THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.
AND THE SUBSIDIARIES MCRH ALPHA, P.A.
AND GREAT PLANES REPRODUCTIVE CENTERS, P.A.

Arbor Lakes Medical Building, Suite 350
12000 Elm Creek Blvd North
Maple Grove, MN 55369

Phone 763.494.7700
Toll Free 800.508.9763
Fax 763.494.7706
Web Site www.mcrh.com

Patient Guide
The Midwest Center for Reproductive Health, P.A.

Thank you for choosing The Midwest Center for Reproductive Health, P.A. (MCRH). Please accept our warmest welcome to you from the staff at MCRH, as well as our thanks for your interest in the services we provide. We understand the struggles that you face and truly strive to provide the finest care possible in a compassionate and professional environment. It is our hope that we will lay the foundation for success with our individualized treatment based on the unique needs of each patient. We ask that you use this information as a guide in order to familiarize you with MCRH and prepare yourself for what to expect before, during, and beyond your first appointment.

Before Your Appointment:
To ensure your new patient appointment is most beneficial to you, we begin by asking that the following forms be thoughtfully completed and received in our office one week before your appointment. Please feel free to return your completed forms by mail or fax to (763) 494-7706. If you choose to fax your completed forms, please bring the original copy to your scheduled appointment. If you have a copy of your medical records, you may include a copy with the following forms:

___ **Patient Registration Form and Consent for Treatment** – Carefully read and complete both pages of this form. Since this serves as a consent for services, completion of this form is required before your appointment. Be sure to have both patient and spouse or partner (if applicable) initial, sign, and date.

___ **History Forms** (both female and spouse/partner) – Each of you should individually complete the appropriate form to the best of your knowledge. Please indicate “not applicable” when this is the case. Completion of these forms allows the staff at MCRH to better understand your individual situation and provide a more individualized discussion during your consultation.

____ **Medical Records** – It is most beneficial if medical records from current and/or previous infertility treatment are received in our office before your consultation. In order to expedite the transfer of your previous medical records, enclosed is an **“Authorization for Release of Medical Information”** form for you to return directly to your physician. If you and/or your partner have more than one physician that you have been working with, please feel free to duplicate or to ask MCRH for additional copies of this form. Any medical records released from other facilities will have pertinent information extracted and will be returned to you at the time of your new patient consultation. If your new patient consultation is done via phone, the records will be mailed back to you.

____ **Preparing for Pregnancy** – Please read this guide for information to best optimize your chances for successful treatment.

You should also expect a telephone call from one of the MCRH nursing staff before your appointment. The nurse will confirm your appointment, the receipt of your new patient paperwork and your medical records, and will ask any questions regarding your medical history. This phone conversation will help further to clarify your individual situation and any specific topics you wish to discuss during your initial consultation.

What to Expect at Your New Patient Appointment:

Your initial appointment is scheduled as a consultation with Dr. Corfman. In order to give you both the opportunity to meet him and other members of the MCRH team, we strongly recommend both you and your spouse or partner attend the new patient consultation. During this appointment you will have the opportunity to have a dialogue between you and Dr. Corfman, review any previous treatments, and discuss options for further treatment. Generally, this appointment is approximately 30 minutes in length however, please keep in mind that your appointment may be longer or shorter depending on your unique requirements. **It is with sensitivity to all patients and with regards to the particular nature of our practice, we ask that children do not accompany you to your appointment.**

Office Location:

Our office is located in Maple Grove, MN. Please see the map on our website for specific location. There are also many additional satellite locations in other areas as well. Please see the Practice Locations page for alternate locations. If you have any questions regarding directions, please call the front desk at: (763) 494-7700 or (800) 508-9763 and select option 1.

Cancellation Policy:

A fee will apply for appointments not cancelled at least 72 hours in advance. While we regret the need to do this, this policy allows us to better serve all of our patients who may be waiting for an appointment time.

Billing and Insurance Policies and Questions:

Understanding your medical insurance coverage and your benefits for infertility treatment can be confusing and time consuming. Our Business Office staff is available to answer questions as they arise. However, because plans vary greatly, it is probably best to start by contacting your insurance company directly. Please see the Insurance and Financial Information on our website.

The fee for a new patient consultation is generally $370, although this can vary depending on the amount of time spent, the complexity of your medical history, and your options for treatment. This appointment may or may not be covered by insurance and includes chart preparation, extraction of your previous medical records, medical records review with a member of the nursing staff before your appointment, and your physician consultation.

MCRH participates with a number of insurance plans, however, coverage varies. We ask you to contact your insurance company before your appointment. If we do not participate directly with your insurance, there may be “out of network” benefits allowing you to see Dr. Corfman.

If you have questions or concerns regarding fees or insurance coverage, please contact the Business Office by calling (763) 494-7736. Many times all it takes is a phone call to ease your insurance concerns and answer your questions.

We look forward to meeting you at your new patient consultation.
Please do not hesitate to call with further questions.

Additional Helpful MCRH Information

Office Hours:

- Monday through Thursday, 7:00 a.m. - 4:00 p.m.
- Friday, 7:00 a.m. - 12:00 p.m.
- Weekend/holiday hours are available by appointment.

Appointment Scheduling:

- Telephone hours are as follows:
  Monday through Thursday, 8:00 a.m. - 12:00 p.m., 1:00 p.m. - 4:00 p.m.
- Friday, 8:00 a.m. - 12:00 p.m.
  Please feel free to call for appointments, medication refills, general questions, and other routine clinic communications during these times.

After clinic hours and weekends:

- **Non-emergency calls** should be made to the nurse line at (763) 494-7726. Messages may be left at any time and if necessary, a nurse will return your call by the following day.
- **In case of an emergency,** the answering service may be phoned at (763) 494-7700 or (800) 508-9763. A nurse will be paged to return your call and medical direction will be given.

  Please note that in order to serve all of our patients, we ask that you only page the on-call nurse in an emergency. Non-emergent pages will be billed accordingly.

Laboratory Services:

- Monitoring services and procedures that can be performed at MCRH include: ultrasounds, specific blood testing, intrauterine insemination, post coital testing and sonohysterograms.
- Laboratory services are coordinated between our office and affiliated laboratories.
- Patients may also choose to coordinate specified laboratory procedures through the services affiliated with their satellite physician.

Andrology Services:

- Andrology services include: semen analysis, semen analysis with strict criteria, antisperm antibody testing, intrauterine insemination preparation, and cryopreservation of back up semen specimen.
- Andrology services are available and conducted through our Reproductive Biology Laboratory by appointment. Testing will be done from 9:30 a.m. - 1:00 p.m. Monday through Thursday and 9:30 am - 10:00 am on Friday.

Support Services/Social Worker:

- Sally Sibbitt, MSW, LICSW, is a clinical social worker specializing in working with infertility and reproductive loss, as well as with other issues. She is a valuable member of our team and we encourage you to utilize her services. She may be contacted directly by calling (952) 925-3533.

Medical Records Policy:

- If you would like to receive a copy of your medical records after becoming a patient of ours, please call (763) 494-7700 or (800) 508-9763. An MCRH Authorization for Release of Medical Information and/or a current Patient Registration Form is required and must be signed by both patient and spouse/partner if applicable. As per MCRH policy, appropriate fees will apply.

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Preparing for Pregnancy

While conception is as easy as "falling off a log" for some people, it is not so easy for many of us. We all know couples who are unhealthy and choose unhealthy lifestyles, yet seem to have no trouble becoming pregnant.

Two of the most important lifestyle factors negatively impacting pregnancy and chances of becoming pregnant are smoking and obesity. The medical literature is full of information which shows smoking (yes, even use of chewing tobacco) and being overweight significantly decreases chances to conceive. Furthermore, both smoking and being overweight have very serious negative effects upon you and your unborn baby, and on your baby's health after birth.

Just as the pilot of an airplane meticulously prepares and performs preflight planning, so, too, should you prepare to become pregnant. When you ask our team at The Midwest Center for Reproductive Health to help you launch and "get this baby off the ground," we recognize that you are also committing to do what is necessary to optimize chances for success. We take your commitment very seriously, just as we take seriously our commitment to help you achieve a pregnancy and a healthy baby.

For those of you who are significantly overweight, we want you to know that we do not wish to begin infertility treatment until you are in a position to be successful. What defines being "significantly overweight"? The National Institutes of Health has adopted a measurement which correlates height and weight with health risks, termed the body mass index (BMI). Studies have shown a body mass index between 19 and 25 to be in a healthy range, whereas a BMI of 30 or greater to be associated with significant health risks. To determine your BMI please go to www.bmi-calculator.net or consult with your local health care provider.

Should your BMI be above 30, it is important for you to know that many studies have shown significant negative impacts upon your chances to conceive, greatly increased chances of complications during your pregnancy and increased chances for health problems in your baby. With this in mind, we discourage initiation of infertility treatment until your BMI is 30 or under.

Having a BMI over 30 is not only a problem for women trying to conceive, but also for men. Sperm function is significantly compromised with elevated BMI.

Should your BMI be 35 or greater, we ask that you seek care with your local health care provider and establish a plan for reducing your BMI ***before*** you schedule an appointment with Dr. Corfman.

Should you be users of tobacco products, it is important for you to be tobacco and smoke-free before you initiate infertility treatment. When you do your part to prepare for pregnancy, you put yourself in an excellent position to be a parent of a healthy baby. We know that is your goal, and we will be there to help you when you're ready.

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Full completion of this form is mandatory prior to providing any medical services.

PATIENT REGISTRATION RECORD/CONSENT FOR TREATMENT

Date _____ Appt. Date _____ Physician Referred: Yes____ No____ If yes, Name_____

FEMALE PATIENT INFORMATION (Print legal name as it appears on driver's license, social security card, etc.)

Patient_____
Last First MI Nickname

Address_____ City_____

State_____ Zip_____ Phone (_____) _____-_____ *Choose one:* Home Cell Voicemail Y / N

Birth Date _____-_____-_____ Age_____ Social Security Number _____-_____-_____

Current Marital Status _____Married _____Divorced _____Single _____Widowed

*Marital Status is required to provide necessary consenting and patient chart preparation.

Email address: _____

Employer_____ Phone (_____) _____-_____ OK to Call Y / N

Employer's Address_____ City_____ State_____ Zip_____

INSURANCE INFORMATION

Patient's Primary Insurance Company/Plan Name _____

Group # _____ Contract/ID#_____ Policy Holder Name_____

Eff Date_____ Insurance Company Address_____

Insurance Company Phone Number (on back of card) _____

Do you have secondary insurance? Y / N Policy Information: _____
*Please refer to the business office information in your new patient packet for specifics regarding insurance.

SPOUSE/PARTNER INFORMATION ❒ **Spouse OR** ❒ **Partner** (Print legal name as it appears on driver's license, social security card, etc.)

Spouse/Partner Name_____
Last First MI Nickname

Birth Date _____-_____-_____ Age_____ Social Security Number _____-_____-_____

Employer_____ Phone (_____) _____-_____ *Choose one:* Work Cell Voicemail Y / N

Employer's Address_____ City_____ State_____ Zip_____

SPOUSE/PARTNER INSURANCE INFORMATION

Insurance Company/Plan Name_____

Group # _____ Contract/ID#_____ Policy Holder Name_____

Eff Date_____ Insurance Company Address_____

Do you have secondary insurance? Y / N Policy Information: _____
*Please refer to the business office information in your new patient packet for specifics regarding insurance.
*Please fill in spouse/partner insurance information. Most policies do not have the same ID numbers for policy holder and spouse/partner.

EMERGENCY CONTACT

Name of Person to Contact (not living with you)_____ Relationship_____

Address_____ Phone (_____) _____-_____

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CONSENT FOR SERVICES

The following information must be **initialed and signed** by **both** patient and spouse/partner below. Please indicate if spouse/partner is not applicable. **Full completion of this form is mandatory prior to The Midwest Center for Reproductive Health, P.A (MCRH) and its subsidiaries providing any medical services.**

_____ Patient Initial _____ Spouse/ Partner Initial

CONSENT FOR TREATMENT. I hereby consent to and authorize the physician(s) and their designees to perform whatever routine diagnostic procedures, treatment, laboratory tests, and to administer such medications in his/her opinion are necessary or advisable.

_____ Patient Initial _____ S/P Initial

TESTING. I understand that while receiving care accidental exposure to my blood or other body fluid may occur. If this rare event occurs, I understand that my blood will be tested for the presence of Bloodborne Pathogens (Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus). These tests are necessary to help protect and counsel the exposed individual. I understand that results of the tests will be a part of my medical record and will not be released except with my prior consent or as required or permitted by law.

_____ Patient Initial _____ S/P Initial

MEANS OF COMMUNICATING. I authorize the practice to disclose or provide protected health information about my/our treatment directly to me at the address, home phone, work phone and/or cell phone number that I/we have indicated on my Patient Registration and Consent for Treatment form. I understand that it is my responsibility to notify the practice of any change in this manner of communication. I understand that the practice has no control regarding persons who may have access to the mailing address and listed numbers I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed will no longer be the responsibility of the practice.

_____ Patient Initial _____ S/P Initial

RELEASE OF MEDICAL RECORDS. I hereby authorize MCRH to release to myself, spouse/partner, my referring physician, insurance company, physicians referred by MCRH, or legal guardian, any information including records of treatment and diagnosis, concerning my past and present medical care. I understand that my medical records will be maintained jointly with my spouse/partner's throughout my care at MCRH. Additionally, I authorize access to MCRH Reference Laboratory results if previously tested. I understand and accept the risks associated with releasing medical records via fax, mail, or in rare cases email with appropriate authorization.

_____ Patient Initial _____ S/P Initial

NOTICE OF PRIVACY PRACTICES. I acknowledge the receipt the Notice of Privacy Practices effective March 15, 2016.

_____ Patient Initial _____ S/P Initial

IDENTIFICATION. I understand MCRH requires validation to secure patient's identity via picture ID at the time of new patient appointments to comply with HIPAA Privacy Practices. I understand MCRH requires my Social Security Number to use as my unique identifier throughout my care.

_____ Patient Initial _____ S/P Initial

RELEASE OF PERSONAL PROPERTY RESPONSIBILITY. I understand that MCRH is not responsible for the loss of valuables and assumes no responsibility for any losses.

_____ Patient Initial _____ S/P Initial

PAYMENT/INSURANCE CONSENT. I acknowledge responsibility for payment for services rendered to me at MCRH. I understand it is my responsibility to obtain a referral from my primary care physician for all care received at MCRH if my insurer requires it. **Claims will be submitted under the company/facility name and not the physician**. I acknowledge and accept responsibility for all charges denied or identified as non-covered by my insurer. If my account becomes delinquent, I agree to pay all costs the center may incur in collecting its fees including collection agency & attorney fees. If charges on my account are not fully paid within 120 days of the date of service, I also agree to pay interest from that date at a rate of 1.5% per month. Unless full payment is made on the date of service, I authorize my insurer to pay my medical benefits directly to MCRH.

_____ Patient Initial _____ S/P Initial

SATELLITE PATIENTS: I acknowledge that while being seen at any location other than Maple Grove, Dr. Corfman may not be a provider in my insurance network at that facility. Billing will be through GPRC for visits at a satellite location. Management fees, education and phone appointments will be billed through MCRH or MCRH Alpha.

_____ Patient Initial _____ S/P Initial

MAPLE GROVE PATIENTS: MCRH Alpha is an "in network" provider for non-IVF treatment for Health Partners, Cigna, BCMN, Preferred One and TriCare. **IVF Patients**: IVF Treatment will be billed through MCRH, which is "out of network" with all insurance companies.

Patient Legal Name Printed _____

Patient Signature _____ Date _____

Spouse/Partner Legal Name Printed _____

Spouse/Partner Signature _____ Date _____

THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.

Female History Form

Each of you should individually complete the appropriate form to the best of your knowledge.

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Duration of Relationship _____ Duration of attempting pregnancy_____

Nature of present employment (title, brief description) _____

II. MEDICAL HISTORY

Height _____ Weight _____

Do you have or have you ever been diagnosed with or treated for (check all that apply):

____ Chronic Headaches
____ Dizziness
____ Epilepsy
____ Loss of Balance
____ Neurological Problem
____ Poor Sense of Smell
____ Seizures
____ Visual Disturbance
____ Anxiety/Depression
____ Asthma
____ Chronic Bronchitis
____ Tuberculosis

____ Anemia
____ Cancer Specify: _____
____ Hirsutism (excessive hair growth)
____ Thyroid Disease/Surgery
____ Appendicitis
____ Colitis
____ Diabetes
____ Eating Disorders
____ Gall Bladder Disease/Surgery
____ Hepatitis
____ Liver Problems

____ Breast Discharge
____ Chlamydia
____ Endometriosis
____ Gonorrhea
____ Herpes
____ Ovarian-Cysts
____ PCOS
____ Pelvic Infection
____ Syphilis
____ HIV/AIDS
____ Kidney Infection
____ Arthritis
____ Lupus Erythematosus

Cardiovascular History

Bleeding Disorder	Yes	No
Blood Clots	Yes	No
High Blood Pressure	Yes	No
History of Heart Disease	Yes	No
Heart Murmur	Yes	No
Antibiotics needed for dental/surgical procedure	Yes	No

Allergies

General Allergies	Yes	No	If yes, list: _____
Drug Allergies	Yes	No	If yes, list: _____
Latex Allergy	Yes	No	
Iodine Allergy	Yes	No	
Egg Allergy	Yes	No	

Prescribed Medications:

Past Year	Yes	No	If yes, list: _____
Current	Yes	No	If yes, list: _____

Over-the-Counter Medications:

Current	Yes	No	If yes, list: _____
Homeopathic/Herbal	Yes	No	If yes, list: _____

Current Use of the Following:

Alcohol	Yes	No	If yes, type: _____ amount per week:_____
Smoking	Yes	No	If yes, number of packs per day _____
Recreational Drugs	Yes	No	If yes, type: _____ frequency:_____

III. CONTRACEPTIVE/SEXUAL HISTORY

Have you used in the past (check all that apply):
____ Birth Control Pills Name: _____
____ IUD Name: _____
____ Depo-Provera

If you've ever been on oral contraceptives (pills), were your periods regular after stopping the pills? Yes No

Do you use lubricants for intercourse? Yes No If yes, type: _____

Is intercourse painful or difficult for you? Yes No

How many times per week do you and your partner have intercourse? _____

How many times do you have intercourse at the time of ovulation? _____

Indicate your sexual orientation by circling one of the following: Heterosexual Homosexual Bisexual Transgender

IV. MENSTRUAL AND PREGNANCY HISTORY

Age at first period? _____

Are your periods regular? Yes No
If yes, what is the usual length (from onset of period to the onset of your next period) ? _____
If no, how many times per year do you menstruate? _____
Progesterone or Provera needed to initiate bleeding? Yes No

What is the usual duration of your flow? _____

Are cramps: ____mild ____moderate ____severe

Do you bleed or spot between periods? Yes No

How many pregnancies (including elective abortions) have you had? _____

Pregnancy	Year conceived	How long to conceive?	Infertility therapy required to conceive?	(choose one) Elective Abortion? Miscarriage? Ectopic? Pre-term Delivery? Full-term Delivery? Stillborn?		Date baby born	Vaginal delivery or C-section?	Complications?	Male or female	Is current partner the father?
1st					__ wks					Yes No
2nd					__ wks					Yes No
3rd					__ wks					Yes No
4th					__ wks					Yes No
5th					__ wks					Yes No

V. FAMILY HISTORY

Is there a family history of cancer/malignancy
_____ Ovarian Yes No whom: _____
_____ Breast Yes No whom: _____
_____ Other Yes No whom: _____

Is there a history of hormonal disorders in your family? Yes No
If yes, who and what type _____

Is there a family history of
Cystic Fibrosis? Yes No If yes, whom: _____
Tay Sachs Disease Yes No If yes, whom: _____
Sickle Cell Anemia Yes No If yes, whom: _____
Diabetes Yes No If yes, whom: _____

With which of the following racial/ethnic group do you identify? Check the appropriate racial/ethnic group?

___ American Indian/Alaska Native ___ Asian ___ Black/African American

___ Hispanic/Latino ___ Native Hawaiian or Other Pacific Islander ___ White/Caucasian

___ Unknown/Not Stated

VI. INFERTILITY HISTORY/TREATMENT

Have you been treated for infertility before? Yes No

If yes, who was your physician? _____

Infertility diagnosis? _____

Which of the following tests have you had performed? Check all that apply and list the results if known:

____ Postcoital Test When?_____ Results:_____

____ Hormonal Testing (FSH,LH, prolactin, estrogen, DHEA-S, testosterone, progesterone) When?_____ Results:_____

____ Sonohysterogram When?_____ Results:_____

____ Hysterosalpingogram (HSG) When?_____ Results:_____

____ Mycoplasma/Chlamydia cultures When?_____ Results:_____

____ Thyroid tests When?_____ Results:_____

____ Pap Smear (most current) When?_____ Results:_____

____ Other - Specify When?_____ Results:_____

Immunology/Recurrent Pregnancy Loss Testing (if applicable)

Anticardiolipin Antibody Yes No When?_____ Results:_____

Lupus Anticoagulant Yes No When?_____ Results:_____

Anti-Chlamydial Antibody Yes No When?_____ Results:_____

Have you ever had any of the following procedures/surgeries:

Appendectomy Yes No Date: _____

Cervical Conization or Cautery Yes No Date: _____

C-Section Yes No Date: _____

D & C Yes No Date: _____

Hysteroscopy Yes No Date: _____

Laparoscopy Yes No Date: _____

Laparotomy Yes No Date: _____

Tubal Ligation Yes No Date: _____

Tubal Reversal Yes No Date: _____

Other _____ Yes No Date: _____

Indicate the following treatment types you have undergone or are currently undergoing:

_____ Clomid Number of Cycles: _____

_____ Letrozole Number of Cycles: _____

_____ Superovulation Number of Cycles: _____

_____ Intrauterine Insemination (IUI)

___ Husband's Sperm Number of Cycles: _____

___ Donor Sperm Number of Cycles: _____

_____ In Vitro Fertilization Yes No

Number of Fresh Cycles: _____ Number of Frozen Cycles: _____

Facility/location where treatment occurred _____

THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.

Male History Form

Each of you should individually complete the appropriate form to the best of your knowledge.

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Nature of present employment (title, brief description) _____

II. MEDICAL HISTORY

Height _____ Weight _____

Do you have or have you ever been diagnosed with or treated for (check all that apply):

____ Neurological Problem
____ Poor Sense of Smell
____ Seizures
____ Visual Disturbance

____ Anxiety/Depression
____ Anemia
____ Cancer Specify: _____

____ Heart Disease
____ High Blood Pressure
____ Thyroid Disease/Surgery

____ Asthma
____ Tuberculosis

____ Kidney Infection

____ Colitis
____ Diabetes
____ Gall Bladder Disease/Surgery
____ Hepatitis
____ Liver Problems

____ Breast Discharge
____ Chlamydia
____ Gonorrhea
____ Herpes
____ Mumps
____ Mumps/Testes Involvement
____ Prostatitis
____ Syphilis
____ HIV/AIDS
____ Testes Infection
____ Testes Injury
____ Testes Tumor
____ Undecended Testes

Allergies

General Allergies	Yes	No	If yes, list: _____
Drug Allergies	Yes	No	If yes, list: _____

Prescribed Medications:

Past Year	Yes	No	If yes, list: _____
Current	Yes	No	If yes, list: _____

Over-the-Counter Medications:

Current	Yes	No	If yes, list: _____
Homeopathic/Herbal	Yes	No	If yes, list: _____

Current Use of the Following:

Alcohol	Yes	No	If yes, type: _____ amount per week:_____
Smoking	Yes	No	If yes, number of packs per day _____
Recreational Drugs	Yes	No	If yes, type: _____ frequency:_____

Do you frequently use saunas, steam baths, or whirpools? Yes No

Have you had a high fever (over 102° F) during the past three to four months? Yes No

III. SEXUAL HISTORY

Have you ever tried to produce a child with another partner? Yes No

Have you produced a child with another partner? Yes No
If yes, how long did it take to produce the child? _____
When? _____

Do you have trouble getting an erection? Yes No

Do you have trouble maintaining an erection? Yes No

Do you have trouble with ejaculations? Yes No
If yes, ___ premature ejaculations ____ retrograde ejaculations

Do you feel that your ejaculate is deposited into the vagina? Yes No

Do you have any abnormal discharge from your penis? Yes No

How many times per week do you and your partner have intercourse? _____

How many times do you have intercourse around ovulation? _____

Have you recently noticed a change in your sexual drive? Yes No

Have you had an injury or an abnormality of penis, testicles or prostate? Yes No
If yes, when? _____ Outcome/result _____

Indicate your sexual orientation by circling one of the following: Heterosexual Homosexual Bisexual Transgender

Has your partner ever conceived a child with someone other than yourself? Yes No

IV. FAMILY HISTORY

Is there a history of hormonal disorders in your family? Yes No
If yes, who and what type _____

Is there a family history of

Cystic Fibrosis?	Yes	No	If yes, whom: _____
Tay Sachs Disease	Yes	No	If yes, whom: _____
Sickle Cell Anemia	Yes	No	If yes, whom: _____

With which of the following racial/ethnic group do you identify? Check the appropriate racial/ethnic group:

___ American Indian/Alaska Native ___ Asian ___ Black/African American

___ Hispanic/Latino ___ Native Hawaiian or Other Pacific Islander ___ White/Caucasian

___ Unknown/Not Stated

V. INFERTILITY HISTORY/TREATMENT

Have you been treated for infertility before? Yes No

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

Is your partner currently seeing a doctor for evaluation of infertility? Yes No

If yes, specify physician name and location _____

Which of the following tests have you had performed? Check all that apply and the results, if known:

____Semen Analysis	When? _____	Results: _____
	When? _____	Results: _____
	When? _____	Results: _____
____Chlamydia Test	When? _____	Results: _____
____Mycoplasma Test	When? _____	Results: _____
____Antisperm Antibody Test	When? _____	Results: _____
____Hamster Egg Penetration Assay	When? _____	Results: _____
____Chromosome Test	When? _____	Results: _____
____Testicular Biopsy	When? _____	Results: _____
____X-ray or ultrasound of Testes	When? _____	Results: _____
____Hormonal Assays (FSH, LH, prolactin Testosterone)	When? _____	Results: _____
____Thyroid Tests	When? _____	Results: _____
____Other - Specify _____	When? _____	Results: _____

Have you every had any of the following procedures or surgeries:

Hernia Repair	Yes	No	Date: _____
Varicocele Repair	Yes	No	Date: _____
Vasectomy	Yes	No	Date: _____
Vasectomy Reversal	Yes	No	Date: _____
Other _____	Yes	No	Date: _____

What drugs have you taken for infertility? Check all that apply:

___Clomiphene Citrate (Serophene®, Clomid®)
___hMG (Pergonal®)
___Bromocriptine (Parlodel®)
___Testosterone or Male Hormone
___hCG (Profasi®, A.P.L.®)
___Urofollitropin or FSH (Metrodin®)
___Other - specify _____

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Web Site www.mcrh.com

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights under the Privacy Rule Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability list - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:
The Midwest Center for Reproductive Health P.A., 12000 Elm Creek Blvd N., Suite 350, Maple Grove, MN 55369
We will not retaliate against you for filing a complaint.

THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.
AND THE SUBSIDIARIES MCRH ALPHA, P.A.
AND GREAT PLANES REPRODUCTIVE CENTERS, P.A.

Arbor Lakes Medical Building, Suite 350
12000 Elm Creek Blvd North
Maple Grove, MN 55369

Phone 763.494.7700
Toll Free 800.508.9763
Fax 763.494.7706
Web Site www.mcrh.com

Patient Authorization for Release of Medical Information

The Patient Authorization will give our office the authority to provide the person or entity you and your spouse/partner (if applicable) designate on the form with access to your protected health information (**PHI**). The Patient Authorization is limited to accessing only the information that you and your spouse/partner (if applicable) designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your joint health information to a person or entity that may be involved in your healthcare. Due to the nature of treatment received at MCRH and its subsidiaries, records for patient and spouse/partner will be maintained **jointly** and this Authorization pertains to all medical records regarding patient and spouse/partner (if applicable).

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Directions for Completion of Authorization for Release of Medical Information Form

Patient Information: Please complete the entire section with patient demographic information.

Clinic/Health Provider: This identifies who is to provide the release of Protected Health Information.

Receiving Party: This information identifies a person or entity you and your spouse/partner (if applicable) have authorized the Provider to release your PHI.

Description of Information to be Released: The type and amount of health information that we disclose is determined by you and your spouse/partner (if applicable). We can disclose or provide access to all of your health information or it can be limited to a specific item.

Release Type: This information tells us how you would like your PHI transmitted to a person or entity. Please see our Medical Record Release and Payment policy for more information. If you wish to view your records, please contact MCRH at 800-508-9763 to schedule a medical record review appointment.

Release Purpose: The purpose of your release of PHI is required to be documented by MCRH. This also helps us in determining if a fee is applicable for reproduction of records.

Termination or Expiration: The Authorization will expire at the end of the calendar year of your last signature unless you specify an earlier termination. You must renew or submit a new Authorization after the expiration date to continue the Authorization. Please list the date of expiration if earlier than the end of the calendar year. You have the right to terminate the Authorization at any time by submitting a written request to our Privacy Manager. Termination of this Authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization. MCRH may require a signed Authorization on disclosures.

Redisclosure Statement: The practice places no condition to sign the Authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your PHI disclosure under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Signature and Date: Because your medical records are kept jointly at MCRH, both patient and spouse/partner (if applicable) will need to sign and date the Authorization. PHI on both parties will be released unless indicated under Information to be Released.

Copies: We will provide you with a copy of this signed authorization upon request.

The Midwest Center for Reproductive Health, P.A. and its subsidiaries MCRH Alpha, P.A, and Great Planes Reproductive Centers, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION	**Name:** _____ **Date of Birth:**_____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____
CLINIC/HOSPITAL/ HEALTH CARE PROVIDER *(Who has the information you want released?)*	☐ Midwest Center for Reproductive Health, P.A. and its subsidiaries **Name:** _____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____
RECEIVING PARTY *(Where do you want to information sent or who may have a copy of your PHI per your request?)*	☑ Midwest Center for Reproductive Health, P.A. *OR* ☐ SELF 12000 Elm Creek Blvd N, Suite 350, Maple Grove, MN 55369 Ph: 800-508-9763 Fax: 763-494-7766 *OR* **Name:** _____ **Address:** _____ **Day Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____
INFORMATION TO BE RELEASED (*What do you want sent or released? Check the applicable box)*	☐ Any and all records (including ALL types of records listed below) ☐ Billing Records ***please review policy for details* ☐ Copies of Films/images ☐ Only records type checked below: **FEMALE:** ☐ Operative report ☐ Biopsy report ☐ Current pap ☐ HSG/Sono reports and films ☐ Post coital results ☐ Rubella ☐ Antisperm antibody results ☐ Blood tests including infectious disease results ☐ Flow sheet from ovulation cycles **MALE:** ☐ Semen analysis results ☐ Antisperm antibody results ☐ Urology-Operative reports
RELEASE INSTRUCTIONS (How and when do you want the information?)	Date Information is Needed: _____ ***please allow 7-10 business days for processing* ***please review policy for details* Release Method/Format Request: (check ONE) ☐ Paper ☐ CD/DVD (patient only) ☐ View my records ☐ Fax (facility only)
PURPOSE OF RELEASE (***Why** this is needed?)*	☐ Continuing care ☐ Transfer of care ☐ Insurance application ☐ Personal use or review ☐ Insurance payment/claim ☐ Litigation/Legal ☐ Other: _____ ***applicable fees may apply to releases*

- This Authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new Authorization after the expiration date to continue the Authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this Authorization at any time by submitting a written request to our Privacy Manager. Termination of this Authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this Authorization on the delivery of healthcare or treatment. We have no control over the person(s) you have listed to receive your protected health information. Therefore, your PHI disclosure under this Authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.
- Your signature indicated your authorization to release your PHI as described above.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
SPOUSE / PARTNER / GUARDIAN SIGNATURE **DATE** *Copies of signed authorizations are available upon request.*

Please save this file to your computer, then e-mail using the secure e-mail available on our website.

OR

Here is a mailing label to send your New Patient Forms and Release of Information to MCRH prior to your new patient appointment.

Midwest Center for Reproductive Health
12000 Elm Creek Blvd N, Suite 350
Maple Grove, MN 55369