COASTAL
FERTILITY SPECIALISTS
Because Your Dreams Matter.

Reproductive Endocrinology and Infertility

John A. Schnorr, M.D.
Heather M. Cook, M.D.
Jessica E. McLaughlin, M.D.
Carrie K. Riestenberg, M.D.
Andrea M. Peterson, M.D.

Dear Prospective patient:

Thank you for your interest in Coastal Fertility Specialists. Enclosed is our New Patient information packet. This packet contains information about our physicians, facility, and some of the services we provide here at Coastal Fertility Specialists. It will also provide you with the necessary forms and resources to take the very important first step in your journey.

We are here to help you obtain your fertility related medical records from your physician(s) and from your partner's physician(s), answer any questions you may have and then finally will help to schedule your initial consultation.

Coastal Fertility Specialists participates in and accepts assignments with the following insurance companies: AETNA Healthcare, State BCBS, CIGNA, Tricare, Triwest, United Healthcare, Blue Choice and all BCBS PPO. We will file claims on your behalf and you will be responsible for paying your copay/coinsurance, deductible, and any non-covered/non-payable charges at the time of service.

If your insurance company does not provide infertility benefits or coverage for your possible treatment, you will be responsible for paying for your services in full at the time services are rendered.

If your insurance is one that we are not contracted with but you have coverage for the services rendered, we will assist you in filing your claims with reimbursement directed to you. You will be responsible for paying for your services in full at the time services are rendered.

Cancellation policy: If you need to cancel/reschedule your appointment, please be sure to inform us *no later than 48 hours prior* to your scheduled consultation. If you cancel/reschedule within 48 hours, we will require a deposit to rebook your appointment.

Again, please feel free to contact one of us at any time if you have questions or concerns. We truly appreciate your inquiry and look forward to hearing from you soon.

Sincerely,

The Coastal Fertility New Patient Coordinator Team

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WHAT TO EXPECT DURING YOUR FIRST VISIT FOR INFERTILITY EVALUATION AND TREATMENT

Welcome and thank you for choosing Coastal Fertility Specialists. We hope your first visit to Coastal Fertility Specialists will enable you to get a chance to tour our facility and meet our staff. To make the most of your first visit, we feel it is important that we receive any fertility-related medical records that you may have from your current or past physician's or your partner's physicians prior to your appointment.

The physicians at Coastal Fertility Specialists have over 50 years combined years of reproductive endocrinology experience. In addition to our doctors we have 22 registered nurse's and 3 nurse practitioners that specialize in the evaluation and treatment of infertility to provide the individualized compassionate patient care you deserve.

Please remember during your evaluation and treatment that infertility is common, affecting over one in nine couples and that couples seeking treatment have a high success rate. In fact, greater than 90% of couples seeking treatment ultimately conceive and the vast majority of couples conceive through very simple treatment protocols.

Infertility treatment in itself can be anxiety provoking and stressful for those involved. Couples undergoing infertility treatment may experience feelings and emotions they have never confronted before. Both acute and chronic stress reactions are common. Coping with infertility treatment can be overwhelming. Our program utilizes the skills of several different professionals trained to help with the emotional aspects of infertility and we can refer you to an experienced counselor at your request.

To maximize your visit, we strongly recommend that your partner is present for your visit. Having them present allows us to review their medical history and discuss the causes, evaluation and treatment approaches to improve your reproductive health. If infertility is part of the reason for your visit, a semen analysis before the visit will help us to address any male factor causes during your initial visit, saving you time and money.

We request that you arrive approximately fifteen (15) minutes prior to your initial consultation so that you can complete and finalize any remaining paperwork. Your evaluation will then start with a one hour consultation with one of our reproductive endocrinologists at Coastal Fertility Specialists. During this initial consultation, a comprehensive evaluation will be performed to identify all possible causes of infertility. This evaluation typically includes an ultrasound of the uterus and ovaries to help assess their shape and physiologic status. This will be followed by a discussion of the possible etiologies of your infertility and discussion of the tests that will help to establish the diagnosis. Several treatment options will be discussed along with the advantages and disadvantages of each treatment option and their associated costs.

Please remember that 20% of all couples have more than one cause of infertility and therefore, even if you are currently suspicious about or know a current cause of your infertility, a thorough evaluation is necessary to identify other causes. It is also important to remember that approximately 40% of all cases of infertility are from a male factor cause. The male factor evaluation can only be performed
with a semen analysis and we therefore strongly recommend that a semen analysis be performed before or during your initial visit so we can discuss the presence or absence of a male factor component.

Following this consultation, you will be able to meet with your assigned nurse coordinator who will help to coordinate your care. She will be in charge of scheduling your diagnostic testing and starting your treatment plan. After your nursing visit you will then have the opportunity to meet with one of our financial coordinators to discuss your potential insurance coverage and the typical costs associated with your evaluation and treatment plan.

Please be reassured that you will receive all of the information and guidance necessary to make informed and appropriate treatment decisions together with your treatment team. Your satisfaction is very important to us. We look forward to seeing you soon!

Sincerely,

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TREATMENT OPTIONS

Coastal Fertility Specialists provides a wide range of treatment options from both basic to advanced infertility treatments. We have a very specialized team of infertility professionals focused on providing you with the information and guidance needed to make informed and appropriate treatment decisions.

After your initial consultation and completion of your infertility evaluation your treatment plan can be specialized depending upon the cause of your infertility. One of the first steps of infertility treatment is often intrauterine insemination.

OVULATION INDUCTION AND INTRAUTERINE INSEMINATION (IUI)

Fertility medications are used to stimulate the woman's ovaries to produce more than one egg and to enhance the pregnancy rates. Frequent blood tests (to monitor hormone levels) and ultrasounds are required to monitor egg development. When the eggs are mature an intrauterine insemination is performed.

Intrauterine insemination (IUI) is an outpatient procedure in which the male patient produces a semen specimen that is taken to our lab to undergo special washing techniques. These techniques select sperm with the best motility and increase the amount of normal sperm found in the final volume to be used for insemination. A catheter is gently inserted through the cervix to place sperm into the uterus close to the fallopian tubes.

Candidates for intrauterine insemination include patients with an infertility diagnosis of:

- ✤ Endometriosis
- ✤ Cervical factor
- ✤ Positive sperm antibody test
- ✤ Male factor
- ✤ Unexplained infertility

The cost of an IUI cycle can vary from $1,800- $2,200. Medication can range from $200- $700.

Success rates vary depending upon the age and diagnosis of the patient.

IN-VITRO FERTILIZATION (IVF)

In-Vitro fertilization (IVF) is an option for many couples who cannot conceive through conventional therapies. Prior to beginning an IVF cycle, preliminary testing will be required on both the male and female patients. At your consultation, the doctor and nurse coordinator will discuss the testing necessary for your specific treatment plan.

During in-vitro fertilization treatment, the female patient will need fertility drugs to stimulate egg production and control the timing of ovulation. This will help maximize the number of eggs produced and increase the chance of fertilization. Frequent blood tests (to monitor hormone levels) and ultrasounds (to monitor follicle development) will also be required.

The egg retrieval procedure is performed at our Mount Pleasant, SC location and will require I.V. sedation. Once the eggs are retrieved and the sperm is collected, they will be united by our Embryologist for incubation in our laboratory. If the sperm quality is compromised, the eggs will be inseminated with a single sperm by a micromanipulation procedure known as ICSI (Intracytoplasmic sperm injection).

Three or five days after the retrieval, the embryo(s) will be transferred into the uterus. Eligible patients are those with infertility due to a condition not responsive to conventional therapy, including one or more of the following:

Tubal blockage or failed tubal reversal

- ✤ Endometriosis
- ✤ Cervical factor
- ✤ Pelvic adhesions
- ✤ Antibody problems
- ✤ Male factor
- ✤ Unexplained infertility/failed conventional therapy

The estimated cost of treatment for an IVF cycle can range from $15,525- $17,275. Medication can range from $2,000- $6,000, depending on the medication prescribed and the pharmacy.

The estimated cost of treatment for an IVF cycle with Donor eggs can range from $21,500- $30,000.

Success rates vary and depend on the age and diagnosis of the patient.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THIS FORM NEEDS TO BE SENT TO YOUR PHYSICIAN(S), NOT TO CFS
Please send this form to any physicians (OB/GYN, Urologist, Infertility Specialist. etc) who have participated in your fertility-related care ASAP.

Patient Name: _____
First Middle/Maiden Last

SS#: _____ DOB: _____

INFORMATION RELEASED FROM:	*INFORMATION RELEASED TO:*
PRACTICE NAME:	COASTAL FERTILITY SPECIALISTS
PHYSICIAN NAME:	ATTN: NEW PATIENT COORDINATORS
ADDRESS:	1375 HOSPITAL DRIVE
	MOUNT PLEASANT, SC 29464
PHONE:	PHONE: (843) 883-5800
FAX:	FAX: (843) 628-5880

Dear Dr. _____:

I am considering treatment at Coastal Fertility Specialists. Please forward a summary letter, this sheet, and the below listed information to Coastal Fertility Specialists. All records need to be submitted by appointment date: _____.

Please include the following if applicable:

- All semen analyses
- Hysterosalpingogram (HSG) reports and films
- Any operative notes and pathology
- ALL LAB RESULTS
- Any other pertinent records related to infertility including notes on IUI and IVF

I request and authorize the above-named physician or health care provider to release information to Coastal Fertility Specialists. I certify this request has been made voluntarily and that the information given above is accurate. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Copies of medical records may be mailed or faxed to the above address.

Sincerely,

_____ _____
Signature Date

PLEASE ENCLOSE THIS LETTER WITH THE COPIES OF RECORDS

COASTAL FERTILITY SPECIALISTS

Patient Information Form

PLEASE PRINT AND RETURN THIS FORM AS SOON AS POSSIBLE. ALL INFORMATION WILL REMAIN CONFIDENTIAL. THANK YOU!

PATIENT_____

(LAST) (FIRST) (MIDDLE) (MAIDEN NAME) (NAME CALLED)

HOME ADDRESS _____ PHONE (H)_____ (C)_____

CITY _____ STATE _____ COUNTRY _____ ZIP _____

SSN _____ DOB ____/_____/_____ AGE _____ MARITAL STATUS_____ RACE _____

MAY WE CONTACT YOU VIA EMAIL YES ❑ NO ❑ IF SO, EMAIL ADDRESS: _____

==========

HAVE YOU/SPOUSE BEEN HERE BEFORE? YES ❑ NO ❑ PHYSICIAN WHO REFERRED YOU? _____

PHYSICIAN'S ADDRESS (AT LEAST CITY/STATE) _____ (P) _____

EMPLOYED BY _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY_____ STATE _____ ZIP _____

WORK PHONE _____ MAY WE CONTACT YOU THERE? YES ❑ NO ❑

*WE DO NOT SAY THE NAME OF OUR FACILITY

==========

HOW DID YOU HEAR ABOUT OUR PRACTICE? CIRCLE ONE: DOCTOR _____

FRIEND FAMILY BILLBOARD RADIO POSTER INTERNET FERTILITY NETWORK SITE OTHER _____

==========

PARTNER'S NAME _____

(LAST) (FIRST) (MIDDLE) (NAME CALLED)

SSN _____ DOB _____ AGE _____ RACE _____

EMPLOYED BY _____ MOBILE PHONE _____

EMAIL _____

==========

INSURANCE COVERAGE (PRIMARY)

NAME OF INSURANCE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____

POLICY # _____

GROUP # _____

POLICY HOLDER _____

PARTNER COVERED YES ❑ NO ❑

INSURANCE COVERAGE (SPOUSE/PARTNER)

NAME OF INSURANCE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____

POLICY # _____

GROUP # _____

POLICY HOLDER _____

PARTNER COVERED YES ❑ NO ❑

==========

I, _____ HEREBY MAKE ASSIGNMENT OF ALL SURGICAL, MEDICAL, AND MAJOR MEDICAL INSURANCE BENEFITS TO COASTAL FERTILITY SPECIALISTS, TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO EXECUTE AN ASSIGNMENT OF BENEFITS. I UNDERSTAND THAT REGARDLESS OF ANY INSURANCE COVERAGE I MIGHT HAVE, I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES TO THIS ACCOUNT. I FURTHER AGREE IN THE EVENT OF NON-PAYMENT TO BEAR THE COST OF COLLECTION AND/OR COURT COSTS AND REASONABLE LEGAL FEES SHOULD THIS BE REQUESTED.

PATIENT SIGNATURE _____ DATE _____

PARTNER SIGNATURE _____ DATE _____

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PATIENT FINANCIAL POLICY

In order for Coastal Fertility Specialists (CFS) to maintain a healthy financial position, it is necessary to implement and adhere to collection policies. The policies and procedures listed below will enable CFS to remain a viable health care provider.

Insurance Coverage

The patient or his/her legal guarantor is ultimately responsible for all services incurred. CFS participates and accepts assignments with the following insurance companies: AETNA healthcare, State BCBS, CIGNA, Tricare, Optum VA, United Healthcare, Blue Choice, and BCBS PPO. CFS will bill insurance plans if the patient provides the required insurance information and signs an Assignment of Benefits statement. CFS may submit claims for covered services to non-contracted insurance plans as a courtesy, however, the services must be paid in full at the time services are rendered. If the patient has dual coverage, and we do not participate with your primary insurer, the services must be paid in full at the time services are rendered. All information given regarding the ability to pay, third-party insurance, employment, etc., will be subject to verification. Patients with a contracted insurance plan that covers only a portion of the services must pay the difference between the charges and the anticipated insurance payment at the time the services are rendered. All patients receiving medical services are required to provide their social security number prior to services being rendered. Patients with no social security number are required to pay prior to or at the time of services. Patients may be requested to make full payment of unpaid balances when insurance payments are not received after 60 days from the date of billing. A pre-pay deposit may be required prior to all services beginning.

Uninsured Patients/Non-covered services

Uninsured patients are required to pay all services in full prior to the services being incurred.

Payment methods

The following payment methods are accepted: cash, check, money order, credit cards (American express, Discover, Mastercard, and Visa) and outside lending institutions. Returned checks will be handled in accordance with the Patient Financial Services Department NSF procedures. A $35.00 bank fee and a $25.00 administration fee will be assessed for each returned check. Patients receiving services at our Myrtle Beach, Savannah, and Lexington offices may be required to pre-pay for all services rendered. If payment is made by credit card via telephone, a credit card receipt will be emailed to the patient after the payment is processed.

Cryopreservation and Storage

If you have consented to freeze your embryos, oocytes, and/or sperm, a storage fee will occur. If storage fees are not paid within the 30 day period, the fee will be considered delinquent and will enter a collections process that may result in reporting the debt to a credit bureau. Cryopreservation is not included in the deposit estimate and is due within 15 days of transfer. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees.

Cancellation of Cycle

If a cycle is canceled for any reason, you will be charged for the actual procedures performed according to the standard fee schedule utilized by CFS. Any difference between the cost of the actual procedures performed and the deposit amount will be refunded to the patient/guarantor once the patient has been released from care and all insurance dispositions received.

If you are undergoing an IVF cycle and convert to an IUI cycle, you will only be charged for the actual procedures performed during both cycles. An excess amount paid in your cycle deposit will be refunded to the patient/guarantor once the patient has been released from care and all insurance dispositions received.

Refunds

Overpayments or credit balances greater than $10.00 will be refunded to the appropriate party after review of the account. Patient refunds will not be processed until the patient is released from care and all insurance dispositions have been received.

In-House Collections

All patient balances must be paid within 30 days of the time of service. Patients with unpaid delinquent accounts over 90 days old will be referred to outside collection, reported to one of the credit reporting agencies and will be denied of receiving further services at CFS.

Referral for Outside Collections

All accounts that cannot be collected by CFS will be referred to a collection agency, magistrate, or attorney for further collection action in accordance with established guidelines as deemed appropriate by the Fair Debt Collection Practices Act. CFS may take legal action, including the lien on personal property, in order to collect balances owed. Any fees assessed will be the responsibility of the debtor.

HIPAA Notice of Privacy Practices Acknowledgement

I have received, read and understand Coastal Fertility Specialists Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of Coastal Fertility Specialists. I understand that I may request , in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

"I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable copayment and deductibles, are my responsibility."

_____ _____

Print Patient/Guarantor Name Date

_____ _____

Signature of Patient/Guarantor Date

COASTAL FERTILITY SPECIALISTS

Insurance Waiver

Insurance Carrier Name: _____

1. **Verification/Authorization of Coverage Obtained but Claims denied**
   I understand that any predetermination and/or benefits verification is not a guarantee. Claims must be submitted and reviewed by the insurance carrier prior to any payment. Any claims denied by my insurance company will become my responsibility for payment.

2. **Receipt of Insurance Payments**
   I understand that if my insurance company pays me directly, I am obligated to turn over all payments to the practice in a timely manner, otherwise the practice may not be able to submit to any other additional carriers.

3. **Non-covered services or exclusions**
   I agree to be financially responsible for all non-covered services and understand that payment is required at the time of service.

4. **Exceed Plan Limits**
   It is possible that I could exceed my insurance plan limits. I agree to be financially responsible for any services that exceed my plan limits.

5. **Non-billable Services**
   I understand that there are some services that do not have a valid billing code and are non-billable to any insurance company. I have been made aware of these services, agree to be financially responsible, and understand that payment is required prior to these services being rendered. These services may include but are not limited to a cycle management fee (IVFMM, FETMM, &/or S4042), facility fee for procedures (OFAC), ZYMOT, and the Trial Transfer procedure.

In accordance with my understanding of the above, I hereby agree to payment at time of service or prior to the start of my treatment cycle if applicable.

Patient Name (Print) _____ MPI: _____

Patient Signature _____ Date: _____

Practice Employee _____

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ELECTRONIC COMMUNICATION CONSENT

E-mail communication provides a fast and easy way to communicate with your healthcare provider for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- E-mail communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard e-mail services, such as AOL, Optonline, Yahoo, and Hotmail are not secure. This means that the e-mail messages are not encrypted and can be intercepted and read by unauthorized individuals. Transmitting email that contains protected health information through an e-mail system that is not encrypted does not meet the security guidelines as required by the Health Information Protection and Accountability Act.
- Your email address will not be used for external marketing purposes without your permission. You may receive a group mailing from the practice, however, the recipient's email address will be hidden.

Provider Responsibilities

- The provider will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider may route your email messages to other members of our staff for informational purposes or for expediting a response.
- Designated staff may receive and read your email.
- The provider will make every attempt to respond to your email within 2 business days. If you do not receive a response from the provider within 2 business days, please contact the Practice.
- Copies of the emails sent and received from and to you will be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should contact 911. For emergent or time sensitive situations, you should contact your healthcare provider through the office.

- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- Please key in your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the provider's message by a return email to the provider.

Electronic Communication Consent

I have read and understand the above description of the risks and responsibilities associated with electronic communication with the healthcare provider.

I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

I have been given the opportunity to discuss electronic communication with my healthcare provider and have had all of my questions answered.

In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my provider, I hereby consent to electronic communication via non-secure email services.

I understand that I may revoke my consent to communicate electronically at any time by notifying Coastal Fertility Specialists in writing at the provided address, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance on the consent.

I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secure network.

I further agree to be held accountable to comply with the patient responsibilities as outlined above.

PATIENT

_____

Patient authorized E-mail address

_____

Patient Signature Date

PARTNER

_____

Partner Authorized email address

_____

Partner Signature Date

CFS'S HIPAA/RELEASE OF INFORMATION /AND INSURANCE AUTHORIZATION

Private Insurance Authorization for Assignment of Benefits/Information Release

I authorize that the payment of medical benefits be made on my behalf directly to Coastal Fertility Specialists for any services furnished to me by the physician(s). I understand that I am financially responsible for any amount not covered by my contract. I authorize the release of my insurance company information concerning healthcare, advice or treatment provided to me necessary for processing insurance claims.

Initials _____/_____

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I have received, read, and understand Coastal Fertility Specialists Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of Coastal Fertility Specialists. I understand that I may request,in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Initials _____/_____

Agreement of Financial Responsibility

Fertility services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventative, pre-existing, or non-covered you will be responsible for your balance.

Initials _____/_____

Authorization to Release and/or Obtain Medical Records

I hereby authorize my primary care physician, my referring physician, and Coastal Fertility Specialists' physicians, the release, use, and disclosure of my entire medical record by mail, phone, and fax to carry out my treatment, payment, and healthcare operations.

Initials _____/_____

Authorized Methods of Communication (PLEASE CHECK ALL THAT APPLY)

1. It is okay to leave call back phone number only: ❑ Home ❑ Cell ❑ Work
2. It is okay to leave a detailed message on answering machine/voicemail: ❑ Home ❑ Cell ❑ Work
3. It is okay to discuss my healthcare treatment with :

❑ Spouse_____ ❑ Family Member_____

❑ Partner _____ ❑ Other _____

Initials _____/_____

In case of any dispute or claim arising from any and all materials and services provided by CFS, the patient agrees to submit to the exclusive jurisdiction and venue of the Ninth Judicial Circuit Charleston County, Court of Common Pleas, and will comply with all requirements necessary to give such court jurisdiction over the parties and the controversy. PATIENT AGREES THAT ANY DISPUTE OR CLAIM BETWEEN THEM WILL BE DECIDED BY NON-JURY TRIAL AND CLIENT HEREBY KNOWINGLY, INTELLIGENTLY, AND EXPRESSLY WAIVES ANY RIGHT TO A JURY TRIAL AND TO ANY TYPE OF CLASS ACTION.

I/we understand that the authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility will be valid for one (1) year from the date of signature and can only be revoked upon written notice. By signing below I/we acknowledge that this form has been read in full and explained as necessary.

_____

Patient's Signature Date of Birth Date

_____

Partner's Signature Date of Birth Date

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NOTICE OF PRIVACY AND PRACTICES

*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.

If you have any questions about this notice, please contact Isabel Bryan, privacy officer, at 1375 Hospital Drive, Mount Pleasant, SC 29646; telephone (843) 883-5800.

Who will follow this notice: This notice describes the information privacy practices followed by our employees, staff, and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular healthcare provider from our office is not available) who provide call coverage for your healthcare provider.

Your Health information: This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and your rights and obligations regarding the use and disclosure of that information.

How we may use and disclose health information about you: For treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to describe what treatment is appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy , scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. If you indicate interest in the Shared Risk Refund Program, we will provide relevant information concerning your medical condition to our providers for determination of your qualifications for this payment program.

For Health care operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Business associates: There are some services provided at Coastal Fertility Specialists through contacts with business associates. Examples include: the management of services of Coastal Fertility Specialists, ultrasound analysis services of Cycle Clarity, LLC and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associates so they can perform the job we have asked them to do, and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Appointment reminders: We may contact you as a reminder that you have an appointment for treatment options/medical care at the office.

Treatment alternatives: We may tell you about or recommend possible treatment options/alternatives that may be of interest to you.

Health related products and services: We may tell you about health related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health related products and services. If you advise us in writing (at the address listed at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes. You may revoke your consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time. If you revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

Special situations: We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations: To avert a serious threat to health or safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by law: We will disclose health information about you when required to do so by federal, state, or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in the care at the office.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces , or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

FOOD AND DRUG ADMINISTRATION (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Public health risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health oversight activities: We may disclose health information to a health oversight agency for adults, investigators, inspections, or listening purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil right laws.

Law enforcement, Lawsuits, and Disputes: We may release/disclose health information about you if you are involved in a lawsuit or dispute, or if we are asked by a law enforcement official in response to a court or administrative order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment , determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform that person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

Other uses and disclosures of health information: We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific written authorization. We must obtain your authorization separate from any consent we may have obtained from you. If you give us authorizations to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a specially signed, written authorization (different from the authorization and consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed consent and a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding information we maintain about you: Right to inspect and copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to CFS, Privacy Official at 1375 Hospital Drive, Mt. Pleasant, SC 29464, (843) 883-5800 in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances, If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by the office. To request an amendment, complete, and submit a Medical Record Amendment/Correction form to CFS Privacy Official, 1375 Hospital Drive, Mt. Pleasant, SC 29464, (843) 883-5800. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) We did not create, unless the person or entity that created the information is no longer available to make the amendment. (2) It is no part of the health information that we keep. (3) You would not be permitted to inspect and copy. (4) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations. To obtain this list you must submit your request in writing to CFS Privacy Official, 1375 Hospital Drive, Mt. Pleasant, SC 29464, (843) 883-5800. It must state a time period, which may not be longer than six years and may not include dates before May 8, 2012. Your request should indicate in what form you want the list (for ex., on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to request restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, such as a family member or friend. For example, you could ask that we do not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the request for restriction on use/disclosure of medical information to CFSl, 1375 Hospital Drive, Mt. Pleasant, SC 29464, (843) 883-5800.

Right to Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only communicate with you at work or by mail. To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to the CFS Privacy Official, 1375 Hospital Drive, Mt. Pleasant, SC 29464, (843) 883-5800. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper copy of this notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time, even if you have agreed to receive it electronically. To obtain such a copy, contact the CFS Privacy Official, 1375 Hospital Drive, Mt. Pleasant, SC 29464, (843) 883-5800.

Changes to this notice: We reserve the right to change this notice, and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Complaints: If you have complaints, questions, or would like additional information regarding this notice or the privacy practices of Coastal Fertility Specialists, please contact.

PRIVACY OFFICIAL COASTAL FERTILITY SPECIALISTS, 1375 Hospital Drive, Mt. Pleasant, SC 29464, (843) 883-5800. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Official in our office or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

OFFICE OF CIVIL RIGHTS, 61 Forsyth Street, SW Suite 3B70, Atlanta, GA 30323

COASTAL FERTILITY SPECIALISTS
FEMALE MEDICAL HISTORY INTAKE

NAME_____ PREFERRED NAME _____ AGE_____ DOB_____

OCCUPATION _____ HOW DID YOU FIND US? _____

HEIGHT _____ WEIGHT _____ PARTNER'S NAME _____ AGE _____

REASON FOR VISIT

DIFFICULTY GETTING PREGNANT? YES NO MULTIPLE MISCARRIAGES (2 OF MORE)? YES NO

OTHER _____

MENSTRUAL HISTORY

AGE AT FIRST PERIOD? _____ FIRST DAY OF LAST MENSTRUAL PERIOD? _____

DO YOU HAVE A PERIOD EVERY MONTH? _____

TYPICAL NUMBER OF DAYS BETWEEN THE START OF ONE PERIOD TO THE START OF THE NEXT: _____

HOW LONG IS THE PERIOD BLEEDING: _____

DO YOU HAVE PAIN WITH YOUR PERIODS? YES NO

IF YES: WHAT MEDICATION DO YOU NEED? _____

DO YOU MISS WORK DUE TO PAIN? _____

ANYTHING MORE WE SHOULD KNOW? _____

PREGNANCY HISTORY

Preg #	Date	Live birth (weeks)	Vaginal Yes/No	C-section Yes/No	Miscarriage (weeks)	Ectopic (weeks)	Elective Abortion (weeks)
1							
2							
3							
4							

PLEASE LIST COMPLICATIONS THAT OCCURRED IN ANY OF THE PREGNANCIES: _____

_____

COMMENTS ON PREGNANCIES: _____

_____

SEXUAL HISTORY

WHAT TYPES OF CONTRACEPTIVES HAVE YOU USED? (PLEASE CIRCLE ALL THAT APPLY)

BIRTH CONTROL PILLS BIRTH CONTROL PATCHES INJECTABLE (ex. DEPO PROVERA) FOAM JELLY

CONDOMS IUD DIAPHRAGM TUBAL STERILIZATION? (TYPE) _____

HOW LONG HAVE YOU BEEN OFF BIRTH CONTROL? _____

HOW MANY TIMES A WEEK DO YOU HAVE INTERCOURSE? _____

DO YOU HAVE PROBLEMS WITH INTERCOURSE? _____

DO YOU USE LUBRICANTS WITH INTERCOURSE? (WHICH ONES?) _____

HAVE YOU EVER HAD ANY SEXUAL TRANSMITTED DISEASES? _____

HAVE YOU EVER BEEN TREATED FOR PELVIC INFLAMMATORY DISEASE? _____

NAME: _____ AGE: _____ DOB: _____

IS SO, WHEN? _____

IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT YOUR SEXUAL HISTORY? _____

_____

SOCIAL HISTORY

DO YOU SMOKE? YES NO FORMER HOW MANY/DAY _____ HOW MANY YRS? _____

LAST CIGARETTE? _____ DO YOU DRINK ALCOHOL? _____

IF SO: HOW MANY DRINKS/WEEK? _____

DO YOU DRINK CAFFEINATED BEVERAGES (COFFEE, TEA, SODA)? _____

HOW MANY PER DAY? _____ TYPE? _____

DO YOU USE RECREATIONAL DRUGS (MARIJUANA, COCAINE, ETC)? _____

IF SO, DESCRIBE USE _____

DO YOU EXERCISE? _____ HOW MANY HRS/WK? _____

TYPES OF EXERCISE _____

MEDICAL/SURGICAL HISTORY

PLEASE LIST ALL MEDICAL PROBLEMS THAT YOU ARE CURRENTLY BEING TREATED FOR: _____

_____

_____

PLEASE LIST ALL MEDICAL PROBLEMS THAT YOU HAVE BEEN TREATED FOR *IN THE PAST*: _____

_____

_____

PLEASE LIST ALL SURGERIES (OPERATIONS) THAT YOU HAVE HAD:

TYPE OF SURGERY	DATE	REASON FOR SURGERY	ANY COMPLICATIONS?

PLEASE LIST ALL MEDICATIONS (INCLUDING OVER THE COUNTER) THAT YOU ARE CURRENTLY TAKING & DOSAGE:

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO IF SO, PLEASE LIST: _____

SYSTEM REVIEW (PLEASE CIRCLE ALL THAT APPLY)

GENERAL: WEIGHT LOSS OR GAIN FEVER/CHILLS FATIGUE

HEAD: DIZZINESS HEADACHES DIFFICULTY SEEING DIFFICULTY HEARING DIFFICULTY SMELLING

RESPIRATORY: DIFFICULTY BREATHING ASTHMA

BREAST: DISCHARGE LUMPS PAIN

CARDIOVASCULAR: CHEST PAIN IRREGULAR HEART BEATS

NAME: _____ AGE: _____ DOB: _____

GASTROINTESTINAL: NAUSEA VOMITING DIARRHEA BLOOD IN STOOLS
CONSTIPATION HEPATITIS COLITIS

URINARY: FREQUENT URINATION LEAKING URINE BLOOD IN URINE

HORMONAL: DIABETES THYROID PROBLEMS

MUSCULOSKELETAL: WEAKNESS JOINT PROBLEMS PAIN MUSCLE PAIN INJURIES

NEUROLOGICAL: MIGRAINES NUMBNESS MEMORY LOSS WEAKNESS SEIZURES BALANCE PROBLEMS

SKIN: EXCESS HAIR ACNE HAIR LOSS NEW SKIN CHANGES OTHER: _____

HEMATOLOGIC: BLOOD CLOTS IN LEGS OR LUNGS CLOTTING PROBLEMS ANEMIA
BLEEDING PROBLEMS EASY BRUISING TRANSFUSIONS

MENTAL HEALTH: DEPRESSION ANXIETY OTHER: _____

OTHER PROBLEMS NOT INCLUDED ABOVE: _____

FAMILY HISTORY

PLEASE LIST ALL SIGNIFICANT MEDICAL PROBLEMS IN YOUR RELATIVES: _____

_____

GENETIC HISTORY

PLEASE LIST ANY KNOWN BIRTH DEFECTS, GENETIC DISORDERS, PROBLEMS WITH MENTAL FUNCTION OR MENTAL DEVELOPMENT, OR PROBLEMS WITH GROWTH IN YOUR FAMILY: _____

_____

PRIOR INFERTILITY TESTING AND TREATMENT (IF TESTING DONE, LIST RESULTS):

MALE: SEMEN ANALYSIS _____ HORMONAL TESTING _____

GENETIC TESTING _____ EVALUATION W/UROLOGIST _____

ANATOMIC ASSESSMENT: ULTRASOUND: _____

HYSTEROSALPINGOGRAM (HSG)_____ SALINE SONOGRAPHY _____

LAPAROSCOPY _____ OTHER _____

OVARIAN FUNCTION ASSESSMENT: HORMONAL TESTING _____

ULTRASOUND: _____ OTHER TESTING: _____

FERTILITY TREATMENTS (IF TREATMENT DONE, LIST WHEN AND NUMBER OF ATTEMPTS)

PILLS TO CAUSE OVULATION (CLOMIPHENE, LETROZOLE) _____

INJECTABLE MEDICATIONS (GONAL F, FOLLISTIM, MENOPUR) _____

WAS INTRAUTERINE INSEMINATION USED FOR ANY TREATMENTS? _____

IN VITRO FERTILIZATION (IVF)			
FRESH IVF	IVF #1	IVF #2	IVF #3
MEDICATIONS USED			
# EGGS RETRIEVED			
CONV INSEM OR ICSI			
# EGGS FERTILIZED			
# EMBRYOS TRANSFERRED			

OUTCOME OF CYCLE			
# EMBRYOS FROZEN			
WERE EMBRYOS TESTED?			

FROZEN EMBRYO TRANSFERS (FET)			
FET'S	FET #1	FET #2	FET #3
MEDICATIONS USED			
# EMBRYOS THAWED			
# EMBRYOS TRANSFERRED			
OUTCOME OF CYCLE			
WERE EMBRYOS TESTED?			

OOCYTE DONATION (OD)			
FRESH IVF	OD #1	OD #2	OD #3
MEDICATIONS USED			
# EGGS RETRIEVED FROM DONOR			
CONV INSEM OR ICSI			
# EGGS FERTILIZED			
# EMBRYOS TRANSFERRED			
OUTCOME OF CYCLE			
# EMBRYOS FROZEN			
WERE EMBRYOS TESTED?			

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US?

_____

_____