History and Physical

Family Beginnings

A. Identifying Data Date this form when completed

Your name Partner's name

Age Birth date Height Weight

Length of marriage (or relationship)

Patient Self-Reported Ethnicity: (circle all that apply)

American Indian or Alaska Native	Hispanic or Latino	Black or African American
Asian	Native Hawaiian or Other Pacific	White

Partner Self-Reported Ethnicity:

American Indian or Alaska Native	Hispanic or Latino	Black or African American
Asian	Native Hawaiian or Other Pacific	White

How long have you been trying unsuccessfully to get pregnant?

Have you previously been pregnant?

Have you previously tried to get pregnant?

Reason for your visit today?

B. Pregnancy History

Times pregnant Term births Premature births

Miscarriages Elective abortion Adopted children

	Date	Miscarriage	Elective abortions	Ectopic	Months to Conceive	Infertility Treatment	Weight & Sex	C-Section	Complication	Is current partner the father?
1.										Yes
2.										Yes
3.										Yes
4.										Yes
5.										Yes

C. Contraceptive Use

	Type	From when to when	Reason discontinued
1.			
2.			
3.			
4.			
5.			

D. Operations and Hospitalizations

	Date	Diagnosis	Operation	Where performed	Physician
1.					
2.					
3.					
4.					
5.					
6.					
7.					

E. Medications: List all prescriptions and over the counter drugs used in the past year.

	Date	Dosage and frequency	From when to when	Reason for taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				

F. Allergies

To what (drug or substance)	When	what type of reaction?

G. Menstrual (hormonal) history

Date your last menstrual period began
Your age at your first period
Are your periods regular?
How many days from onset to onset?
How many days do your period last?
Do you bleed between periods?
Do you always have premenstrual symptoms? ☐ always ☐ rarely ☐ never?
Vigorous exercise: Type hours/week
Type hours/week
If you have a hormonal disorder, please specify type and treatment

Pelvic pain/cramps: ☐ none ☐ during your period ☐ before your period ☐ after your period
☐ at mid cycle ☐ during intercourse ☐ with urination ☐ with bowel movements
☐ cause you to miss usual activities ☐ cause you to miss work
Pelvic pain/cramps are ☐ mild ☐ moderate ☐ severe ☐ getting worse ☐ improving
☐ not changing ☐ on the right side ☐ on the left side ☐ in the middle
What medications do you take for pain/cramps?

Do you have or have you had:

	Yes	No		Yes	No
Hot flashes	☐	☐	Increased facial or body hair	☐	☐
Breast discharge	☐	☐	Increased acne	☐	☐
Vision problems	☐	☐	Weight gain (> 10 lb.)	☐	☐
Poor sense of smell	☐	☐	Weight loss (>10 lb.)	☐	☐
Chronic headache	☐	☐	Special dietary habits	☐	☐
Head injury	☐	☐	Vomiting	☐	☐
Seizures	☐	☐	Diabetes	☐	☐
Thyroid disorder	☐	☐	Autoimmune disease	☐	☐
Excessive stress	☐	☐	Psychiatric treatment	☐	☐

If you answered yes to any question, please explain

H. Physical Conditions/Infections

Do you have, or have you had:

	Yes	No		Yes	No
Pelvic infection	☐	☐	Appendicitis	☐	☐
Chlamydia	☐	☐	Colitis or enteritis	☐	☐
Antichlamydial antibodies	☐	☐	Endometriosis	☐	☐
Gonorrhea	☐	☐	Pelvic Adhesions	☐	☐
Syphilis	☐	☐	Uterine fibroids or myoma	☐	☐
Mycoplasma	☐	☐	Abnormal uterus (shape, etc.)	☐	☐
Urea plasma	☐	☐	Ovarian cysts	☐	☐
Tuberculosis	☐	☐	Toxoplasmosis	☐	☐
			Cytomegalovirus	☐	☐

I. Combined

Do you have or have you had:

	Yes	No		Yes	No
Cervitis	☐	☐	Recurring vaginitis	☐	☐
Genital Herpes	☐	☐	Abnormal pap smears	☐	☐
Genital warts/condyloma	☐	☐	Cryo (freezing) or		
Trichomonas	☐	☐	surgery of the cervix	☐	☐

How many times a week do you have sexual intercourse? _____
How many times do you have intercourse around ovulation? _____
Do you use lubricants for intercourse? _____
Do you douche before or after intercourse? _____
Have you ever had unwanted sexual experiences? _____
Do you have any sexual problems at this time? _____

J. Other medical history

Your occupation _____
Years of formal education _____
Cigarettes--packs smoked/day _____
Alcohol--type and number of drinks/week _____
Marijuana--amount _____
Other drugs--type and amount _____
Ever used intravenous drugs? _____
Caffeine drinks per day _____
Radiation exposure _____
Toxic Exposure _____
Video display terminal--hours/day _____
Electric blanket use _____
Hot tub or sauna use _____
List all serious or chronic illnesses or injuries not already described
_____
_____
Do you or family members have: ☐ infertility ☐ hormonal disorder ☐ other inherited disorders?
If yes, please explain _____
_____
_____

K. Partner's Medical History

Your partner's age ____ Occupation _____
List all serious or chronic illnesses or injuries _____
Medications _____
_____
Cigarettes--packs smoked/day _____
Alcohol--type and number of drinks/week _____
Marijuana--amount _____
Other drugs--type and amount _____
Ever used intravenous drugs? _____
Caffeine drinks per day _____
Radiation exposure _____
Toxic exposure _____
Video display terminal--hours/day _____
Electric blanket use _____
Hot tub or sauna use _____
Any problems with erection or ejaculation _____
Has semen analysis ever been abnormal? _____
Has your partner seen a doctor for infertility evaluation? _____
Doctor _____
Diagnosis _____
Treatment _____
Has your partner ever fathered a pregnancy with another woman? _____
Any inherited diseases in your partners' family? _____

Does your partner have or has he had:

	Yes	No		Yes	No
Chlamydia	☐	☐	Vasectomy	☐	☐
Antichlamydial antibodies	☐	☐	Vasectomy reversal	☐	☐
Gonorrhe	☐	☐	Varicocele	☐	☐
Syphilis	☐	☐	Varicocele surgery	☐	☐
Genital Herpes	☐	☐	Biopsy of testicles	☐	☐
Genital warts/condyloma	☐	☐	Hernia surgery	☐	☐
Mycoplasm	☐	☐	Abdominal surgery	☐	☐
Urea plasma	☐	☐	Cancer	☐	☐
Urethritis/epididymitis	☐	☐	High blood pressure	☐	☐
Prostatits	☐	☐	Diabetes	☐	☐
Penile discharge or pain	☐	☐	Colitis	☐	☐
Undescended testicle	☐	☐	Seizures	☐	☐
Injury to the testicle(s)	☐	☐	Psychiatric treatment	☐	☐
Mumps with injury to the testicles	☐	☐	Excessive stress	☐	☐
Physical abnormality	☐	☐	Strenuous exercise	☐	☐
DES exposure in womb	☐	☐	Tight underwear	☐	☐

L. Previous Evaluation
Have you had:

	Not Done	Result Normal	Result Abnormal	Approx. date	Values (if known)
Basal Body temperature (BBT)	Not Done				
Urine LH surge	Not Done				
Endometrial biopsy	Not Done				
Blood tests:					
FSH	Not Done				
LH	Not Done				
Prolactin	Not Done				
Thyroid tests (TSH, T4)	Not Done				
DHEAS	Not Done				
Testosterone	Not Done				
Estradiol	Not Done				
Progesterone	Not Done				
Postcoital test	Not Done				
Cervical Mucus penetration test	Not Done				
Mycoplasma culture	Not Done				
Chlamydia culture	Not Done				
Antichlamydial antibodies	Not Done				
Female antisperm antibodies	Not Done				
Hysterosalpingogram (HSG)	Not Done				
Ultrasound	Not Done				
IVP (kidney x-ray)	Not Done				
Laparoscopy	Not Done				
Hysteroscopy	Not Done				
Karyotype	Not Done				
Anticardiolipin	Not Done				
Lupus anticoagulant	Not Done				
Antinuclear antibodies (ANA)	Not Done				
Coagulation screen	Not Done				
Biochemistry/hematology panel	Not Done				
Blood type	Not Done				
Other	Not Done				

Has your partner had:

Semen analysis	Not Done				
Hamster egg penetration assay	Not Done				
Semen anti-sperm antibodies	Not Done				

List all causes of infertility previously diagnosed

Previous Treatment

	How many Months?	Dose (If known)	Approx. dates taken
Antibiotics			
Clomiphene (Clomid, Serephene)			
hMG (Repronex)			
FSH (Gonal-F, Follistim)			
HCG (Profasi, Novarel)			
Progesterone			
Dexamethasone			
GnRH Agonist / Antagonist (Ganarelix, Lupron)			
Danazol			
Intrauterine insemination			
Insemination with donor sperm			
IVF (in vitro fertilization)			
GIFT			
Other			

Please use the remainder of this page to explain any additional information you feel we may need.

Family Beginnings, PC

8435 Clearvista Pl, Suite 104
Indianapolis, IN 46256

Authorization to Release Medical Information

(Please complete in full)

Patient Name _____ Daytime Phone # _____ Date of Birth _____

Address _____ City, State Zip _____

To Release Medical Information To:

Family Beginnings
8435 Clearvista Pl, Suite 104
Indianapolis, IN 46256
Phone: (317) 595-3665
Fax: (317) 595-3666

Authorizes Disclosure From:

_____
Name of Health Provider/Organization/Individual

_____
Street Address

_____
City, State Zip

_____
Phone: Fax:

Purpose of This Disclosure:

☐ Transition to New Physician/Continued Medical Care

Information to Be Disclosed:

(Note: Please see Disclosures Requiring Special Consent for AIDS/HIV, Mental Health, Alcohol/Drug Use, and Developmental Disabilities.)

Date Range: _____ to _____

_____ This authorization shall also extend to records of future treatment, after the date of signature as long as such treatment occurs while this authorization is still in effect.
Initials (Please initial if you also wish to have future records not yet created to be included with this release)

☐ Office Visit Notes ☐ Ultrasound Reports ☐ Ultrasound Pictures

☐ Laboratory Reports: _____

☐ Specific information related to: _____

Your Rights Regarding This Authorization

Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. I am aware that I have the right to revoke this authorization by providing written notice to the health care provider who has been given this authorization.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Expiration Date: This authorization is effective for one (1) year from the date signed unless otherwise indicated. _____

Date (Optional)

_____ _____

Patient or Legal Representative Signature/Relationship *Date of Signature*

Disclosures Requiring Special Consent:

My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for:

☐ AIDS/HIV/STDs ☐ Mental Health Care ☐ Alcohol/Drug Use ☐ Developmental Disabilities

_____ _____

Patient or Legal Representative Signature/Relationship *Date of Signature*

(Photostatic copy shall be valid as original.)

Family Beginnings, PC
8435 Clearvista Pl, Suite 104
Indianapolis, IN 46256

Credit Card Authorization Form

The undersigned authorizes Family Beginnings to debit my card for future appointments and/or for future cryo-preservation storage fees.

The following conditions apply to the recurring payments program:

You may discontinue the charge on this card by providing Family Beginnings with my consent to stop all charges to this card. You may discontinue the recurring credit card payment plan by providing Family Beginnings with a notarized discard or donation form. Please be aware that the Family Beginnings financial policy requires recurring card payments for all cryopreservation storage.

Please complete the authorization information below:

_____ _____
Patient's Name (Appointment scheduled / specimen stored under) *Date of Birth*

I (the name entered above) authorize Family Beginnings to charge my card for telehealth, appointments performed in their clinic, or for annual storage fees. For storage fees, I authorize Family Beginnings to charge my card $400.00 annually on the first day of the month my specimen was initially cryopreserved. Please note, you will owe $400.00 per specimen batch stored at our facility.

_____ _____ _____
Name appearing on card *Last 4 digits of card* *Expiration Date*

***Please note if the credit card listed above is not currently on file in your account, we will send you an invoice to pay your bill online to save your card in our system for your next charge. Our credit card processing system allows you to store multiple cards for payment. We suggest that you set the card you wish to charge your storage fees to as your primary or default credit card in the system.

I authorize the above-named business to charge the card(s) indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing and provide a completed disposition form to the practice. I agree to notify the business in writing of any changes in my account information within 15 days prior to my account being charged. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this card and that I will not dispute the payments with the company of my card provided the transactions correspond to the terms indicated in this authorization form.

_____ _____
Signature of Patient *Date*

Family Beginnings, PC

Privacy of Your Health and Personal Information

Family Beginnings, PC understands that information about you and your health is personal. At Family Beginnings, we are committed to fully protecting personal information as possible and limiting disclosures to the minimum necessary to provide cost-effective, quality care.

The following information summarizes ways in which we may use and disclose personal information about you. This Notice of Privacy Practices fully explains this topic. In addition, the Notice of Privacy Practices details your privacy rights, and certain obligations we have regarding the use and disclosure of medical information.

Family Beginnings is pleased to provide this update on its privacy practices and looks forward to continuing service to you.

Notice of Privacy 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.

Family Beginnings is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

How Family Beginnings May Use or Disclose Your Health Information

The following categories describe the ways that Family Beginnings may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment: We may use medical information about you to provide you with medical treatment or services. For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.

Payment Functions: We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under your plan.

Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Family Beginnings and make sure that all of our patients receive cost-effective, quality care. These quality and cost improvement activities may include evaluating the performance of your doctors, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.

Appointment Reminders: We may want to use your health information for appointment reminders. For example, we may look at your records to determine the date and time of your next appointment with us and then contact you regarding the appointment. Or we may look at your medical information and decide that another treatment we offer

or service we provide may interest you. For example, a physician may review your records to determine if a new treatment will be beneficial for you.

Required by Law: As required by law, we may use and disclose your health information. For example, we may disclose medical information when required by a court order in a proceeding of litigation such as a malpractice action.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities: We may disclose your health information to health agencies during audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

Judicial and Administrative Proceedings: We may disclose your health information during any administrative or judicial proceedings.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying, locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors: We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.

Organ and Tissue Donation: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.

Public Safety: We may disclose your health information to appropriate people to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the public.

National Security: We may disclose your health information for military, national security, prisoner and government benefits purposes.

Worker's Compensation: We may disclose your health information as necessary to comply with worker's compensation or similar laws.

For Research: Under certain circumstances, and only after a special approval process, may we use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.

To those involved with your care or payment of your care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps to pay for your care. We may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

When Family Beginnings May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use

or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Statement of Your Health Information Rights

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. Family Beginnings is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to the Practice Administrator at Family Beginnings, 8435 Clearvista Pl, Suite 104, Indianapolis, IN 46256.

2. Right to Request Confidential Communications. You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status at a work location, or through a written letter sent to a private address. To request confidential communications, you must submit your request in writing to the Human Resources Director at Family Beginnings, 8435 Clearvista Pl, Suite 104, Indianapolis, IN 46256. We are not required to agree to your request but must accommodate reasonable requests.

3. Right to Inspect and Copy. You have the right to inspect and copy health information about you that may be used to make decisions about your treatment or plan benefits. To inspect and copy such information, you must submit your request in writing to Member Services. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

4. Right to Request Amendment. If you believe your health information is incorrect, you may ask us to correct the information. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To make an amendment, you must submit your request in writing to the Practice Administrator. You must also provide a reason for your request.

5. Right to Accounting of Disclosures. In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before January 1, 2007. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, health care operations, limited data sets, national security, law enforcement/corrections, and certain health oversight activities. To request this accounting of disclosures, you must submit your request in writing to the Practice Administrator.

6. Right to Paper Copy. You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this Notice, contact our office at (317) 595-3665.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Human Resources Director at (317) 595-3665.

Changes to this Notice of Privacy Practices

Family Beginnings reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, Family Beginnings is required by law to comply with the current version of this Notice.

Complaints About Privacy Practices

Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to [HIPAA Compliance Manager] at (317) 595-3665. Family Beginnings will not retaliate against you in any way for filing a complaint. All complaints to Family Beginnings must be submitted in writing to [HIPAA Compliance Manager], HIPAA Compliance Manager at Family Beginnings, 8435 Clearvista Pl, Suite 104, Indianapolis, IN 46256. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

Authorization for Disclosure of Medical Records

Patient Name: _____ Date of Birth: _____

I authorize the disclosure of my medical record information to the following person or organization:

Recipient Name: _____

Recipient Address, Phone, Fax, or Email: _____

Please select the medical record information authorized for disclosure:

☐ My entire medical record / complete patient file

☐ Only the specific document(s) listed below:

Specific document(s): _____

Patient Signature: _____ Date: _____

Patient Receipt of Notice of Privacy Practices

I have received a copy of the Family Beginnings Notice of Privacy Practices describing Family Beginnings' commitment to privacy, my right to privacy and how Family Beginnings may use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

By signing below, I am acknowledging that Family Beginnings will use and disclose my protected health information to provide my medical care and receive payment for services provided to me. I have the right to review the Notice of Privacy Practices prior to signing this acknowledgement.

Patient Signature: _____ Date: _____

Financial Disclosure

Family Beginnings, P.C. is committed to providing quality care to our patients. The following are financial policies we have established for our practice. If you have any questions regarding these policies, please talk with our billing department.

It is important to recognize your insurance policy is a contract between you and your insurance company. We recommend reviewing your insurance policy to understand your infertility/IVF benefits and limitations. If there is no coverage for fertility diagnosis or treatment, all services will be self-pay and due at the time of appointment.

Insurance Coverage and Financial Counseling

- Family Beginnings financial counselors are available to help guide you through understanding your infertility and IVF insurance benefits. We will provide an estimate of your expected financial responsibility prior to treatment whenever possible.
- Insurance benefit information is provided to Family Beginnings by your insurance company. Family Beginnings cannot guarantee coverage or payment, as final determinations are made by the insurance carrier after claims are processed. Because infertility coverage can be complex, patient deposits may be required prior to treatment.

Coverage Limitations & Patient Responsibility

- Even with infertility or IVF coverage, some services may be considered non-covered or experimental under your plan. Family Beginnings will review benefit details when possible; however, if insurance denies coverage for any reason, you are responsible for all charges not covered.

Referrals, Authorizations & Case Management

- Many insurance plans require referrals, prior authorizations, or enrollment in plan-specific case management programs before infertility services are covered.
- **Treatment cannot begin until Family Beginnings confirms that all required referrals and authorizations are on file.**
- If you choose to begin treatment without required referrals, authorizations, or enrollments, insurance coverage will not apply, and you will be considered self-pay. Full payment will be required prior to services being rendered.

Self-Pay Patients

- **Payment Requirement:** Patients without insurance coverage are required to pay in full prior to the start of treatment or any scheduled appointments. Services will not be provided until payment has been received.
- **Out-of-Network / Non-Participating Insurance:** If Family Beginnings does not participate with your insurance plan, or is considered out of network, all services are self-pay and payment is due at or before your scheduled appointment. As a courtesy, Family Beginnings may provide an itemized statement (HCFA/ledger) for patients who wish to submit claims directly to their insurance for possible reimbursement. Reimbursement is not guaranteed.

Third Party Labs

Family Beginnings takes no responsibility for any outside lab costs to patients. Utilizing non-Family Beginnings entities, such as pharmacy, anesthesia, or laboratory services, requires the details outlined below:

- **Anesthesia:** Anesthesia costs are self-pay. Patients will be responsible for a $625 anesthesia fee that is paid directly to **Northside Anesthesia Services. THESE CHARGES MUST BE PAID PRIOR TO PROCEDURE.**
- **Laboratory Services:** Patients are responsible for confirming whether laboratory services are covered under their insurance plan and for any financial responsibility owed directly to the laboratory.
- **Out-of-Network Providers:** Some services, including laboratories, anesthesia, or third-party vendors, may be considered out of network and may result in additional patient responsibility.

Specimen Storage

- I acknowledge that a valid credit card must be maintained on file for payment of annual storage fees for any cryopreserved specimens, including embryos, oocytes, or sperm. I authorize automatic annual billing to the credit card on file unless written notice and alternative payment arrangements are approved in advance.
- I understand that it is my responsibility to keep my contact information up to date, including my phone number, email address, and physical mailing address, to ensure I receive all storage-related notifications and billing communications. The clinic will make reasonable attempts to contact me for up to 90 days. If I do not respond or update my contact information within that time, the account may be referred to collections.
- I understand that additional fees may apply for specimen intake, handling, coordination, and shipping when specimens are transported to or from the clinic, including transfers to other clinics or storage facilities. These fees are separate from treatment or storage costs and may vary based on the destination and services required.

Settling Your Financial Obligations

- All outstanding balances that remain unpaid after 120 days may be referred to an outside collection agency or attorney.
- If we refer the unpaid balance to a collection agency, you are responsible for paying any reasonable attorneys' fees and legal expenses Family Beginnings may incur in attempting to collect payment from you.
- Any further treatment may be delayed until your outstanding balance is resolved.

If I_____*(initial)* decline recommended testing (such as genetic carrier screening or repeat testing), my insurance may deny coverage or prior authorization for certain services. Some insurance plans require specific testing to show that a procedure is medically necessary.

I_____*(initials)* acknowledge I have read and understand the following financial disclosures. If any of the disclosures apply, I could be financially responsible for payment in full. It is my responsibility to provide accurate and timely benefit information prior to all visits.

I_____*(initials)* understand insurance verification is completed prior to my scheduled visit utilizing the insurance information I have provided, if applicable. I may present new or updated insurance at or after my visit. Family Beginnings will be unable to provide accurate estimates if the correct insurance is not provided at least 72 hours prior to my/our scheduled visit.

For patients with insurance/self-pay, I_____*(initials)* may be required to seek treatment/lab from a physician, anesthesiologist, genetic testing facility, laboratory, or other providers. Family Beginnings recommends outside testing based on treatment and does not have any responsibility for outside testing billing/costs or benefit verification for referrals outside of Family Beginnings.

I acknowledge_____*(initials)* and understand I have elected to be seen as a self-pay patient, and I agree to assume all financial responsibility to pay in full today for all service(s) rendered, as applicable.

I acknowledge_____*(initials)* refunds are subject to an account review and may take up to 30 days to process. All pending insurance claims must be fully resolved in both the patient's and partner's accounts before a refund can be issued. Refunds are returned to the original credit card used for payment. Any payments made in cash will be refunded by check.

I have read and understand all the terms and conditions presented in this financial policy. I agree to be financially responsible for services rendered.

For services that have not been paid in full, or those requested by me to be submitted to insurance, I hereby consent to allow Family Beginnings to release information regarding my/our services to the insurance carrier(s) whose information has been provided by me/us.

By typing my name in the signature field below, I acknowledge that I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this form.

_____

Patient Name

_____

Date

CONSENT TO TREATMENT

Medical Treatment: The patient consents to the treatment, services, office visits, and procedures which may be performed at Family Beginnings, PC, which may include but are not limited to multiple visits, laboratory procedures, ultrasound evaluation, x-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered under the general or specific instructions of the responsible physician or other health care providers.

The office may establish certain criteria which will automatically trigger the performance of specific tests, which the patient agrees may be performed without any further separate consent.

Legal Relationship between Healthcare Providers and Patients: Except as described below under "Monitoring-Only Patients," the patient will be treated by his/her attending doctor and other Family Beginnings healthcare providers and will be under their care and supervision.

Monitoring-Only Patients: No Physician-Patient Relationship

Family Beginnings accepts monitoring patients who are referred to our clinic, from time to time, by an outside clinic, agency, or physician. For these patients, Family Beginnings agrees to perform ultrasounds and bloodwork/laboratory testing as ordered by the patient's home clinic or referring physician.

The patient, the referring clinic, and (where applicable) the intended parents understand and agree that, for monitoring services only, Family Beginnings and its physicians are *not* the patient's treating providers or caregivers, and that **no physician-patient relationship is established** between Family Beginnings and the patient for these services. All decisions regarding the patient's medical care remain the responsibility of the patient and the referring/home clinic physician.

Family Beginnings will send documentation of each monitoring visit to the referring clinic in a timely fashion.

During ultrasound exams, patients may not use FaceTime or other video-conferencing technology to allow another person to observe remotely, and surrogates and egg donors may not bring another person into the ultrasound room.

This section applies only to patients receiving monitoring services at Family Beginnings under the direction of an outside referring clinic, agency, or physician. It does not apply to patients under the direct care of a Family Beginnings physician.

Acknowledgment

I have read, understand, and agree to this Consent to Treatment. I am the patient, the parent of a minor child, or the legal representative of the patient, and I am authorized to act on the patient's behalf in signing this agreement. If I am a monitoring-only patient, I additionally understand and agree that Family Beginnings is not my treating provider, that no physician-patient relationship exists between Family Beginnings and me for these services, and that all medical decisions regarding my care remain with me and my referring/home clinic physician.

Family Beginnings Patients:

Signature: _____ Date: _____

For monitoring-only patients — complete this section only if applicable:

☐ I am receiving monitoring-only services at Family Beginnings, referred to by the clinic/agency named below.

Referring Clinic/Agency Name: _____

Referring Physician Name: _____

Referring Clinic Representative Signature: _____ Date: _____

Monitoring Patient Signature_____ Date_____