiol, progesterone and BhCG tests for Montgomery patients in our care. Patients who have blood drawn and prepared before the courier picks up at 10:30 a.m. will have results available by 4:00 p.m. on the same day. Patients expecting "same-day results" should call their personal voice mailbox (1-800-338-0765) for results and instructions. There will still be certain situations in a treatment cycle when Montgomery-area patients will have to travel to Birmingham for their services.

We also offer on-site Andrology services, which include semen analysis and semen prep for inseminations. A separate collection area is available in the Montgomery office.

For patient convenience, the Birmingham office is the primary communication channel for the ART Fertility Program's offices. All inquiries, appointments, requests for the physicians or nurses and LH surges, including those for the Montgomery office, are to be scheduled through the Birmingham office. Questions about treatment and lab results, including after-hours calls to our answering service, are to be handled through the Birmingham office.

We request that all payments for services be paid by personal check or credit card. Cash cannot be accepted at the Montgomery office.

Please call our toll free number 1-800-476-9784 with all questions and concerns. Thank you for your continued support.



ART FERTILITY PROGRAM OF ALABAMA

Kathryn L. Honea, M.D.
Virginia L. Houserman, M.D.
Cecil A. Long, M.D.
M. Chris Allemand, M.D.

TUSCALOOSA OFFICE OVERVIEW OF SERVICES

The ART Fertility Program of Alabama is pleased to be part of the Tuscaloosa, Northport and western Alabama community with a permanent office in Tuscaloosa/Northport, Alabama. The office is located at 650 Energy Center Blvd., Suite 1703, Northport, AL 35473.

The Tuscaloosa office is limited in its scope of services. Tuesdays and Thursdays the office is open from 7:00 a.m. to 2:30 p.m. The Tuscaloosa office is not available for weekend and holiday services. The Birmingham office; however, is open on weekends and certain holidays to accommodate patient care.

New patient visits as well as return visits are performed by a physician in the Tuscaloosa office.

Additionally, a CRNP provides services in Tuscaloosa such as physical exams, cultures, ultrasounds, etc. The CRNP is in constant communication with the Birmingham office and the physicians, and works under physician direction to provide services such as monitoring, ultrasounds, intrauterine inseminations (IUI) with non-frozen sperm, injection instructions, counseling and venipuncture.

We can provide "same-day results" for estradiol, progesterone and BhCG tests for Tuscaloosa patients in our care. Patients who have blood drawn and prepared before the courier picks up at 10:30 a.m. will have results available by 4:00 p.m. on the same day. Patients expecting "same-day results" should call their personal voice mailbox (1-800-338-0765) for results and instructions. There will still be certain situations in a treatment cycle when Tuscaloosa-area patients will have to travel to Birmingham for their services.

We also offer on-site Andrology services which include semen prep for inseminations. A separate collection area is available in the Tuscaloosa office.

For patient convenience, the Birmingham office is the primary communication channel for the ART Fertility Program's offices. All inquiries, appointments, requests for the physicians or nurses and LH surges, including those for the Tuscaloosa office, are to be scheduled through the Birmingham office. Questions about treatment and lab results, including after-hours calls to our answering service, are to be handled through the Birmingham office.

We request that all payments for services be paid by personal check or credit card. Cash cannot be accepted at the Tuscaloosa office.

Please call our toll free number 1-800-476-9784 with all questions and concerns. Thank you for your continued support.