Pacific Reproductive Center
Helping Create Families Every Day

Patient Name _____

Date: _____

PRC Office Location: _____

How were you Referred?

By a Physician? If yes, please provide their name:

_____

Check what Specialty:

- ☐ Family Practice
- ☐ OBGYN
- ☐ Urology
- ☐ Other _____

Word of mouth

- ☐ Friend _____
- ☐ Other _____
- ☐ Family: _____

Do we have your permission to send them a thank you? If yes, please initial _____

Radio:

- ☐ KOLA (Corona Area)
- ☐ KFROG (Corona Area)
- ☐ KFI (LA Area)
- ☐ Jill (LA Area)
- ☐ KEZ (Palm Springs)
- ☐ Radio Iran
- ☐ Other _____

Yellow Pages:

- ☐ Chinese Yellow Pages
- ☐ Iranian Yellow pages
- ☐ Arabic Yellow pages

Magazines:

- ☐ Inland Empire Magazine
- ☐ OC Magazine
- ☐ Raytheon Magazine
- ☐ Southern CA Happenings
- ☐ Employee Savings Magazine South
- ☐ Employee Savings Magazine North
- ☐ Resolve Magazine
- ☐ Other _____

Newspapers:

- ☐ LA times Newspaper
- ☐ Desert Sun Newspaper
- ☐ Arabic Newspaper
- ☐ Other ----------

Internet: Search Engine Used:

- ☐ GOOGLE
- ☐ MSN
- ☐ AOL
- ☐ YAHOO
- ☐ Other _____

T.V. Commercials:

- ☐ KCBS 2
- ☐ KABC 4
- ☐ KNBC 7
- ☐ Other _____

Other: (Please Specify)

- ☐ Drive by PRC Sign/ building
- ☐ PRC Staff _____

Pacific Reproductive Center
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Office Only
Location: _____
Physician: _____

Please tell us how you heard about PRC: _____

Patient Information

First Name: _____ Initial: _____ Last Name: _____

Address: _____ City: _____ ST: _____ Zip _____

Preferred Contact Number: _____ Alternative: _____

Email: _____ Social Security: _____

Occupation: _____ Employer: _____

Age: _____ Birthdate: _____ Height: _____ Weight: _____

Primary MD: _____ OB-GYN: _____

Partner Information

First Name: _____ Initial: _____ Last Name: _____

Address: _____ City: _____ ST: _____ Zip _____

Preferred Contact Number: _____ Alternative: _____

Email: _____ Social Security: _____

Occupation: _____ Employer: _____

Age: _____ Birthdate: _____ Height: _____ Weight: _____

Primary Insurance – Please provide your card as we will need a copy (front/back) for your chart.

Company: _____ Subscriber: _____ Birthdate: _____

Group #: _____ Policy/Member ID: _____ Partner covered? □ No □ Yes

□ PPO □ HMO □ POS □ EPO Medical Group (if applicable): _____

Secondary/Partner Insurance – Please provide your card as we will need a copy (front/back) for your chart.

Company: _____ Subscriber: _____ Birthdate: _____

Group #: _____ Policy/Member ID: _____ Partner covered? □ No □ Yes

□ PPO □ HMO □ POS □ EPO Medical Group (if applicable): _____

Emergency Contact: _____ Contact #: _____ Relationship: _____

I hereby authorize Pacific Reproductive Center, INC., to release any medical information necessary to process my insurance claims (if applicable), and to release medical benefit reimbursement directly to PRC for professional services. I fully understand that I am responsible for all charges incurred for services provided.

_____ _____ _____ _____

Patient Signature Date Partner Signature Date

Patient Name: _____

Female Medical History & Information

Reason for your visit: □ **Fertility Evaluation** □ **Fertility Preservation** □ **Fertility Treatment**

Pregnancy History

Year you conceived?	How long to conceive?	Vaginal , C-section, D&C, Abortion, Miscarriage	Current Partner	Fertility treatment used?

Prior Fertility Treatment

Have you had prior fertility testing or treatment? □ No □ Yes - If yes check all that apply:

□ Clomiphene with natural intercourse □ Clomiphene with insemination (IUI)

□ Injectable medications with natural intercourse □ Injectable medications with intrauterine insemination (IUI)

□ In vitro fertilization (IVF) □ Frozen Embyro Transfer (FET)

□ Donor or Recipient □ Surrogacy

Menstrual History

How old were you when you had your first period: _____

Are your periods (check all that apply): □ Absent □ Regular □ Light □ Heavy

□ Spotting before periods □ Spotting between periods

□ Irregular How many periods do you have yearly?_____

What medication have you used to start a period? _____

Number of days between periods: _____ Number of days of bleeding: _____

Do you have severe cramping or pelvic pain with your period? □ No □Yes __Always __Sometimes __ Recently __ Past

Sexual History

Have you used over-the-counter ovulation kits to time intercourse? □ No □ Yes

How often do you have intercourse? # of times per week: _____ # of times per month: _____ Not applicable: _____

Do you have pain with intercourse: □ No □ Yes

Do you use lubricants (KY Jelly, etc.) during intercourse? □ No □ Yes – What type: _____

Have you ever used contraceptives: □ No □ Yes – What type: _____

Have you ever had any of the following sexually transmitted diseases or pelvic pain? (Check all that apply)

□ Chlamydia □ Gonorrhea □ Syphilis □ Genital Warts/HPV □ Hepatitis □ Herpes

□ HIV/AIDS □ PID □ Other: _____

Patient Name: _____

Medical History

Do you have any current, chronic medical conditions (IE: diabetes, cholesterol, etc.)?

□ No □Yes – What type: _____

Are you currently taking any prescribed medications?

□ No □ Yes – What type: _____

Are you currently taking any over-the-counter or herbal medications?

□ No □ Yes – What type: _____

Are you allergic to any medications? □ No □ Yes – What type: _____

Additional information you would like to share: _____

_____

Surgical History

Year of surgery?	Physician?	What type of surgery?	Complications?

Do you have any problems with anesthesia? □ No □ Yes – Describe: _____

Social History

Do you smoke cigarettes? □ No □ Yes – How many per day: _____ How many years: _____

Do you drink alcohol? □ No □ Yes – Beer: # per week: _____ Wine: # per week: _____ Liquor: # per week: _____

Do you use marijuana, cocaine, or other similar drug? □ No □ Yes – Describe: _____

Do you exercise? □ No □ Yes – Describe: _____

Additional information you would like to share: _____

_____

Family Ancestry

What is your ancestry? □ African-American □ American Indian/Native American □ Ashkenazi Jewish

□ Asian-American □ Cajun/French Canadian □ Caucasian □ Eastern European □ Hispanic/Latino

□ Northern European □ Southern European □ Other: _____

Patient Name: _____

Does anyone in your immediate family have a history of a medical condition (IE: Diabetes, Cancer, High Blood Pressure, Autism etc.)?

□ Mother _____

□ Father _____

□ Brother(s) _____

□ Sister(s) _____

□ Maternal Grandmother: _____

□ Maternal Grandfather: _____

□ Paternal Grandmother: _____

□ Paternal Grandfather: _____

Would you like to be screened for: □ Cystic Fibrosis □ Sickle Cell □ Tay Sachs □ Thalasemia

Additional information you would like to share: _____

_____

Continued on next page....

Patient Name: _____

Male Medical History & Information

Medical History

Have you been evaluated by an urologist?: □ No □ Yes

Have you had a semen analysis? □ No □ Yes Do you have difficulty with erections? □ No □ Yes

Do you have retrograde ejaculation of sperm into the bladder: □ No □ Yes

Have you had a vasectomy? □ No □ Yes – Date: _____ Reversal? □ No □ Yes – Date: _____

Have you been exposed to radiation or harmful chemicals? □ No □ Yes – Describe: _____

Have you been diagnosed with cancer? □ No □ Yes – Describe: _____

Have you had chemotherapy for cancer? □ No □ Yes

Do you have any current, chronic medical conditions (IE: diabetes, cholesterol, etc.)?

□ No □Yes – What type: _____

Are you currently taking any prescribed medications?

□ No □ Yes – What type: _____

Are you currently taking any over-the-counter or herbal medications?

□ No □ Yes – What type: _____

Are you allergic to any medications? □ No □ Yes – What type: _____

Additional information you would like to share: _____

_____

Sexual History

Have you previously conceived with another woman? □ No Birth control used? □ No □ Yes
□ Yes How many children?: _____ Age of youngest child? ____

Have you ever had any of the following sexually transmitted diseases? (Check all that apply)

□ Chlamydia □ Gonorrhea □ Syphilis □ Genital Warts/HPV □ Hepatitis □ Herpes

□ HIV/AIDS □ Other: _____

Social History

Do you smoke cigarettes? □ No □ Yes – How many per day: _____ How many years: _____

Do you drink alcohol? □ No □ Yes – Beer: # per week: _____ Wine: # per week: _____ Liquor: # per week: _____

Do you use marijuana, cocaine, or other similar drug? □ No □ Yes – Describe: _____

Do you exercise? □ No □ Yes – Describe: _____

Additional information you would like to share: _____

_____

Family Ancestry

What is your ancestry? □ African-American □ American Indian/Native American □ Ashkenazi Jewish

□ Asian-American □ Cajun/French Canadian □ Caucasian □ Eastern European □ Hispanic/Latino

□ Northern European □ Southern European □ Other: _____

Would you like to be screened for: □ Cystic Fibrosis □ Sickle Cell □ Tay Sachs □ Thalasemia

CONSENT FOR THE USE AND DISCLOSURE

HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this facility creates and maintains health records describing my health history. I understand that the surgery center may use this information as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payers can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided a Notice of Privacy Practices, which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this facility reserves the right to change its notice and practices. If the facility changes the notice, I can obtain a revised copy by asking the administrator. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the facility is not required to agree to the restrictions requested. If the facility does agree to such restrictions, however, they must comply with such restrictions. I understand that I may revoke this consent in writing, except to the extent that the facility has already taken action in reliance on it.

HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual can also request that confidential communication, whether telephone communication or correspondence, be directed to an alternate site such as the individual's office.

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

Home Telephone: (____)_____
- □ O.K. to leave message with detailed information
- □ Leave message with call back number only

Work Telephone: (____)_____
- □ O.K. to leave message with detailed information
- □ Leave message with call back number only

Cellular Phone: (____)_____
- □ O.K. to leave message with detailed information
- □ Leave message with call back number only

Written Communication
- □ O.K. to mail to any home address
- □ O.K. to mail to:_____
  _____
- □ O.K. to fax to: (_____)_____

Email: _____

I hereby consent to the release of Protected Health Information to the following individual(s) (Example: Family member, friend, etc.). I understand this authorization will in effect until which time it is revoked.

_____Names/Relationship (please print)

_____Names/Relationship (please print)

_____

Signature of patient or patient's representative Date

_____

Printed name of patient's representative Relationship to patient

PACIFIC REPRODUCTIVE CENTER

Appointment of Administrative Representative; Assignment of Benefits And Rights; Assignment of Causes of Action; and Authorization to Release Information

1. **APPOINTMENT OF REPRESENTIVE:** The undersigned hereby appoints PACIFIC REPRODUCTIVE CENTER (herein "PRC"), or its assignee, as my duly authorized representative and assignee during any: (1) Administrative claims process; (2) Appeal or Review process for a denied or underpaid claim; or (3) State or Federal legal process, necessary to collect claims submitted on my behalf for health insurance benefits, but denied or underpaid by my plan. The CLAIMS ADMINISTRATOR, PLAN ADMINISTATOR or GROUP INSURANCE ADMINSTRATOR for my medical insurance plan are all hereby notified and directed by me to henceforth regard any and all communications, particularly including all requests for information, received from my representative during the administrative process, as though these communications had been received from me. I understand that the United States Department of Labor has published the national minimum standards for the administrative processing review of claims, found at **29 CPR 2560.503-1**. I ask all administrators to abide by these minimum standards. I demand complete and timely disclosure to my representative of (a) All pertinent documents, including the identity of their signatory or authors, and (b) The identity of any person or entity possessing the discretion to approve or deny my claim. In addition, I demand compliance with applicable California enactments regarding full and fair review of claims.
2. **BUSINESS PURPOSE AND RIGHT TO RECEIVE BENEFITS:** The duly authorized representative and assignee named above in (1) is Authorized to directly receive payment for the medical benefits due to me, under my insurance or plan. This assignment of benefits by me is complete. I retain no interest in the benefits due to me under these claims for medical care and facility fees. This assignment is given by me in return for the medical care and related services I have received or will receive, from the health providers associated with my representative and assignee. I understand that if my claims are denied and the denial is upheld, I remain financially responsible for payment of all charges incurred to the extent allowed by law. Additionally, regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for the services rendered to the extent allowed by law. I understand that my assignment of these rights and my appointment of an administrative representative services a valid business purpose. The purpose is to provide an effective mechanism for my doctors and other health care providers to deal with an administrative or legal process that may be necessary to collect the benefits due for the services provided. The medical and business purpose, my assignee is not necessarily my health care provider for assignments created under federal law in **MISIC v. BUILDING SERVICE HEALTH 789 F2D 1372 (9th CIR. 1986)**. In furtherance of this business purpose, my assignee is not necessarily my health care provider for any specific claim, but is rather the individual(s), organization, group and/or corporation designated by my providers to deal with all administrative and legal matters.
3. **JUDICIAL REVIEW:** If my claim for benefits is administratively denied in whole or in part, I hereby assign ALL causes of action for judicial review to the individual(s), organization, group and/or corporation designated in (1). My assignee may 'STAND IN MY SHOES", as that phrase is understood under assignment law. I intend my personal standing under the ERISA civil enforcement procedures (codified at **29 U.S.C. 1132**) to be transferred to my assignee, so that he, she, they or it may seek judicial review of benefits claim denies, under I 132(a)(l)(B). My assignment also includes my right to seek review as a "claimant", under 1132(c), of any administrator's refusal or failure to provide information, 30 days after a written request.
4. **RELEASE OF INFORMATION:** I also authorize release of information and payment of medical benefits to the physician or supplier for services described. I certify that the information given by me in the applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.
5. **DIRECT PAYMENT BY INSURANCE TO PATIENT:** If my insurance company pays me directly for services performed at PRC it is understood that I will promptly bring such payment and/or check directly to PRC and endorse over to PRC, or immediately issue PRC a personal check for same amount.
6. **FINANCE CHARGES:** a monthly finance charge of 1.5% (18% per annum) may be assessed on any unpaid balances due. This applies to any balance that is determined to be responsibility of patient and/or guarantor.

Date:_____ **Printed Name of Patient and Assignor:** _____

Signature of Assignor:_____

WOMENS HEALTH SURGICAL CENTER

Appointment of Administrative Representative; Assignment of Benefits And Rights; Assignment of Causes of Action; and Authorization to Release Information

1. **APPOINTMENT OF REPRESENTIVE:** The undersigned hereby appoints WOMENS HEALTH SURGICAL CENTER (herein "WHSC"), or its assignee, as my duly authorized representative and assignee during any: (1) Administrative claims process; (2) Appeal or Review process for a denied or underpaid claim; or (3) State or Federal legal process, necessary to collect claims submitted on my behalf for health insurance benefits, but denied or underpaid by my plan. The CLAIMS ADMINISTRATOR, PLAN ADMINISTATOR or GROUP INSURANCE ADMINSTRATOR for my medical insurance plan are all hereby notified and directed by me to henceforth regard any and all communications, particularly including all requests for information, received from my representative during the administrative process, as though these communications had been received from me. I understand that the United States Department of Labor has published the national minimum standards for the administrative processing review of claims, found at **29 CPR 2560.503-1**. I ask all administrators to abide by these minimum standards. I demand complete and timely disclosure to my representative of (a) All pertinent documents, including the identity of their signatory or authors, and (b) The identity of any person or entity possessing the discretion to approve or deny my claim. In addition, I demand compliance with applicable California enactments regarding full and fair review of claims.
2. **BUSINESS PURPOSE AND RIGHT TO RECEIVE BENEFITS:** The duly authorized representative and assignee named above in (1) is Authorized to directly receive payment for the medical benefits due to me, under my insurance or plan. This assignment of benefits by me is complete. I retain no interest in the benefits due to me under these claims for medical care and facility fees. This assignment is given by me in return for the medical care and related services I have received or will receive, from the health providers associated with my representative and assignee. I understand that if my claims are denied and the denial is upheld, I remain financially responsible for payment of all charges incurred to the extent allowed by law. Additionally, regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for the services rendered to the extent allowed by law. I understand that my assignment of these rights and my appointment of an administrative representative services a valid business purpose. The purpose is to provide an effective mechanism for my doctors and other health care providers to deal with an administrative or legal process that may be necessary to collect the benefits due for the services provided. The medical and business purpose, my assignee is not necessarily my health care provider for assignments created under federal law in **MISIC v. BUILDING SERVICE HEALTH 789 F2D 1372 (9th CIR. 1986)**. In furtherance of this business purpose, my assignee is not necessarily my health care provider for any specific claim, but is rather the individual(s), organization, group and/or corporation designated by my providers to deal with all administrative and legal matters.
3. **JUDICIAL REVIEW:** If my claim for benefits is administratively denied in whole or in part, I hereby assign ALL causes of action for judicial review to the individual(s), organization, group and/or corporation designated in (1). My assignee may 'STAND IN MY SHOES", as that phrase is understood under assignment law. I intend my personal standing under the ERISA civil enforcement procedures (codified at **29 U.S.C. 1132**) to be transferred to my assignee, so that he, she, they or it may seek judicial review of benefits claim denies, under I 132(a)(l)(B). My assignment also includes my right to seek review as a "claimant", under 1132(c), of any administrator's refusal or failure to provide information, 30 days after a written request.
4. **RELEASE OF INFORMATION:** I also authorize release of information and payment of medical benefits to the physician or supplier for services described. I certify that the information given by me in the applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.
5. **DIRECT PAYMENT BY INSURANCE TO PATIENT:** If my insurance company pays me directly for services performed at WHSC it is understood that I will promptly bring such payment and/or check directly to WHSC and endorse over to WHSC, or immediately issue WHSC a personal check for same amount.
6. **FINANCE CHARGES:** a monthly finance charge of 1.5% (18% per annum) may be assessed on any unpaid balances due. This applies to any balance that is determined to be responsibility of patient and/or guarantor.

Date:_____ **Printed Name of Patient and Assignor:** _____

Signature of Assignor:_____