MALE 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

MALE 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 company to disclose protected health information as follows:
(Male Patient)

1. **Company authorized to make disclosure: NCRM**
2. **Person authorized to receive the disclosed information:**
   Partner_____ Other_____
3. **<u>Specific description</u> of the protected health information that may be used or disclosed:_____**
   _____
   _____
4. **I understand that the information received pursuant to this authorization <u>may</u> 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:**

	Circle one		Initial here
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 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 re 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

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

MALE PATIENT HISTORY

Name _____

Are you, or have you ever, been exposed to any of the following during employment or military service? If so, explain:

Heat _____ Toxic Fumes _____

Chemicals _____ Nuclear Radiation _____

Other _____

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

_____

_____

Do you frequently take saunas or steam baths? _____

Do you, or have you ever, used:

Alcohol? How many drinks per week? _____

Cigarettes? How many packs per day? _____

Illicit or recreational drugs? _____

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) _____

_____

Chlamydia
Chronic Bronchitis

Chronic Headaches
Colitis
Cystic Fibrosis
Diabetes
Dizziness
Epilepsy
Fever
Gallbladder Problems
Gonorrhea
Heart Disease
Hepatitis
Herpes
High Blood Pressure
Kidney Infection
Liver Problems
Loss of Balance
Measles : German
Measles: Regular

Mumps
Mumps w/Testes Involved
Neurological Problems
Nongonococcal Urethritis
Parasitic Infection
Pneumonia
Prostatitis
Rheumatic Fever
Scarlet Fever
Seizures
Syphilis
Testes Infection
Testes Injury
Testes Tumor
Thyroid Problems
Tuberculosis
Visual Disturbances
Weight Loss

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: _____

_____

Phone # _____ Fax# _____

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