Please read and answer the following before completing this package:

Have you had your tubes tied? Yes No

Has your partner had a vasectomy? Yes No

Do you have any children together? Yes No
If so, ages _____

Do either of you have any children from
prior relationships? Yes No
If so, ages _____

Did you have any prior fertility treatment? Yes No
If so, where and when?_____

What treatment was done?_____

DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY
PATIENT HISTORY FORM

Date of Visit: _____

PERSONAL INFORMATION

First Name: _____ M.I.: ___ Last Name: _____
Date of Birth: ___/___ /__ Age: ___ SS# (mandatory): _____
Location: (Boro) _____ Your Employer:_____
Occupation: _____ Ethnic Background: _____
Religion: _____ Phone Numbers: Work: (____) ____-_____
Mobile: (____) ____-_____ Fax: (____) ____-_____
Home Address: _____ Apt. # : ____ City: _____
State: ____ Zip Code: _____ Home Telephone: (____) ____-_____
E-mail address: _____
Driver's License Number: _____ State: _____
Partner's First Name: _____ Last Name: _____
Date of Birth: ___/___/___ Age: ___ SS#(mandatory): _____
Partner's Employer: _____ Occupation: _____
Religion: _____ Phone Numbers: Work: (____) ____-_____
Mobile: (____) ____-_____ Fax: (____) ____-_____
Driver's License Number: _____ State: _____
Insurance Company: _____ Subscriber ID#: _____
Insured: _____ Gynecologist: _____
Referred by:_____
Pharmacy : _____ Telephone: _____

PRESENT PROBLEM

Reason for your clinic visit:

□ Infertility □ Polycystic Ovarian Syndrome □ Abnormal Hair Growth
□ Irregular Periods □ Pelvic Pain □ Endometriosis
□ Absent Periods □ Recurrent Miscarriages
□ Other, please specify:_____

Years of Duration: _____
Physician: _____

Describe as thoroughly as possible the background of your present problem. Include all symptoms, how long you have experienced them and indicate whether they have become worse, lessened or stayed the same in severity over time.

_____
_____
_____

Physician Notes:

_____
_____
_____

GENERAL MEDICAL HISTORY

Do you have any allergies? □ No □ Yes
Specify:

Childhood illnesses - Routine: □ chicken pox □ measles □ mumps
□ Others: (Describe): _____

Your general health: □ Excellent □ Good □ Fair □ Poor

Have you ever been in a serious accident? □ No □ Yes
(Describe):

_____
_____

Have you ever had a blood transfusion? □ No □ Yes
Approximate date(s): _____

List all serious medical illnesses with date(s): If hospitalized, where?

_____
_____

List all surgical procedures you have had, the approximate date(s), duration of your hospitalization(s) and name of hospital(s):

_____
_____

Have you undergone a surgical sterilization procedure? □ No □ Yes (Describe):

_____
_____

List current medications: State the name of medication, indication for its use, and how long you've taken it. Include both prescription and over-the-counter medication.

Medication Starting Through Amount Indications

1. _____
2. _____
3. _____

Do you smoke cigarettes? □ No □ Yes Number of packs per day: _____
If you smoked in the past and have quit, give the approximate dates of smoking: _____

Drug usage in past year:
□ Marijuana □ Cocaine □ Depressants □ Stimulants □ Other

State the substances and extent of exposure:
_____

Do you drink alcohol? □ Daily □ Weekly □ Monthly □ Never

Have you had any difficulty or recent change in your habits of sleep, diet, exercise?
□ No □ Yes
Describe: _____

Present weight: _____ Height: _____
Any recent, significant weight changes? □ No □ Yes
Describe:_____

FAMILY HISTORY

Check any of the following disorders which have occurred in your family. This section does not refer to any problems that you yourself have had.

□ Cancer (specify) _____
□ Diabetes
□ Thyroid disorders
□ Heart disease
□ Hypertension
□ Blood clotting disorders
□ Tuberculosis
□ Chromosome (genetic) abnormality
□ Obesity
□ Psychiatric disorders
□ Infertility
□ Multiple Miscarriages
□ Seizures
□ Baby with birth defects/retardation
□ Other: (specify) _____

If you checked any of the above, please explain:
_____

MENSTRUAL HISTORY

At what age did you begin to menstruate? _____
What were the dates of your last two menstrual periods? _____

Have you ever gone more than three months without having a period?
□ No □ Yes How long? (Mos./Yrs.)_____
Approximate dates when this occurred: _____

Are you normally: □ REGULAR? □ IRREGULAR?
Please describe:_____

What is the average length of your menstrual cycle? (Interval from first day of bleeding until the day before bleeding of the next cycle): _____
Has this changed since puberty? □ No □ Yes
Explain: _____
How many days does your period last? _____

Is your flow □ LIGHT □ MEDIUM □ HEAVY?

Does this vary? □ No □ Yes
Please explain: _____

Do you have pain during periods? □ No □ Yes
Please describe: _____
Do you have pain between periods? □ No □ Yes
Please describe: _____
Do you bleed between periods? □ No □ Yes
If yes, describe frequency and amount of blood loss: _____

GYNECOLOGICAL HISTORY

Have you had regular GYN exams? □ No □ Yes
Date of last exam: _____
Date and result of last pap smear: _____
Have you had regular breast examinations? □ No □ Yes
Date of last exam: _____
Date & findings of last abnormal exam: _____
Date & findings of last mammogram: _____

Have you ever had a milky discharge from one or both breasts? □ No □ Yes
If so, when? _____

Have you had a history of: (If yes, please give date)
□ Chlamydia □ Gonorrhea □ Pelvic (tubal) infection

OBSTETRICAL HISTORY

□ Not Applicable (Continue on to next section)

	Number	Dates(s)	Months took to Conceive	Sex/Wt.	Vaginal/C-section
Full term deliveries (37 weeks or more)					
Premature deliveries (Less than 37 weeks)					
Miscarriages					
Induced Abortions					
Stillbirths					
Newborn Deaths					

	Number	Side	Date	Treatment
Ectopic Pregnancies				

Were any of your children born with congenital defects? □ No □ Yes
If yes, state which delivery and describe the congenital defect:
_____

Dates of pregnancies with present husband/partner: _____
Number of living children from this marriage/relationship: _____

Did you have any pregnancies/children from a previous spouse/partner?: □ No □ Yes
If yes, list dates of pregnancies: _____
And living children: _____
If applicable, dates of pregnancies through artificial insemination:
_____donor sperm only _____living children

CONTRACEPTION

□ Not Applicable (continue on to next section)

Please check any of the following methods of contraception you are currently using and/or have used in the past. Fill in the dates of usage.

Method	Type	Dates of Usage
□ Birth control pills		_____
□ IUD		_____
□ Diaphragm		_____
□ Condom		_____
□ Jellies/Foam		_____
□ Withdrawal		_____
□ Sterilization:	□ Male □ Female	
□ Other:	_____	

INTERCOURSE HISTORY

Frequency of intercourse: ____ times per week ____times per month □ N/A
Do you have any problems with intercourse? □ N/A □ No □ Yes
If yes, describe your problems with intercourse:

_____

_____

Do you have noticeable discharge? □ N/A □ No □ Yes
Please describe your discharge (color, consistency, presence of odor, itching, etc.):

_____

Any changes in libido? □ N/A □ No □ Yes
Any pain during or after intercourse? □ N/A □ No □ Yes
Do you bleed during or after intercourse? □ N/A □ No □ Yes

REVIEW OF SYSTEMS

Check any of the following disorders you currently have or have a history of:

CENTRAL NERVOUS SYSTEM
□ Seizures □ Migraine headaches □ Other: _____
□ None

ENDOCRINE

□ Diabetes □ Thyroid disease □ Excessive growth of hair on various parts of the body
□ Hair loss □ Rapid weight gain □ Rapid weight loss □ Unexplained rash
□ Excessive hunger/thirst □ Other: _____

EENT

□ Eye disorders □ Problem with sense of smell □ Double or blurry vision
□ Other: _____

RESPIRATORY

□ Shortness of breath □ Bronchitis □ Cough producing blood □ Asthma (date of last attack)
□ Pneumonia □ Tuberculosis□ Other:_____

CARDIOVASCULAR

□ Chest pain □ Rheumatic fever □ Heart valve disease □ Palpitations □ High blood pressure
□ Given prophylactic antibiotics □ Mitral valve prolapse □ Other: _____

HEMATOLOGIC

□ Blood clotting disorder □ Sickle cell anemia or trait □ Thrombophlebitis
□ Other: _____

GASTROINTESTINAL

□ Nausea/Vomiting □ Blood in stool □ Ulcers □ Hepatitis □ Constipation
□ Spastic colon □ Other: _____

GENITO-URINARY

□ Bladder infections (cystitis) □ Kidney infection □ Vaginal infections
□ Frequent urination □ Urinary Tract Infection □ Other: _____

MUSCULO-SKELETAL

□ Unusual muscle weakness □ Decreased energy/stamina
□ Rheumatoid arthritis □ Lupus erythematosus
□ Other: _____

SKIN

□ Unexplained rash □ Skin Cancer □ Dermatits □ Acne □ Injuries
□ Other: _____

HUSBAND/PARTNER HISTORY

Are you married? □ No □ Yes
Duration of present marriage/relationship: _____

Has husband/partner initiated a pregnancy in a previous relationship? □ No □ Yes
Please give dates and outcome of pregnancy: _____
Has husband/partner had a previous relationship where pregnancy did not occur even though no contraception was used? □ No □ Yes
How long a period was involved? _____

Any difficulty in achieving/maintaining an erection? □ No □ Yes
Any difficulty with ejaculation? (E.g., retrograds, premature)? □ No □ Yes

Any history of possible reproductive tract problem, (including dates) e.g.,
Prostatitis:_____ Epididymitis:_____ Orchitis:_____ Testicular tumor:_____
Injury to testes: _____
Any history of transmissible disease? □ No □ Yes
□ Gonorrhea □ Chlamydia □ Non-specific urethritis □ Syphillis
Any history or reproductive tract surgery? □ No □Yes
□Please give procedure and date: _____

HUSBAND/PARTNER-MEDICAL HISTORY

Do you have any allergies? □ No □ Yes
Please specify:_____

Childhood illnesses- Routine: □ chicken pox □ measles □ mumps
Others: (Describe):_____

Your general health: □ Excellent □ Good □ Fair □ Poor
Have you ever been in a serious accident? □ No □ Yes
(Describe):_____
_____

Have you ever had a blood transfusion? □ No □ Yes
Approximate date(s):
_____

List all significant medical illnesses requiring treatment. Include dates and name of physician/hospital which husband/partner has experienced:
_____
_____

List all surgical procedures, approximate date and hospital which husband/partner has undergone:
_____
_____

Have you undergone a surgical sterilization procedure? □ No □ Yes

List current medications: State the name of medication, indication for its use, and how long medication has been taken. Include both prescription and over-the-counter medication.

Medication Starting Through Amount Indications

1._____
2._____
3._____

Does husband/partner smoke cigarettes? □ No □ Yes
Number of packs per day: _____

If husband/partner smoked in the past and has quit, give the approximate dates of smoking:
_____

Drug usage in past year: □ Marijuana □ Cocaine □ Depressants □ Stimulants □ Other:_____
State the substances and extent of exposure: _____

Do you drink alcohol? □ Daily □ Weekly □ Monthly □ Never

Any difficulty or recent change in your habits of sleep, diet, exercise? □ No □ Yes
Please describe:
_____
_____

Any recent illnesses or change in health? □ No □ Yes
Please describe: _____

Present weight: _____ Height: _____
Any recent, significant weight changes? □ No □ Yes
Please describe: _____

Has husband/partner been exposed to any of the following:
□ High temperatures □ Hot tubs □ Radiation □ Chemicals □ Toxic substances

PAST INFERTILITY EVALUATION

Months Infertile prior to coming to Genesis Fertility _____

Check all that apply:	Date(s)	Results
□ Husband/partner		
□ Semen analysis		
□ Temperature charts		
□ Postcoital test (Huhners)		
□ Endometrial biopsy		
□ X-ray of tubes		
□ Diagnostic laparoscopy		
□ Hysteroscopy		
□ Hormonal tests		
□ Chromosomal studies		

PRIOR FERTILITY TREATMENT

□ Not Applicable

Number of prior non-ART gonadotropin treatment cycles (both with and without intrauterine insemination)_____

Number of prior fresh ART cycles (this number should include any cancelled cycles):
_____ IVF (in vitro fertilization)
_____Other (GIFT, ZIFT, or TET)

Number of prior frozen embryo transfer procedures (please do not include cancelled cycles)_____

Medications taken:

_____

_____

Please feel free to use the following "comments section" for any additional information you feel may be helpful in your infertility evaluation:

_____

_____

_____

_____

_____

_____

_____

_____

Authorization for the Release of Protected Health Information

We understand that information about your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your authorization before we may use or disclose your protected health information from the medical record maintained by this office for the purposes described below. The form provides that authorization and helps us make sure that you are properly informed of how this information will be used of disclose. Please read the information below carefully before signing this form.

I hereby authorize: _____

To release the protected information from the medical record(s) of:

PATIENT'S NAME: _____
To the individual below:

☐ **Richard V. Grazi, M.D.** ☐ **Jennifer K. Makarov, M.D.**

□ **Diana Chavkin, M.D.** ☐ **Katherine Melzer Ross, M.D.**

MMC Reproductive Endocrinology
6010 Bay Parkway
Brooklyn, NY 11204

Tel (718) 283-8600 / Fax (718) 283-6580

For the purpose of Continuing Medical Treatment

I request the entire record only for the dates of service as follows:
_____

Specific Understandings

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. You understand that once the information is disclosed pursuant to the authorization, the information may be subject to re- disclosure by the recipient and may not be protected by federal privacy regulations (if the recipient is not required by law to protect the privacy of the information). You have a right to see and request a copy of the information described on this authorization form in accordance with hospital policies. You also have a right to receive a copy of this form after you have signed it.

Signature

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and that I agree to all of the above.

_____

Signature of Patient or Personal Representative

_____ _____

Print Name of Patient or Personal Representative Date

MMC REPRODUCTIVE ENDOCRINOLOGY FPP

'DBA' GENESIS FERTILITY & REPRODUCTIVE MEDICINE

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this Notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may separate written explanations of special privacy protections that apply to HIV-related information and mental health information.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority

IT MAY BE NECESSARY FOR US TO CONTACT YOU BY CALLING YOUR HOME, WORK , CELL OR EMERGENCY NUMBER OR BY EMAILING YOU FOR APPOINTMENTS AND RESULTS. IF YOU ARE NOT AVAILABLE, WE MAY LEAVE A MESSAGE FOR YOU TO CONTACT THE OFFICE. UNLESS YOU HAVE SPECIFICALLY INSTRUCTED US NOT TO, WE WILL ASSUME THAT YOU DO NOT OBJECT. YOU MUST ALSO NOTIFY US IF YOU DO NOT WISH TO DISCUSS YOUR MEDICAL CONDITION WITH IMMEDIATE FAMILY MEMBERS. THANK YOU.

I PREFER TO BE CONTACTED AT (PLEASE CHECK BOX AND ENTER INFORMATION):

□ **Home Number**: (____) ____-_____ □ **Work Number**: (____) ____-_____

□ **Cell Number**: (____) ____-_____ □ **Emergency Number**: (____) ____-_____

□ **E-Mail**: _____ □ **All of the above**

****

(For internal use where signature above cannot be obtained.)

Except in emergency treatment circumstances, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we make a good faith effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices on the first date after April 14, 2003 we provide treatment, products or services to the patient (including at the time of admission, at a first visit to a hospital department, or any other first service contact with the patient). We must make a good faith effort to obtain written acknowledgment when reasonably practicable following an emergency treatment situation. If such acknowledgment cannot be obtained, we must document our good faith efforts to obtain the acknowledgment and why it was not obtained.

Describe good faith efforts to obtain written acknowledgment (**include your name and the date**):

1. _____

   Name: _____ Date: _____

2. _____

   Name: _____ Date: _____

3. _____

   Name: _____ Date: _____

THE ORIGINAL OF THIS FORM MUST BE PLACED IN THE MEDICAL RECORD.

MMC REPRODUCTIVE ENDOCRINOLOGY FPP

'DBA' GENESIS FERTILITY & REPRODUCTIVE MEDICINE

NOTICE OF PRIVACY PRACTICES

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices, provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contracting our Privacy Officer Michael Pagliuca. Information on contracting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your health information with other **health care professionals** who provide treatment and/or service to you either at Maimonides Medical Center or at other facilities or offices. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you **choose** to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include other providers who treat you, as well as insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, health care providers who treat you and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law (e.g. court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

Thank You Cards and Birth Announcements: We may post the cards and announcements that you send to us in our facility for public viewing. If you would not like us to post your cards or announcements, you must indicate this to us either verbally or in writing.

Electronic Mail: If you would like to communicate with our staff via electronic mail, please be aware of the following:

- Email should never be used for emergency problems. In the event of an emergency, please call 911.
- Email should never be used for urgent problems. In these cases, you should go to an urgent care or immediate care facility.
- Email should be concise. If you have a problem that is too complex or sensitive to discuss via email, you should make an appointment by calling 718-283-8600.
- Fees may be assessed for any communications or consultations with a physician or other clinical staff member via email. However, fees shall not be assessed for questions involving general information such as clinic hours, location of the clinic, etc.
- The physicians and other clinical staff members offer you the opportunity to communicate via email. Transmitting health information by email, however, has a number of risks you should consider before using email to communicate with the clinical staff. These include, but are not limited to, the following risks:
    - Email can be circulated, forwarded, and stored in numerous paper and electronic files.
    - Email can be immediately broadcast worldwide and be received by unintended recipients.
    - Email senders can easily type in the wrong email address.
    - Email is easier to falsify than handwritten or signed documents.
    - Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
    - Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
    - Email can be intercepted, altered, forwarded, or used without authorization or detection.
    - Email can be used to introduce viruses into computer systems.
    - Email can be used as evidence in court.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be available for a nominal charge for each page and the staff time will not be charged. If you would like the copies mailed to you, postage will be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

HIPAA Notice of Privacy Practices – This form does not constitute legal advice and covers only federal, not state, law.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. When we make routine disclosures of your health information to a professional for treatment and/or payment purposes, the disclosures are not necessarily recorded. Therefore records of routine disclosures are not available. You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment, or healthcare operations.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions. However, if we do agree to the additional restrictions, we will abide by our agreement, except in cases of emergencies. Please contact our Privacy Officer if you would like to further restrict access to your health information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies, if you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information. To file a complaint, please request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: MMC Reproductive Endocrinology, FFP 'DBA' Genesis Fertility & Reproductive Medicine
Privacy Officer: Michael Pagliuca
Telephone: (718) 283-8600
Address: 6010 Bay Parkway, Brooklyn, NY 11204

CONSENT FOR COMMUNICATION VIA E-MAIL (Clinician-Patient)

I, _____, hereby consent to have my physician,_____, and his staff communicate with me through email whenever he/she deems this to be appropriate. I furthermore agree to have my physician use email communication with other physicians, nurses, laboratory personnel, administrative and other staff members, as he/she deems necessary and appropriate, to facilitate my medical care and treatment.

I understand that GENESIS uses a SECURE E-MAIL that provides confidentiality, but cannot ensure that your e-mail account itself is secure. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, and staff, including responsible parties not affiliated with my physician's practice, such as referring physicians and pharmacists, regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that GENESIS FERTILITY does utilize an encryption software program to minimize the risks of such interceptions.

I also understand that any e-mail communications between my physician and me or members of his/her office staff, or between my physician and other physicians, nurses, laboratory personnel, administrative and other staff members, regarding my medical care and treatment may be printed out and made a part of my medical record.

I understand that in an urgent or emergent situation I should call my physician or go to the Emergency Room and not rely on e-mail.

Signature: _____ Date: _____

E-Mail Address: _____

Directions to Genesis

6010 Bay Parkway
Brooklyn, NY 11204
Tel: 718-283-8600
Fax: 718-283-6580

By Car:
There is valet parking available for patient escorts or their family members

From Long Island:
Take the Belt Parkway to exit 5 (Bay Parkway). Go straight down to 61st street, then n

left turn. The parking garage is immediately on the right hand side of 61st street.

From New Jersey and Staten Island:
Take the Verrazano Bridge to Belt Parkway, staying in the right lane to exit 5, and the
first left onto Bay Pkwy. Look for 6010 right after 61st St, on the left side.

From Manhattan and Queens:
Via Brooklyn Bridge: Take exit toward Bklyn-Qns Expy. [BQE] Merge onto Camden Plaza W/Old Fulton St. Turn left onto
Vine St. Take the Interstate 278 W/BQE ramp. Merge onto I-278 W. to exit 24 on the left for NY-27 E/Prospect Expy. Merge
onto Prospect Expy. Continue onto Ocean Pkwy. Turn right onto Bay Pkwy. Slight left onto Ocean Pkwy. Make a slight right
onto Bay Pkwy. Look for 6010 right after 60th St, on the right side.

Via Manhattan Bridge: Take ramp to Interstate 278/Bklyn-Qns Expy. [BQE] Merge onto Jay St. Turn right onto Sands St. Merge onto I-278 W via the ramp to BQE/Staten Is. Take exit 24 on the left for NY-27 E/Prospect Expy. Merge onto Prospect Expy. Continue onto Ocean Pkwy. Turn right onto Bay Pkwy. Slight left onto Ocean Pkwy. Make a slight right onto Bay Pkwy. Look for 6010 right after 60th St, on the right side.

From Queens & Long Island:
Take I-495 W. to exit 17 toward Brooklyn. Merge onto I-278 W. to exit 24 on the left for NY-27 E/Prospect Expy. Merge onto Prospect Expy. Continue onto Ocean Pkwy. Turn right onto Bay Pkwy. Slight left onto Ocean Pkwy. Make a slight right onto Bay Pkwy. Look for 6010 right after 60th St, on the right side.

By Brooklyn Bus:
From Boro Park
Tak▪e the B11 to Ave I/Ocean Parkway. Walk east to Ave I towards Ocean parkway, turn right on Ocean parkway, and turn right on Ave J. Transfer to the B6. Take the B6 to Bay Parkway/60th Street.

Take the B16 to 60th Street/Ft. Hamilton Parkway. Transfer to the B9. Take the B9 to 60th Street - Bay Parkway.

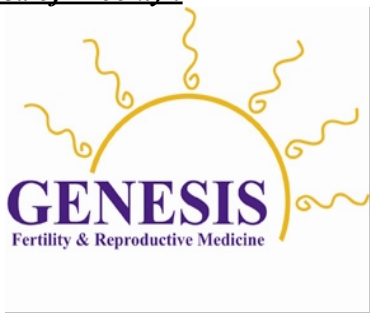
From Park Slope and Sunset Park:
Take the B63 to 60th Street. Transfer to the B9. Take the B9 to 60th Street - Bay Parkway.

From Kings Highway:
Take the M2 to 5th Ave W 55th Street or the M101 to 3rd Ave E 23rd Street. Transfer to the BM4 EXPRESS bus. Take the BM4 bus to Ocean Ave/Ave J. Transfer to the B6. Take the B6 to Bay Parkway – 60th Street.

From Ocean Parkway and Z/Coney Island Stillwell Avenue Train Station:
Take the B1 to Bay Parkway/86th Street. Transfer to the B6. Take the B6 to Bay Parkway/62nd Street. Walk to 60th Street.

By Subway:
N Train: Take the N train to the Bay Parkway station. Exit near intersection of 66TH ST and Bay Parkway. Once you exit the station take a right and head North East on bay parkway towards W 7th Street.

F Train: Take the F train to the Avenue N station. Exit near Exit near intersection of AVENUE M and McDonald Ave. Once you exit the station go West on Avenue M towards Dahill road. Turn left onto Dahill road. Turn right onto 23rd Ave. Turn right onto 60th Street. Turn left onto bay parkway.
We are at 6010 Bay Parkway between 60th and 61st Street in the Bensonhurst area of Brooklyn



6010 Bay Parkway, 5th Floor
Brooklyn, NY 11228
Tel: 718 283-8600
Fax: 718 283-6580

As a courtesy to our staff and established patients, please arrive on time. If, for any reason, you are unable to keep your appointment, please notify our office at least 48 hours in advance. Should you not do so, we will hold you responsible for full payment of our consultation fee, which is $375.00. For insurance purposes and in deference to the needs of our patients, we request that *children under the under of 14* not be brought to the office.

Patients who are insured by Aetna insurance must call the Aetna Infertility Nurse at 1 (800) 575-5999 prior to each visit with a physician.

If you have any questions with regard to this procedure, you may call our billing office at
(718) 283-6582 or (718) 283-6583
Monday - Friday from 7:30AM - 3:30PM.

Medication and Insurance Policy

IMPORTANT – PLEASE READ CAREFULLY!!

I understand that while the billing associates at GENESIS are here to assist me in managing my insurance coverage as it pertains to infertility treatment, it is my responsibility to investigate my policy and determine what medications are covered and what the procedures are for getting them covered.

I understand that obtaining a prior authorization may be required before I am able to obtain medications under my policy.

Medications that typically require a prior authorization and may or may not be a part of my care include:

Lupron	**Novarel**
Bravelle	**Ovidrel**
Follistim	**Progesterone in oil**
Gonal-F	**Antagon (ganirelix)**
Menopur	**Clomid**

I will call my pharmacy plan to determine which, if any, of these require a prior authorization and <u>will notify the staff no later then 2 weeks before my expected menstrual period</u>.

Further, I will make sure that all of my medications have been ordered and are in my possession <u>before</u> coming in for baseline testing to start my cycle. If I have not received my medications in a timely manner, I will follow up with the staff well in advance of my next menstrual period.

I understand that it can be difficult to obtain a last minute prior authorization and emergency prescription for my medication, and as such, <u>these accommodations cannot be guaranteed</u>. In this event, I understand that I will have to either delay cycling until I can get my medications covered, or pay for them out of pocket.

_____ _____

Patient signature **Date**

_____ _____

Staff signature **Date**

New Patient Questionnaire

We are requesting that all patients complete this anonymous questionnaire. Your input will help us with future patient outreach activates. Thank you for your time.

Patients Name:

Today's Date: **Patients Zip Code:**	**Physician to be seen today:**

Please tell us how you were initially referred to GENESIS: (Check One)
If you were referred by more then one source please check all that apply.

□ Friend/Family
□ Other Patient
□ OB/GYN (Please specify the physician's name): _____
□ Urologist (Please specify the physician's name): _____
□ Primary Care MD (Please specify the physician's name): _____
□ Print Advertisement – Please provide the source: _____
□ Health Insurance Plan – Please specify which plan: _____
□ Donor Egg Advertisement – Please provide the source: _____
□ Pharmacist: _____
□ Nurse: _____
□ Other: _____
□ Brochure
□ Yellow Pages
□ Patient Seminar
□ AFA or Resolve (Circle One)
□ Previous Patient (Self-referred)
□ Internet (If yes, please specify the search engine used; ie Google, Bing) _____
□ If you used the Internet to learn about our center, which search words did you use?

(Please <u>check one</u> search word)

___Infertility ___IVF ___Fertility __In vitro fertilization
Other (Please specify): _____

If you used the Internet, did you go to our Medical Center website first?
□ Yes □ No

Have you ever taken clomiphene citrate (Clomid/Serophene)?

How many cycles did you take clomiphene citrate? _____