

# **FEMALE PAPERWORK**

**PLEASE RETURN COMPLETED  
PAPERWORK TO OUR OFFICE AT  
LEAST 3 DAYS PRIOR TO YOUR  
APPOINTMENT.**

**Mail: NCRM**

**645 Sierra Rose Dr. #205  
Reno, NV. 89511**

**Fax : 775-828-1785**

**E-mail: Reply to e-mail sent to you**

**THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE**  
**645 Sierra Rose Drive, Suite 205**  
**Reno, NV 89511**

**Phone: 775-828-1200**

**Fax: 775-828-1785**

**Hours of Operation:**

**Monday/Wednesday/Friday 7:00AM-4:00PM**

**Tuesday/Thursday 8:00AM-5:00PM**

**Directions to NCRM**

**Directions from the Airport:**

South on Highway 395 for 1.6 miles

Exit #63 marked So. Virginia/Kietzke Ln. and splits to left toward Kietzke Ln.

Left on Kietzke Ln. for 0.4 miles

Right on Sierra Rose Drive.

First Right in to medical complex

Follow drive around to left and watch for two-story 645 Building on left. Directions from Carson City:

North on Highway 395

Exit #62 at Neil Road.

Left on Neil Road.

Exit round-a-bout heading north on Kietzke Ln.

Left on Sierra Rose Drive. (Before Lowe's)

First Right in to medical complex

Follow drive around to left and watch for two-story 645 Building on left.

**Directions from Truckee/Northern California:**

I-80 East to Highway 395 south toward Carson City.

Exit #63 marked So. Virginia/Kietzke Ln. and splits to left toward Kietzke Ln.

Left on Kietzke Ln. for 0.4 miles

Right on Sierra Rose Drive.

First Right in to medical complex

Follow drive around to left and watch for two-story 645 Building on left.

**Directions from Eastern Nevada (Elko, Winnemucca):**

I-80 West to Highway 395 south toward Carson City.

Exit #63 marked So. Virginia/Kietzke Ln. and splits to left toward Kietzke Ln.

Left on Kietzke Ln. for 0.4 miles

Right on Sierra Rose Drive

First Right in to medical complex

Follow drive around to left and watch for two-story 645 Building on left

THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE

**FEMALE NAME**

FIRST MIDDLE LAST  
ADDRESS \_\_\_\_\_

STREET CITY STATE ZIP  
HOME PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

RACE(Optional) \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

OCCUPATION \_\_\_\_\_  
SPOUSE OR PARTNER \_\_\_\_\_

FIRST MIDDLE LAST  
BIRTHDATE \_\_\_\_\_

**\* If your email address has changed please notify us to complete new form.**  
\*\*\*\*\*

PRIMARY INSURANCE \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

POLICYHOLDERS NAME \_\_\_\_\_

DOES INSURANCE COVER BOTH PATIENT AND SPOUSE? YES or NO (circle one)

SECONDARY INSURANCE \_\_\_\_\_

GROUP # \_\_\_\_\_ ID# \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

POLICYHOLDER'S NAME \_\_\_\_\_

DOES INSURANCE COVER BOTH PATIENT AND SPOUSE? YES or NO (circle one)

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE # \_\_\_\_\_

REFERRED BY \_\_\_\_\_

NAME ADDRESS Phone

PRESENT PHYSICIAN \_\_\_\_\_ PHONE # \_\_\_\_\_

Do you have an advanced directive? YES or NO (circle one)

If Yes, With whom is it filed? \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE INFORMATION:** I hereby authorize payment directly to the undersigned physician for medical and/or surgical benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for these services. I also authorize the undersigned physician to release any information acquired in the course of my examination or treatment. This may include electronic transmission (i.e., fax) of medical records.

DATE \_\_\_\_\_ PATIENT SIGNATURE \_\_\_\_\_





## THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE

### Patient-Healthcare Provider Electronic Communication Agreement

Electronic communications, including, but not limited to, emails, internet-based video conferencing through such applications as Skype and “FaceTime” through iPhones and iPads, for example (hereinafter “Electronic Communications”) provide an opportunity to communicate with your healthcare provider relative to issues that are **non-emergent, non-urgent or non-critical**. Electronic Communications are not a replacement for the interpersonal contact that is the very basis of the doctor-patient relationship.

The following is intended to assist you with your determination of whether you wish to supplement your healthcare experience by electronically communicating with members of the healthcare team at The Nevada Center For Reproductive Medicine.

#### General Considerations

- Your Healthcare Provider will treat Electronic Communications with the same degree of privacy and confidentiality as written medical records. Your Healthcare Provider has taken reasonable steps with internal information technology systems to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1992, as amended (HIPAA.)
- Standard email services, including, but not limited to, AOL, Optonline, Hotmail, and Gmail, are not secure. This means that the email messages are not encrypted and can be intercepted and read by unauthorized individuals.
- Electronic communication via internet based video conference providers, including, but not limited to, Skype, claim to have safeguards in place to protect your personal information from unauthorized disclosure. However, there is the possibility that viruses, Trojans or other malicious software may obtain your private information on your computer system and release and/or use your information without your knowledge. There may be other risks associated with internet communication which are unknown at this time.
- Transmitting email that contains protected health information through an email system that is not encrypted do not meet and electronic communication via internet based video conference providers may not meet the security guidelines as required by the HIPAA.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with Healthcare Provider. I acknowledge that commonly used Electronic Communications are not secure and fall outside of the security requirements set forth by HIPAA.

I understand that I can withdraw this consent authorizing Healthcare Provider to communicate with me via Electronic Communications at any time by written notification to Healthcare Provider.

I release and hold harmless Healthcare Provider, its physicians and their staff, employees, affiliates, agents, officers, directors and shareholders from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses, of any kind that I may have resulting from Electronic Communications between Healthcare Provider and me based on this authorization given to Healthcare Provider to communicate with me via Electronic Communications.

Having been informed of the risks associated with Electronic Communications, I still desire to communicate with Healthcare Provider via electronic communications. In consideration for my desire to use Electronic Communications as an adjunct to in-person office visits with Healthcare Provider, I hereby authorize Healthcare Provider to engage in Electronic Communication with me.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Current E-Mail Address \_\_\_\_\_

NEVADA CENTER FOR REPRODUCTIVE MEDICINE

HIPAA PRIVACY RULE AUTHORIZATION  
FOR RELEASE OF HEALTH INFORMATION

I, \_\_\_\_\_ authorize the specified person(s) or  
( Female Patient )  
company to disclose protected health information as follows:

1. Company authorized to make disclosure: NCRM
2. Person authorized to receive the disclosed information:  
Partner \_\_\_\_\_ Other \_\_\_\_\_
3. Specific description of the protected health information that may be used or disclosed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status.
5. I understand that I may revoke this authorization by giving written notice to a representative of The Nevada Center For Reproductive Medicine.
6. I understand that I am entitled to receive a copy of this authorization.
7. I understand that after this information is disclosed, federal law might not protect it, and the recipient might re-disclose it.
8. I give authorization to representatives of NCRM to leave protected health, information on the following:

	<u>Circle one</u>		<u>Initial here</u>
1. Home answering machine	yes	no	_____
2. Cell phone voice mail	yes	no	_____
3. Work voice mail	yes	no	_____

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF PATIENT : \_\_\_\_\_

WITNESS: \_\_\_\_\_



## THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE

Dear New Patient:

Welcome to The Nevada Center for Reproductive Medicine, a specialty clinic for the diagnosis and treatment of infertility problems. We sincerely hope that we are successful in assisting you in your goal of conceiving.

We would like to briefly outline our billing arrangements with you. Our initial office consultation fee ranges from \$280.00 to \$335.00. This does not include any laboratory or special tests that our physician may deem necessary for your particular situation. You will be given a new patient packet of information during your first visit that includes a fee schedule.

We are participating providers in several types of insurance. We will bill your insurance **if** we are contracted with the insurance, and the consultation is a covered benefit under your plan. PLEASE NOTE: We do not bill insurances that we are not contracted with. Your deductible, co-pay or co-insurance amount is due at the time of your visit. If you are covered by insurance that requires an authorization from your primary care physician (PCP), it is **your** responsibility to obtain the authorization prior to being seen in our office. If you do not have your authorization, you will be asked to re schedule your appointment.

For our patients without insurance, payment is required at the time of each visit. We do not have payment plans available. We do have a financial grant available for patients that meet certain income criteria. You must apply and qualify for the reduced fee. For information on the Access program, please contact our financial counselor.

It is necessary that all prior balances be paid before you start any new diagnostic or treatment cycles. Even if your insurance has been billed, the ultimate responsibility of payment of your bill is your obligation.

**Cancellation policy: If you are unable to make your appointment, you must give us a 48 hour notice, or there will be a \$50.00 fee charged to your account. We will be unable to reschedule your appointment until the fee is paid.**

If you have any questions regarding our office policy or our billing procedures, please do not hesitate to ask.

Thank you,

The Nevada Center for Reproductive Medicine

I acknowledge that I have read, understand, and agree to abide by the above information.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE

### NOTICE OF PRIVACY PRACTICES

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

#### Introduction

This Notice of Privacy Practices is being provided to you on behalf of The Nevada Center for Reproductive Medicine (NCRM) with respect to reproductive medical services provided at The Nevada Center for Reproductive Medicine's facilities (collectively referred to herein as "We" or "Our). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

#### Your Rights

Although your health record is the physical property of NCRM, you have the right to:

- request a restriction on certain uses and disclosures of your information as provided by applicable law
- obtain a paper copy of this Notice of Privacy Practices upon request
- inspect and copy your health record as provided for by applicable law
- request an electronic copy of your electronic health record
- request to amend your health record as provided by applicable law
- obtain an accounting of disclosures of your health information as provided by applicable law.
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- request a restriction of disclosure of your health information to your health insurer for services for which you pay "out of pocket" in full
- transmit copies of your health information to third parties when request by you, in writing



## Our Responsibilities:

We are required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- where required by law, notify you in the event that there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at [www.nevadafertility.com](http://www.nevadafertility.com) as well as at our offices and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which we receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect except where we have already relied upon your authorization.

## **Permitted Uses and Disclosures**

*We will and disclose use your health information for **treatment**. For example:* information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

*We will use your health information for **payment**. For example:* A bill may be sent to you or a third party payor, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. If you indicate your interest in participating in the **Attain IVF Program**, we will submit an application providing relevant information concerning your medical condition, your e-mail address, and phone numbers to Integra Med America's Attain Fertility Division for determination of your qualifications for this financing program. They will contact you by e-mail and by phone.

*We will use and disclose your health information for our **health care operations**. For example:* Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and the reproductive medicine service we provide.

## **Other Uses or Disclosures of Protected Health Information**

***Business Associates:*** There are some services provided at NCRM through contacts with business associates. For example: the management services of *IntegraMed America, Inc.* and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that 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.

***Notification:*** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

***Communication with Spouse/Family:*** Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

***Research:*** We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

***Marketing:*** Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

***Food and Drug Administration (FDA):*** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

***Public Health:*** As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

***Law Enforcement:*** We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**Note: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.**

**For More Information or to Report a Problem/Complaint**

If you believe your privacy rights have been violated, you should immediately contact:

**The Privacy/HIPAA Officer at NCRM  
645 Sierra Rose Dr. Suite 205 Reno, Nevada 89511  
(775) 828-1200**

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

If you have any questions or would like further information about this notice, please contact The Privacy/HIPAA Officer at the above address. This notice is also available on our website at [www.nevada fertility.com](http://www.nevada fertility.com)

This notice is effective as of June 11, 2013.

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**THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE**

**NOTICE OF PRIVACY PRACTICES INFORMED CONSENT**

I acknowledge that I have received a copy of The Nevada Center for Reproductive Medicine's notice of privacy practices.

\_\_\_\_\_  
Name of patient (print)

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of witness ( print )

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date



# The Nevada Center for Reproductive Medicine

## FEMALE PATIENT HISTORY

Name \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type \_\_\_\_\_

When was the first day of your last period? \_\_\_\_\_

Are your periods regular? \_\_\_\_\_

If yes, what is the usual number of days between periods? \_\_\_\_\_

If no, how many times per year do you menstruate? \_\_\_\_\_

What is the usual duration of your period? \_\_\_\_\_

What medications do you regularly take? (Prescription and/or over the counter drugs?) \_\_\_\_\_

\_\_\_\_\_

Do you, or have you ever, used:

Alcohol? How many drinks per week? \_\_\_\_\_

Cigarettes? How many packs per day? \_\_\_\_\_

Illicit or recreational drugs? \_\_\_\_\_

How long have you been trying to get pregnant? \_\_\_\_\_

	Year?	Abortion?	Miscarriage?	Ectopic?	Born Alive?	Fertility Drugs Required?	Current Partner Father?
1st Pregnancy	_____	_____	_____	_____	_____	_____	_____
2nd Pregnancy	_____	_____	_____	_____	_____	_____	_____
3rd Pregnancy	_____	_____	_____	_____	_____	_____	_____
4th Pregnancy	_____	_____	_____	_____	_____	_____	_____
5th Pregnancy	_____	_____	_____	_____	_____	_____	_____

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

**Allergies? (Circle) Yes or No**

If Yes, please list: \_\_\_\_\_

\_\_\_\_\_

Anemia  
 Appendicitis  
 Arthritis  
 Blood Transfusions  
 Breast Milky Discharge  
 Breast Soreness  
 Breast Tenderness  
 Cancer (Specify) \_\_\_\_\_

Colitis  
 Color Blind  
 Diabetes  
 Dizziness  
 Endometriosis  
 Epilepsy  
 Fever  
 Gallbladder Problems  
 Gonorrhea  
 Heart Disease  
 Hepatitis  
 Herpes  
 Hirsutism (Excessive Hair Growth)  
 High Blood Pressure  
 Immunized: German Measles  
 Kidney Infection  
 Liver Problems  
 Loss of Balance  
 Measles: German

Measles: Regular  
 Neurological Problems  
 Nongonoccal Urethritis  
 Ovarian Cysts  
 Parasitic Infection  
 Pelvic Infection  
 Pneumonia  
 Poor Sense of Smell  
 Rheumatic Fever  
 Scarlet Fever  
 Seizures  
 Syphilis  
 Thyroid Problem  
 Tuberculosis  
 Ulcers  
 Vaginitis (Trichomoniasis, Yeast)  
 No. of Episodes \_\_\_\_\_  
 Visual Disturbances  
 Weight Loss

Has your partner ever fathered a child with another woman? \_\_\_\_\_

Have you ever been treated for infertility in the past? \_\_\_\_\_

If yes, review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone: \_\_\_\_\_

\_\_\_\_\_



# Nevada Center for Reproductive Medicine

Scott J. Whitten, M.D.  
Reproductive Endocrinology & Fertility  
Medical Director

Russell A. Foulk, M.D.  
Reproductive Endocrinology & Fertility  
Laboratory Director

645 Sierra Rose Dr. Suite #205  
Reno, NV. 89511  
Phone # (775) 828-1200  
Fax # (775) 828-1785

## Authorization to Release Medical Records

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

FROM: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

TO: SCOTT WHITTEN MD OR RUSSELL FOULK MD

645 SIERRA ROSE DRIVE SUITE 205 RENO, NV 89511

Phone # 775-828-1200 Fax# 775-828-1785

I hereby authorize and request the release of the following information:

\_\_\_\_\_ All Medical Records

\_\_\_\_\_ Medical record information for visit date of \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ Lab Reports

\_\_\_\_\_ Hospital and/or Operative reports

\_\_\_\_\_ OB Records

\_\_\_\_\_ Other: \_\_\_\_\_

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment, and infertility treatment. I give authorization for these records to be released.

This authorization is valid for this request only. The Nevada Center for Reproductive Medicine cannot condition treatment or eligibility of benefits on whether the authorization is signed. Protected health information (PHI), once released, has the potential to be re-disclosed by the recipient and is no longer protected by the Nevada Center for Reproductive Medicine.

Signature (patient): \_\_\_\_\_ Date: \_\_\_\_\_



THE NEVADA CENTER FOR REPRODUCTIVE MEDICINE

**NON CONTRACTED INSURANCE WAIVER**

BLUE CROSS BLUE SHIELD HEALTH COMP HUMANA MEDICARE MEDICAID

NPP ( NV PREFERRED PROVIDERS ) TRI WEST MOAA MEDIPLUS FIRST HEALTH /SCOTT WHITTEN

MAIL HANDLERS / SCOTT WHITTEN

Date: \_\_\_\_\_

Dear Patient:

**At this time, your physician is not a contracted provider with your insurance company.**

We only bill insurance companies that we are contracted with. You are responsible for payment in full at the time of service. Our office will provide you with the necessary information for you to submit a claim to your insurance company for reimbursement directly to you.

If you are seeing our provider for a scheduled surgery, we will provide you with a HCFA form to bill your insurance company. You are responsible for payment in full, one week prior to your surgery date.

Thank you for your understanding and cooperation.

**I understand that my provider is not contracted, and that I am responsible for payment in full at the time of service.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Service Representative