WELCOME TO FERTILITY & SURGICAL ASSOCIATES OF CALIFORNIA (FSAC)

Fertility & Surgical Associates of California provides state-of-the-art, personalized reproductive care in a friendly and intimate office setting. We are fortunate to have experienced tremendous growth since we opened our doors in 1999, yet we care for our patients today, the same way we cared for the first patient who walked through our doors – with respect and compassion.

We are constantly striving to improve each aspect of our patient care. This facilitates optimal tailoring of the medication regimen, laboratory techniques, and embryo transfer for each patient. A direct result of this attention to detail and constant review of protocol is our ever-increasing pregnancy rate. Our team-oriented approach is to offer the most time and cost-effective treatment for your particular situation. The physicians at FSAC have advanced, subspecialty training in reproductive medicine, and an outstanding proven track record in all areas of infertility diagnosis and treatment. FSAC comprehensively reviews each IVF cycle with the entire FSAC team (physicians, embryologists, physician assistants, and registered nurses). The physicians at FSAC are recognized as leaders in their field and have received numerous awards from the American Society for Reproductive Medicine and the media for their contributions to reproductive care.

Through our collaboration and research with other leading fertility programs worldwide, we offer the latest and most successful treatments available. FSAC is the only program in the area with an onsite in-vitro fertilization (IVF) laboratory and Ph.D. embryologist, allowing us to provide state-of-the-art laboratory support to achieve the highest pregnancy rates possible.

Our intimate office practice provides the emotional support, which patients need during treatment. Every phone call during office hours is answered by one of our professional staff members. After office hours, patients have communication access to their physician through a 24-hour answering service. To ensure you receive the highest level of comprehensive care during this difficult time, we also provide a "Patient Liaison Network" and access to experienced infertility psychologists, certified acupuncturists, eastern medicine specialists, and licensed donor/surrogate agencies, if you desire.

We look forward to meeting with you. Please do not hesitate to contact our office with questions. We're here to help!

Sincerely,
THE STAFF AT FERTILITY & SURGICAL ASSOCIATES OF CALIFORNIA

Please visit our web site for additional information at www.fertilityassociates.com.

Fertility & Surgical
ASSOCIATES OF CALIFORNIA

www.fertilityassociates.com

To best assist you and make your visit as productive as possible, please complete the following forms before your visit:

- ✓ Patient Information Form
- ✓ Patient Insurance Information Form
- ✓ Eligibility Guarantee Form
- ✓ Assignment of Benefits, Authorization and Financial Statement
- ✓ HIPAA Privacy Rule Individual Consent Agreement
- ✓ Comprehensive History Form
- ✓ Financial Policy (please review and initial each item)

NOTE – Make sure to bring all medical records, HSG films, and operative reports

Although not required, it is highly recommended that both partners be present at the initial consultation. Please feel free to list your questions/concerns as you read our materials, and we will be happy to discuss them with you on your visit to FSAC. As a courtesy to patients on our waiting list, we ask you to inform us at least one week prior to your appointment if you are unable to attend.

We look forward to meeting with you. Please do not hesitate to contact our office with questions.

Sincerely,

The Staff at Fertility & Surgical Associates of California

Fertility & Surgical
ASSOCIATES OF CALIFORNIA

www.fertilityassociates.com

PATIENT'S INFORMATION **FSAC #:** _____ (FOR OFFICE USE ONLY) **TRI-COUNTY SURGERY CENTER #:** _____ (FOR OFFICE USE ONLY)

First Name: _____ **MI:** _____ **Last:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone Number: _____ **Birth Date:** _____ **Age:** _____

Cell Phone Number: _____ **Alternative Phone Number:** _____ **Biological Sex:** □ **M** □ **F** □**Intersex**_____

Drivers License Number: _____ **Expiration Date:** _____

Social Security Number: _____ **Marital Status:** □ **Single** □ **Married** □ **Divorced**

Occupation: _____ □ **Widow** □ **Widower** □ **Domestic Partner**

Employer: _____ **Work Phone Number:** _____

Do we have permission to leave a message for you or your partner on your home, cell, alt, or work phone number? □ **Yes** □ **No**

Do we have permission to release medical information to your partner? □ **Yes** □ **No** **Preferred Pronouns:** _____

Email Address: _____ **Gender:** □ **Male** □ **Female** □ **Other**_____

May we email you or your partner's medical info, updates, and FSAC mailings to the above email address? □ **Yes** □ **No**

Emergency Contact Person: _____ **Relationship to Pt.:** _____

Phone number where they can be reached: _____

How did you hear about us?: _____

I certify that the information on this form is true and correct to the best of my knowledge, and that I will notify FSAC of any changes. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered.

Signature: _____ **Date:** _____

PARTNER'S INFORMATION **FSAC #:** _____ (FOR OFFICE USE ONLY) **TRI-COUNTY SURGERY CENTER #:** _____ (FOR OFFICE USE ONLY)

First Name: _____ **MI:** _____ **Last:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone Number: _____ **Birth Date:** _____ **Age:** _____

Cell Phone Number: _____ **Alternative Phone Number:** _____ **Biological Sex:** □ **M** □ **F** □**Intersex**_____

Drivers License Number: _____ **Expiration Date:** _____

Social Security Number: _____ **Marital Status:** □ **Single** □ **Married** □ **Divorced**

Occupation: _____ □ **Widow** □ **Widower** □ **Domestic Partner**

Employer: _____ **Work Phone Number:** _____

Do we have permission to leave a message for you or your partner on your home, cell, alt, or work phone number? □ **Yes** □ **No**

Do we have permission to release medical information to your partner? □ **Yes** □ **No** **Preferred Pronouns:** _____

Email Address: _____ **Gender:** □ **Male** □ **Female** □ **Other**_____

May we email you or your partner's medical info, updates, and FSAC mailings to the above email address? □ **Yes** □ **No**

Emergency Contact Person: _____ **Relationship to Pt.:** _____

Phone number where they can be reached: _____

How did you hear about us?: _____

I certify that the information on this form is true and correct to the best of my knowledge, and that I will notify FSAC of any changes. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered.

Signature: _____ **Date:** _____

Fertility & Surgical
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www.fertilityassociates.com

PATIENT INSURANCE INFORMATION FORM

PATIENT'S INFORMATION FSAC #: _____ (For Office Use Only) TC SURGERY CENTER #: _____ (For Office Use Only)

FIRST NAME: _____ MI: _____ LAST: _____

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY: _____ PHONE: _____ NAME OF INSURED: _____

INSURANCE ADDRESS: _____ BIRTH DATE: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

CERTIFICATE / ID NUMBER: _____ GROUP / POLICY #: _____

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY: _____ PHONE: _____ NAME OF INSURED: _____

INSURANCE ADDRESS: _____ BIRTH DATE: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

CERTIFICATE / ID NUMBER: _____ GROUP / POLICY #: _____

PARTNER'S INFORMATION *If different from above*

FSAC #: _____ (For Office Use Only) TC SURGERY CENTER #: _____ (For Office Use Only)

FIRST NAME: _____ MI: _____ LAST: _____

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY: _____ PHONE: _____ NAME OF INSURED: _____

INSURANCE ADDRESS: _____ BIRTH DATE: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

CERTIFICATE / ID NUMBER: _____ GROUP / POLICY #: _____

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY: _____ PHONE: _____ NAME OF INSURED: _____

INSURANCE ADDRESS: _____ BIRTH DATE: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

CERTIFICATE / ID NUMBER: _____ GROUP / POLICY #: _____

Fertility & Surgical
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Eligibility Guarantee Form

I, _____, understand that I am eligible for
(Patient Name)

_____ insurance benefits on or as of
(Insurance Company)

_____ through my: own spouse's employment
(Effective Date) (circle one)

_____
(Name of Employer)

I have chosen _____ to be my primary medical group.
(Name of Medical Group)

I understand that if the above is not true, or I am not eligible, or covered under the above-indicated insurance plan, I am responsible for all charges related to services provided to me.

In addition, I understand that all services performed at FSAC require prior authorization from my Primary Medical Group. After initial consultation authorization, FSAC will request authorization for future treatment as indicated by the physician. **However, it is ultimately my responsibility to ensure authorization has been received prior to any treatment being rendered.** If prior authorization is not obtained and I received medical treatment, I will be financially responsible for all incurred charges.

_____ **Date:** _____
Patient's Name

_____
Patient's Signature

_____
Signature of Office Personnel

Fertility & Surgical
ASSOCIATES OF CALIFORNIA

Assignment of Benefits, Authorization and Financial Statement

I hereby authorize payment directly to Fertility and Surgical Associates of California of the surgical and/or medical insurance benefits, if any, otherwise payable to me for the services as described on the attached claim.

I hereby authorize Fertility and Surgical Associates of California to release any medical information during the course of my examination and treatment to my insurance company, pharmacy, or laboratory as necessary.

I realize that I am responsible for payment in full of the charges on my account for services rendered to me by Fertility and Surgical Associates of California.

As a courtesy to our patients we offer to verify insurance coverage. This benefit quote is not a guarantee of coverage as we do not have a mechanism of being able to guarantee the accuracy of the information being provided to our benefit coordinator by your insurance carrier's customer service line. **We encourage our patients to verify their insurance coverage prior to receiving services.**

By signing this agreement, I acknowledge that I have read, understand and agree to the terms of the above policy in its entirety.

Date: _____

_____

Patient's Signature

_____

Patient's Name

Fertility & Surgical
ASSOCIATES OF CALIFORNIA

Open Payments Database Notice

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Date: _____

_____

Patient's Signature

_____

Patient's Name

Fertility & Surgical
ASSOCIATES OF CALIFORNIA

www.fertilityassociates.com

HIPAA Privacy Rule Individual Consent Agreement

Consent to Use and Disclosure of Protected Health Information For Treatment, Payment, or Healthcare Operations (§164.506(a))

I, _____understand that as part of my health care, Fertility and Surgical Associates of California Inc., originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;

A means

- of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of the health care professional.

I have been provided with and understand that Fertility and Surgical Associates of California Inc.'s ***Notice of Privacy Practices*** provides a more complete description of the information.

I understand that:

- I have the right to review Fertility and Surgical Associates of California, Inc., Notice of Privacy Practices prior to signing this consent;
- That Fertility and Surgical Associates of California, Inc., reserves the right to change their notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Fertility and Surgical Associates of California, Inc., is not required by law to agree to the restrictions requested.
- I may revoke the consent in writing at any time, except to the extent that Fertility and Surgical Associates of California, Inc., has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

[ ] Accepted [ ] Denied Date: _____

Signature of Individual or Legal Representative Witness: _____

Social Security Number:_____ Date of Birth: _____

Printed Name of Individual or Legal Representative Witness: _____

Comprehensive History Form

Date Completed _____

What is the primary reason for your consultation? _____

_____

Who referred you to our practice?

_____ Former patient
_____ Friend
_____ Lecture series
_____ Insurer (name)
_____ Internet
_____ Media article
_____ Medical literature
_____ Physician (name)
_____ Self referral
_____ Yellow pages
_____ Other

Comments _____

Religious issues concerning conception or infertility treatment: _____

_____

Male and/or Sperm Source Patient

_____
(name)

_____
(date of birth) (age)

Occupation _____

Preferred Pharmacy _____
Tel. #. _____

Phone (day) _____
(eve) _____
(cellular) _____
(e-mail) _____
(voicemail) _____
(pager) _____

Primary Care Physician

_____
(name)

Address _____
City _____
State, Zip _____
Phone _____
Medical specialty _____
Would you like a summary letter sent? _____

Female and/or Oocyte Source Patient

_____
(name)

_____
(date of birth) (age)

Occupation _____

Preferred Pharmacy _____
Tel. #. _____

Phone (day) _____
(eve) _____
(cellular) _____
(e-mail) _____
(voicemail) _____
(pager) _____

Primary Care Physician

_____
(name)

Address _____
City _____
State, Zip _____
Phone _____
Medical specialty _____
Would you like a summary letter sent? _____

Comprehensive History Form

Duration of relationship _____

Duration of unprotected intercourse _____

How long have you been actively attempting pregnancy?_____

Contraceptive practices

	(yes)	(no)	(dates)
Intrauterine device (IUD)	_____	_____	_____
Oral contraceptives	_____	_____	_____
Other	_____	_____	_____

	(yes)	(no)
Use of lubricants	_____	_____
Douche after intercourse	_____	_____
Painful intercourse	_____	_____
Bleeding/spotting after intercourse	_____	_____

Pregnancies (Female and/or Oocyte Source):

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive	Gender	Is current Partner the Father (Y/N)	Outcome (spontaneous miscarriage, abortion, or terminations, ectopic pregnancy, vaginal delivery, cesarean section, fetal demise or stillbirth) and list complications, if any.
First					
Second					
Third					
Fourth					
Fifth					

Male and/or Sperm Source: Pregnancies from previous marriage(s) or partner(s), if any:

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive	Gender	Outcome (spontaneous miscarriage, abortion, or terminations, ectopic pregnancy, vaginal delivery, cesarean section, fetal demise or stillbirth) and list complications, if any
First				
Second				
Third				
Fourth				

Comprehensive History Form

Female and/or Oocyte Source History

Menstrual History

Age at first menstrual period _____ last menstrual period _____
How often do menses occur? _____ duration of menstrual flow _____
Amount/severity of menstrual flow _____
Medication taken for cramps _____ amount _____ frequency _____

Midcycle: spotting _____ pelvic pain _____ increase mucus _____

When was your last pap smear? _____ When was your last mammogram? _____
Any abnormal pap smears: _____
Do you have or have you ever had (Place a "Check Mark" by any that apply):

Infectious Problems		**Gynecologic Problems**		**Medical Problems**			
Chicken Pox (varicella)		Chlamydia		Anemia		Kidney disease	
Chicken Pox vaccine		Gonorrhea		Bleeding disorders		Kidney infection	
Hepatitis A, B, or C		Syphilis		Blood clots		Liver problems	
German measles-rubella		Pelvic infection (PID)		Blood transfusion		Lost > 15 pounds last year	
Rubella immunization		Mycoplasma/Ureaplasma		Diabetes		Lung disease	
Rheumatic fever		Condyloma-venereal warts		Cancer		Asthma	
Chronic bronchitis		Herpes: genital		Appendicitis		Recurrent urinary infections	
		Abnormal mammogram		Heart disease		Thyroid problems	
Neurological Problems		Abnormal pap smear		High blood pressure		Arthritis	
Migraine headaches		Blocked fallopian tubes		Mitral valve prolapse			
Seizures (epilepsy)		Pelvic adhesions		Excess hair growth		Other Problems:	
		Endometriosis		Hot flashes or night sweats			
		Uterine anomalies		Rh sensitized			
		Cervical Stenosis		Breast discharge			
		DES exposure					

Comments _____

Toxicant Exposure:	(yes)	(no)	(date)	
Alcohol				
none	____	____	_____	
weekend	____	____	_____	
daily	____	____	_____	
Smoking	____	____	_____	
Pesticides	____	____	_____	
Radiation	____	____	_____	
Coffee/caffeine	____	____	_____	(amount)
Other chemicals	____	____	_____	

Comprehensive History Form

Female and/or Oocyte Source History

List all medication you take now (prescription, vitamin, over-the-counter, alternative therapies):

(drug)	(date)	(dose)
(drug)	(date)	(dose)

Are you taking prenatal vitamins? _____

Complete information about allergies you have had: No known allergies (circle N/A)

Drug or Allergen	Reaction	Sensitivity (mild/moderate/severe)

List all surgeries you have had (cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.):

(type of surgery)	(date)
(type of surgery)	(date)
(type of surgery)	(date)

List all other serious illnesses for which you have been under the care of a physician:

(illness)	(date)
(illness)	(date)

Weight _____ Height _____

Special dietary habits: _____

How much do you exercise? _____

Comprehensive History Form

Family History of Female and/or Oocyte Source

Country of origin: Mother _____ Father _____

Ethnic background (circle): African/American Asian Asian-Indian Caucasian
Hispanic Jewish American/Indian Mediterranean Middle Eastern Other: _____

Ethnic group (Circle all that apply)	Have you been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Gaucher				

Are you related to your current partner (consanguinity)? _____

Is there anyone in the family who has had any of the following illnesses:

	Yes	Who		Yes	Who
Endometriosis			Infertility		
Excess body hair			Mental retardation		
Genital abnormalities			Early menopause < 40 yrs old		
Breast cancer			Miscarriages (2 or more)		
Chromosomal disorders			Ovarian cancer		
Delayed development					
Early puberty			Hormone disorders		
Birth defects			Metabolic disorders		
Bleeding disorders			Genetic (inherited) disorders		

Comments _____

Comprehensive History Form

Male and/or Sperm Source History

Growth and development:	(yes)	(no)
Undescended testicles	_____	_____
Delayed puberty	_____	_____
Breast enlargement	_____	_____

Testicular injury:	(yes)	(no)	(date)
Varicocele	_____	_____	_____
Torsion (twisted)	_____	_____	_____
Painful swelling	_____	_____	_____
Severe trauma	_____	_____	_____

Toxicant exposure:	(yes)	(no)	(date)
Alcohol	_____	_____	_____
none	_____	_____	_____
weekend	_____	_____	_____
daily	_____	_____	_____
Smoking	_____	_____	_____
Pesticides	_____	_____	_____
Radiation	_____	_____	_____
Other chemicals	_____	_____	_____

Sexually transmitted diseases:

Chlamydia	_____	_____	_____
Genital warts (HPV)	_____	_____	_____
Gonorrhea	_____	_____	_____
Herpes	_____	_____	_____
Syphilis	_____	_____	_____
Other	_____	_____	_____

Urinary tract:

Bladder/kidney infection	_____	_____	_____
Prostatitis	_____	_____	_____
Other	_____	_____	_____

Frequency of hot tub use:	_____	_____	_____

Comprehensive History Form

Male and/or Sperm Source History

List all medication you take now (prescription, vitamin, over-the-counter, alternative therapies):

(drug)	(date)	(dose)
(drug)	(date)	(dose)

Complete information about allergies you have had: No known allergies (circle N/A)

Drug or Allergen	Reaction	Sensitivity (mild/moderate/severe)

List all surgeries or blood transfusions you have had:

(type of surgery)	(date)
(type of surgery)	(date)

List all other serious illnesses for which you have been under the care of a physician:

(illness)	(date)
(illness)	(date)

	(yes)	(no)
Difficulty with sexual function (Male): (please explain)	_____	_____

Comprehensive History Form

Male and/or Sperm Source Family History

Country of origin: Mother _____ Father _____

Ethnic background (circle): African/American Asian Asian-Indian Caucasian
Hispanic Jewish American Indian Mediterranean Middle Eastern Other: _____

Ethnic group (Circle all that apply)	Have you been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Gaucher				

Are you related to your current partner (consanguinity)? _____

Is there anyone in the family who has had any of the following illnesses:

	Yes	Who		Yes	Who
Infertility			Learning problems		
Genital abnormalities			Mental retardation		
Birth defects			Metabolic disorders		
Chromosomal disorders			Miscarriages (2 or more)		
Delayed development			Short stature		
Early puberty			Testicular cancer		
Hormone disorders			Undescended testicles		
Pituitary tumor			Abnormal breasts		
Lack of sense of smell			Genetic (inherited) disorders		

Comments _____

Comprehensive History Form

Previous Female and/or Oocyte Source Infertility Tests: (result) (date)

Basal body temperature _____ _____
Ovulation predictor kits _____ _____
Endometrial biopsy _____ _____
Post-coital test _____ _____
HSG _____ _____

Chromosome studies _____ _____
Hysteroscopy _____ _____
Laparoscopy _____ _____

Antisperm antibodies _____ _____

Pelvic ultrasound _____ _____

Other _____ _____

Immunologic Screening Tests: (result) (date)

ANA (antinuclear antibodies) _____ _____
Antiphospholipid antibodies _____ _____
Lupus anticoagulant _____ _____
Leukocyte antibody detection _____ _____
Thyroid antibodies _____ _____
Other immunologic testing _____ _____

Previous Male and/or Sperm Source Infertility Tests: (result) (date)

Semen analyses _____ _____

Post-coital test _____ _____
Antisperm antibodies _____ _____
(semen & serum) _____ _____
Hamster test (SPA) _____ _____
Chromosomes _____ _____
Other (SCSA, EFT, etc.) _____ _____

Previous Hormonal Tests:

	Female and/or Oocyte Source		Male and/or Sperm Source	
	Result	Date	Result	Date
Testosterone	_____	_____	_____	_____
Prolactin	_____	_____	_____	_____
TSH	_____	_____	_____	_____
FSH (random)	_____	_____	_____	_____
FSH (day 3)	_____	_____		
Estradiol (day 3)	_____	_____		
DHEA-S	_____	_____		
Progesterone	_____	_____		

Comprehensive History Form

Previous Treatments:

	Yes/No	# cycles	Comments (dose, # days/cycle)
Inseminations (IUIs, without medication)			
Clomiphene (Clomid, Serophene) (with intercourse only)			
Clomiphene with inseminations (IUI)			
FSH * with intercourse only			
FSH * with inseminations (IUI)			
Progesterone supplements			
Dexamethasone, prednisone			
Aspirin			
Heparin			
Parlodel** - dopamine agonist			
IVIG			
Leukocyte immunization			
Other			

Comments _____

_____

_____

Prior in-vitro fertilization (IVF), GIFT, or intracytoplasmic sperm injection (ICSI) results, if applicable

Date of procedure	Procedure	Protocol	# of eggs obtained	# of eggs mature	# of eggs fertilized	# embryos transferred	# embryos frozen	Pregnancy outcome

Comments

_____

_____

_____

_____

_____

*FSH - Pergonal, Humegon, Repronex, Metrodin, Fertinex, HMG, Gonal-F and/or Follistim

** - Parlodel, dopamine agonists - bromocriptine (Parlodel), cabergoline (Dostinex)

Financial Policy

The following is provided to ensure that you understand your financial responsibility prior to seeking treatment at FSAC.

1. You are responsible for obtaining prior authorization(s) from your Primary Care Physicians (PCP) and/or insurance company. Please bring authorization to your first visit or have your PCP mail or fax it to us prior to your initial consultation. We will preauthorize with your insurance carrier all surgical and hospital treatments. _____ (initial)

2. All patients must schedule a financial consult with our financial consultant prior to starting treatment. _____ (initial)

3. After your initial consultation, you are responsible for obtaining subsequent authorizations prior to initiating any treatment. Any services not authorized by your insurance company will be denied and will ultimately become your responsibility. Remember that a prior authorization does not guarantee benefit payment. Contact your insurance company for verification of benefits. _____ (initial)

4. For patients undergoing our 3 Cycle or Donor Cycle package, payment is due prior to initiating treatment. This will be discussed in detail during your financial consultation. _____ (initial)

5. We encourage you to take an active role in understanding your insurance benefits and coverage prior to beginning any fertility treatment. No one is as interested in your insurance coverage as you are. _____ (initial)

6. Sometimes it may take up to 4-6 weeks to obtain authorization from your insurance company. If you choose to begin treatment prior to obtaining authorization, you will be financially responsible. Insurance carriers will not retroactively authorize fertility treatment. _____ (initial)

7. If your insurance company covers ART Treatment (IVF) we must have complete benefits and the authorization directly from your insurance carrier. We will collect any co-payments, deductibles or out-of pocket expenses before beginning treatment. _____ (initial)

8. All past due accounts must be paid in full prior to starting a new cycle. _____ (initial)

9. We accept payment by cash, check, MasterCard, Visa and AmEx. _____ (initial)

10. We deal ethically and honestly with every insurance provider and with every service claim we file. We will only submit for services rendered, specifically as they are rendered with the appropriate diagnosis. _____ (initial)

11. FSAC has professional fees (physician) and facility fees for all IVF treatment. Because the facility portion is not contracted with any insurance carriers, there is no contractual reduction or negotiated fee schedule. You will be responsible for the portion the insurance carrier does not cover. _____ (initial)

12. When using our 3 cycle or Donor cycle package, please note these are discounted rates for patients who have little or no infertility coverage. I am accepting the cash package in lieu of using my insurance. I understand by using this package I am unable to, nor is FSAC able to bill the insurance carrier for reimbursement. FSAC will not make any contracted adjustments if patients knowingly submit those charges to the insurance carrier for reimbursement. _____ (initial)

Patient Rights and Responsibilities

Fertility & Surgical Medical Associates of California and the Tri-County Surgery Center, Inc. believes that a mutual understanding of the Patient Rights and Responsibilities will result in more effective delivery of health care services. Fertility & Surgical Medical Associates of California and the Tri-County Surgery Center, Inc. cares for patients in a manner that respects their dignity. We can best care for patients when they understand their medical situation and participate in making decisions about their care. This requires openness, trust and respect among our patients, physicians and health care professionals. Fertility & Surgical Medical Associates of California is a physician-owned entity by Richard Buyalos, M.D., Gary Hubert, M.D., and Mousa Shamonki, M.D. The Tri-County Surgery Center, Inc.'s Medical Directors are Richard Buyalos, M.D. and Gary Hubert, M.D. and is non-physician owned by Zhen Zhao. The following Patient Rights describe what patients can expect while they receive care at Fertility & Surgical Medical Associates of California and the Tri-County Surgery Center, Inc. The Patient Responsibilities describe how patients should participate in their care at Fertility & Surgical Medical Associates of California and the Tri-County Surgery Center, Inc. Our collaborative approach contributes to sound decision-making for the benefit and well-being of each patient.

Patient Rights

You have the right to:

1. **Be treated with respect, consideration, and dignity at check-in, evaluation and treatment areas with appropriate privacy, provided in a safe environment, and free from all forms of abuse or harassment.**
2. **Become informed of your rights as a patient in advance of, or when discontinuing, the provisions of care. The patient may appoint a representative to receive this information should he or she so desire.**
3. **We will listen to you and respect your personal beliefs and values. You will be able to carry out your beliefs as long as they do not interfere with the well-being of others or with the course of treatment you and your physicians have planned.**
4. **Participate in the development and decisions involving your heath care, except when such participation is contraindicated for medical reasons. We will provide you with information to help you make informed decisions about your care. This information may include your health status, diagnosis, evaluation, treatment, and prognosis, along with related risks, and explanations of procedures you may undergo. We will also let you know when your care results in an outcome that was not planned, and plan with you any future treatment if you desire.**
5. **The name, position and professional status of any individual who is treating you.**
6. **You have access to interpretation services and may learn about your medical care and treatment plans in a language other than English.**
7. **Refuse treatment to the extent permitted by law. You can leave the facility against your physician's advice to the extent permitted by law. If you leave the facility against your physician's advice, or do not follow the recommended plan of care, the facility and your physician will not be held responsible for any harm or financial consequences that your action might cause you.**
8. **Prepare an advance directive that sets forth your wishes should you become unable to make health care decisions. You have a right to appoint an individual to make decisions on your behalf. The Tri-County Surgery Center, Inc. and Fertility & Surgical Medical Associates of California; however, will not honor any advance directives. If you require emergency medical assistance our facility will contact 911 and you will be transferred to a hospital.**
9. **The assessment, reassessment and management of pain.**

10. **Remain free from seclusion or restraints of any form that are not medically necessary.**
11. **Freedom from all forms of abuse, neglect and harassment. We will not discriminate with regard to sex, race, ethnicity, ancestry, religion, color, age, gender identity, sexual orientation, disability, national origin, or source of payment for your care.**
12. **Access your medical record within a reasonable time. You can expect confidentiality regarding communications and records about your care. The facility provides patient information only to those involved in your care or others with a legal right to the information. You or your legal representative may obtain copies of your medical record for a fee. You may make a written request to the Medical Records Department for a copy of your medical records by completing the Medical Records Release Form.**
13. **Change physicians or transfer your care to another facility upon your request. You also may transfer your care whenever you require a service our facility is unable to provide. The facility may not be able to provide a service due to lack of capacity or conflict with its mission or philosophy. In these circumstances, every effort will be made to arrange for transfer to another facility that can provide the requested or required service. The facility will explain to you the reasons for the transfer and other options. The transfer will occur only with your consent and when medically appropriate.**
14. **Information about the relationship of the facility with other health care and educational institutions.**
15. **Contact our facility if you have any questions or concerns, need clarification about facility policies or have any special needs at (805) 778-1122, between 9 a.m. and 4:30 p.m.**
16. **Receive an explanation of your bill. Upon request, you will be given information about the bill, how to seek assistance in paying the bill or how to seek assistance in filing insurance forms.**
17. **There may be ongoing medical studies or research at this facility. You have the right to refuse to participate in any study or research.**
18. **Submit a complaint or grievance to the Practice Administrator if you disagree with or have concerns about your care. Our grievance process provides you the right to a timely response. This includes the results of any grievance process, the date of completion of the grievance process, and the name of a contact person at the facility.**
19. **Contact the following entities if you have a complaint or any concerns about patient care, treatment and/or safety in the facility that have not been addressed:**

Donna Hoffman, Practice Administrator
325 Rolling Oaks Drive, Suite 110
Thousand Oaks, CA 91361
1-805-778-1122

Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
1-847-853-6060

California Department of Public Health (CDPH)
1889 N. Rice Avenue, Suite 200
Oxnard, CA 93030
1-800-547-8267

Patient Responsibilities

You have the responsibility to:

1. **Provide complete and accurate information to the best of your ability about your health, any medications taken, including over-the-counter products and dietary supplements, and any allergies or sensitivities, past illnesses, hospitalizations, and other matters relating to your health, and to answer any questions concerning these matters.**
2. **Follow the agreed upon treatment plan prescribed by your physician and participate in your health care planning by talking openly and honestly about your concerns with your physician and other health care professionals.**
3. **Understand your health problems and treatment to your own satisfaction and to ask questions if you do not understand.**
4. **Cooperate with your physician and other health care professionals in carrying out your health care plan both at the facility and after discharge.**
5. **Participate and cooperate with our health care professionals in creating a discharge plan, which meets your medical and social needs.**
6. **Provide information relating to insurance and other sources of payment.**
8. **Cooperate and abide by the rules, regulations and policies of the practice.**
9. **Provide a responsible adult to provide transportation home and to remain with them as directed by their physician or as indicated on the discharge instructions.**
10. **Accept personal financial responsibility for services performed and for charges not covered by your insurance, or paid by insurance in a timely manner.**
11. **Behave respectfully towards all health care professionals and staff, as well as, other patients and visitors, respecting their need for privacy and a quiet environment.**

This Patient Rights & Responsibilities listing incorporates the requirements of the AAAHC; Title 22, California Code of Regulations, Section 70707; Health and Safety Code Sections 1262.6, 1288.4, and 124960; and 42 C.F.R. Section 482.13.

Fertility & Surgical
ASSOCIATES OF CALIFORNIA

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice of Privacy Practices please contact our Privacy Official:

Donna Hoffman, Practice Administrator
325 Rolling Oaks Drive, Suite 110
Thousand Oaks, CA 91361
1-805-778-1122

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

This medical practice collects health information about you and stores it in a chart and on a medical software database accessed by computers. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a Business Associates Agreement or written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health

care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine, cell phone, or in a message left with the person answering the phone.

5. Sign-In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your first name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

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

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law by first class mail. In some circumstances our business associates may provide the notification. We may also provide notification by other methods as appropriate.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. Upon the request, you will be asked to complete and sign a Medical Records Release Form.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request (Medical Records Release Form) detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in: Paragraphs 1 (treatment); 2 (payment); 3 (health care operations); 6 (notification and communication with family) and; 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for

purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, available at each appointment, and will post the current notice on our website.

E. Effectiveness

This notice was published and became effective on **January 1, 2018.**

F. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights, Attn: Regional Manager
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019; FAX (415) 437-8329; TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.