Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

Patient name

Date of birth

MPI#

PATIENT FORM (Non-Binary)

THIS FORM MUST BE COMPLETED BY ANY PATIENT WHO WILL RECEIVE MEDICAL TREATMENT AND/OR EVALUATION. Not everything on this form will applicable. Please only fill out only applicable information.

This form is intended to better understand your medical history and fertility needs. We understand that discussing and thinking about sensitive topics is difficult and we are here to help you have your family.

Patient Information

Demographics

Legal Name (last, first, middle initial) – please print

Preferred Pronouns

Name you prefer to be called (nickname)

Date of birth | Age

Social Security Number | Marital status

Home address (street, city, state, zip code)

Check the box next to your preferred method of contact:

☐ _____ May we leave a detailed message? ☐ Yes ☐ No
Home phone

☐ _____ May we leave a detailed message? ☐ Yes ☐ No
Work phone

☐ _____ May we leave a detailed message? ☐ Yes ☐ No
Cell phone

Email

Emergency contact name | Phone number

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Employment

Company name

Company address (street, city, state, zip code)

Occupation

Primary Insurance

Insurance company

Address (street, city, state, zip code)

Policy ID number

Group number

Policy holder's name

Other name under which policy may be held

Policy holder's phone number (if different than above)

Secondary Insurance (if applicable)

Insurance company

Address (street, city, state, zip code)

Policy ID number

Group number

Policy holder's name

Other name under which policy may be held

Policy holder's phone number (if different than above)

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Referral/Health Care Provider Information

Specify how you found us.

☐ Referred by physician ☐ Friend/Family ☐ Internet ☐ Insurance List ☐ Education seminar

☐ Radio ☐ Television ☐ Yellow Pages ☐ Other: _____

Name of physician who referred you

Name of medical group

Address (street, city, state, zip code)

Phone number Fax

Were you referred to a specific Fertility Centers of Illinois' physician? ☐ Yes ☐ No

Referred Fertility Centers of Illinois physician

Name of primary health care provider or OB/GYN (if different from above)

Name of medical group

Address (street, city, state, zip code)

Phone number Fax

Are you pursuing evaluation and/or treatment(s): ☐ Single ☐ With spouse or partner

Spouse/Partner name (last, first, middle initial)

Reason for your visit today

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Pregnancy History (ONLY IF APPLICABLE)

Duration of infertility (having sex without contraception): _____ months

Have you previously been pregnant? ☐ Yes ☐ No Have you previously tried to get pregnant? ☐ Yes ☐ No

Times pregnant: _____ Term births: _____ Premature births: _____

Miscarriages: _____ Elective abortions: _____ Adopted children: _____

Please provide details on each pregnancy below (if applicable).

	Date	Miscarriage	Elective abortion	Ectopic	No. months to conceive	Infertility treatment	Weight/Sex	C-section	Complications	Is current partner father?
1.		☐	☐	☐		☐		☐		☐
2.		☐	☐	☐		☐		☐		☐
3.		☐	☐	☐		☐		☐		☐
4.		☐	☐	☐		☐		☐		☐
5.		☐	☐	☐		☐		☐		☐

If you had complications with any of the pregnancies listed above, describe:

_____

_____

_____

Menstrual (Hormonal) History (ONLY IF APPLICABLE)

Date of your last menstrual period: _____ Age at your first period: _____

Are your periods regular? ☐ Yes ☐ No How many days from onset to onset? _____

How many days does your period last? _____ Do you bleed between periods? ☐ Yes ☐ No

Do you have premenstrual symptoms? ☐ Almost always ☐ Rarely ☐ Never

Pelvic pain/cramps: ☐ None ☐ During your period ☐ Before your period ☐ After your period
☐ At mid-cycle ☐ During intercourse ☐ With urination ☐ With bowel movements
☐ Cause you to miss usual activities ☐ Cause you to miss work

Pelvic pain/cramps: ☐ Mild ☐ Moderate ☐ Severe ☐ Getting worse ☐ Improving ☐ Not changing
☐ On the right side ☐ On the left side ☐ In the middle

What medications do you take for pain/cramps? _____

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Hormone Use

Type:_____From when to when:_____Reason discontinued: _____

Type:_____From when to when:_____Reason discontinued: _____

Have you had surgery to remove your uterus? ☐ Yes ☐ No ☐ N/A

Have you ever undergone surgical sterilization tubal ligation or vasectomy? Or reversal? ☐ Yes ☐ No If yes, Which? _____

Have you had surgery to remove your ovaries? ☐ Yes ☐ No ☐ N/A

Have you had surgery to remove your testicles? ☐ Yes ☐ No ☐ N/A

Do you plan to use your eggs while undergoing fertility treatment? ☐ Yes ☐ No

Do you plan to carry a pregnancy while undergoing fertility treatment? ☐ Yes ☐ No

Do you plan on using your sperm while undergoing fertility treatment? ☐ Yes ☐ No ☐ N/A

Have you previously frozen eggs or sperm for fertility treatment? ☐ Yes ☐ No If yes, which? _____

If no, do you have any difficulty with erection or ejaculation? If yes, describe:

_____

_____

_____

Have you ever had a Semen Analysis (SA)? ☐ Yes ☐ No

If yes, were the results ☐ Normal ☐ Abnormal

Has your sperm ever created a pregnancy? ☐ Yes ☐ No

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Medical History

Do you have or have you had (check all that apply):

- ☐ Abnormal pap smears
- ☐ Abnormal uterus (shape, etc.)
- ☐ Antichlamydial antibodies Appendicitis
- ☐ Autoimmune
- ☐ Breast disease
- ☐ Biopsy of testes
- ☐ Discharge
- ☐ Cervicitis
- ☐ Cancer
- ☐ Chlamydia
- ☐ Chronic headache
- ☐ Colitis or enteritis
- ☐ Cryo (freezing) or surgery of the cervix
- ☐ Cytomegalovirus (CMV)
- ☐ DES Exposure in Womb
- ☐ Diabetes
- ☐ Discharge
- ☐ Endometriosis
- ☐ Excessive Stress
- ☐ Genital herpes
- ☐ Genital warts/condyloma
- ☐ Gonorrhea
- ☐ Head injury
- ☐ Hernia Surgery
- ☐ High blood pressure
- ☐ Hot flashes
- ☐ Increased acne
- ☐ Increased facial or body hair
- ☐ Injury to the testicle(s)
- ☐ Mycoplasma
- ☐ Ovarian cysts
- ☐ Pelvic adhesions
- ☐ Pelvic infection
- ☐ Penile discharge/pain
- ☐ Poor sense of smell
- ☐ Psychiatric treatment
- ☐ Recurring vaginitis
- ☐ Reversal Mumps
- ☐ Seizures
- ☐ Special dietary habits
- ☐ Syphilis
- ☐ Thyroid disorder
- ☐ Toxoplasmosis
- ☐ Trichomonas
- ☐ Tuberculosis
- ☐ Undescended testicle
- ☐ Ureaplasma
- ☐ Urethritis/epididymitis
- ☐ Uterine fibroids or myomas
- ☐ Varicocele
- ☐ Varicocele Surgery
- ☐ Vasectomy
- ☐ Vision problems
- ☐ Vomiting
- ☐ Weight gain (10 or more lbs)
- ☐ Weight loss (10 or more lbs)

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List all serious or chronic illnesses or injuries not already described:

Do you or your family members have: ☐ Infertility ☐ Hormonal disorder ☐ Other inherited disorder
If yes, explain:

Has anyone in your direct family ever been diagnosed with breast or ovarian cancer? ☐ Yes ☐ No
If yes, explain:

Was anyone in your family born with any birth defects/intellectually disabled? ☐ Yes ☐ No
If yes, explain:

Do you (or does anyone in your family) have a bleeding/blood clot disorders? ☐ Yes ☐ No
If yes, explain:

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Operations & Hospitalizations

Date:	Diagnosis:	Operation:	Where performed:	Physician:
1.				
2.				
3.				
4.				
5.				

Medications

List all prescriptions and over-the-counter drugs and supplements used during the past year.

Medication name:	Dosage & frequency:	Approximate date(s) taken:	Reason for taking:
1.			
2.			
3.			
4.			
5.			

Allergies

To what: (Drug or substance)	When:	Type of reaction:
1.		
2.		
3.		
4.		
5.		

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Previous Evaluations

Have you had (check all that apply):

		Approximate Date	Values (if known)
Basal body temperature charting	☐ Not done ☐ Abnormal ☐ Normal		
Urine LH surge (ovulation predictor kit)	☐ Not done ☐ Abnormal ☐ Normal		
Endometrial biopsy	☐ Not done ☐ Abnormal ☐ Normal		
AMH	☐ Not done ☐ Abnormal ☐ Normal		
FSH	☐ Not done ☐ Abnormal ☐ Normal		
LH	☐ Not done ☐ Abnormal ☐ Normal		
Estradiol	☐ Not done ☐ Abnormal ☐ Normal		
Prolactin	☐ Not done ☐ Abnormal ☐ Normal		
Thyroid tests (TSH, T4)	☐ Not done ☐ Abnormal ☐ Normal		
DHEAS	☐ Not done ☐ Abnormal ☐ Normal		
Testosterone	☐ Not done ☐ Abnormal ☐ Normal		
Progesterone	☐ Not done ☐ Abnormal ☐ Normal		
Mycoplasma culture	☐ Not done ☐ Abnormal ☐ Normal		
Chlamydia culture	☐ Not done ☐ Abnormal ☐ Normal		
Antichlamydial antibodies	☐ Not done ☐ Abnormal ☐ Normal		
Hysterosalpingogram (HSG)	☐ Not done ☐ Abnormal ☐ Normal		
Ultrasound	☐ Not done ☐ Abnormal ☐ Normal		
Saline sonohystogram	☐ Not done ☐ Abnormal ☐ Normal		
Laparoscopy	☐ Not done ☐ Abnormal ☐ Normal		
Hysteroscopy	☐ Not done ☐ Abnormal ☐ Normal		
Karyotype genetic testing	☐ Not done ☐ Abnormal ☐ Normal		
Anticardiolipin antibodies	☐ Not done ☐ Abnormal ☐ Normal		
Lupus anticoagulant	☐ Not done ☐ Abnormal ☐ Normal		
Antinuclear antibodies (ANA)	☐ Not done ☐ Abnormal ☐ Normal		
Coagulation screen	☐ Not done ☐ Abnormal ☐ Normal		
Biochemistry/hematology panel	☐ Not done ☐ Abnormal ☐ Normal		

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Previous Treatments

	How many months?	Dose (if known)	Approximate dates taken
Clomiphene (Clomid, Letrozole, Femara, Serophene)			
Gonadotropins (Follistim, Gonal-F, Bravelle, Menopur)			
HCG (Novarel, Ovidrel)			
Progesterone			
Dexamethasone or other steroid			
GnRH agonist (Synarel, Lupron)			
GnRH antagonist (Ganirelix, Cetrotide)			
Intrauterine insemination			
Insemination with donor sperm			
IVF (In Vitro Fertilization)			
Donor egg			
Surrogacy			
Other			

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Social History

Current smoker ☐Yes ☐No If yes, number of cigarettes per day: _____

Past smoker ☐Yes ☐No If yes, how long did you smoke?_____When did you quit? _____

Alcohol ☐Yes ☐No If yes, type and number of drinks per week: _____

Marijuana ☐Yes ☐No If yes, number of times used per week: _____

Other drugs ☐Yes ☐No If yes, type and number of times used per week: _____

Intravenous drug use ☐Yes ☐No If yes, type and when? _____

Number of caffeine drinks per day: _____

Radiation exposure ☐Yes ☐No If yes, explain: _____

Toxic exposure ☐Yes ☐No If yes, explain: _____

Video display terminal use ☐Yes ☐No If yes, number of hours per day: _____

Electric blanket use ☐Yes ☐No If yes, frequency: _____

Hot tub or sauna use ☐Yes ☐No If yes, frequency: _____

Vigorous exercise ☐Yes ☐No

Type:_____Hours/week:_____

Type:_____Hours/week: _____

Ethnic Background

The Centers for Disease Control and Prevention (CDC), through the Society for Assisted Reproductive Technology (SART), has statistical reporting requirements which request the race/ethnicity of our patients.

Ethnicity (check all that apply):

☐White

☐Hispanic or Latino

☐Black or African American

☐Asian

☐Native American or Alaskan Native

☐Native Hawaiian or other Pacific Islander

☐Unknown

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In order to determine which genetic tests may be recommended for you, describe your ethnicity/your family's country (or countries) of origin:

Additionally, for genetic testing reasons, please check this box if you are: ☐ Ashkenazi Jewish, Cajun, and/or French Canadian

Have you ever had any genetic testing based on your ethnicity marked above? ☐ Yes ☐ No

If yes, specify the reason(s) for this testing below:

☐ No family history (screening)

☐ Known family history

☐ Known carrier

☐ Egg donor

☐ Infertility

Additional Information

Please list any additional information that you feel your physician and health care team may need.

Signature Area

By signing below, I acknowledge that all information provided is complete and accurate to the best of my knowledge and that I authorize all actions as initialed above.

Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

This Notice of Privacy Practices is being provided to you on behalf of Fertility Centers of Illinois, with respect to medical services provided at Fertility Centers of Illinois facilities (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "Protected Health Information (PHI)." Protected Health Information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received or payment for your health care.

Your Rights

Although your health record is the physical property of Fertility Centers of Illinois, you have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by applicable law
- Obtain a paper copy of this Notice of Privacy Practices upon request
- Inspect and copy your health record as provided for by applicable law
- Request an electronic copy of your electronic health record
- Request to amend your health record as provided by applicable law
- Obtain an accounting of disclosures of your health information as provided by applicable law
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken
- Request a restriction of disclosure of your health information to your health insurer for services for which you pay "out-of-pocket" in full
- Transmit copies of your health information to third parties when requested by you, in writing

Our Responsibilities

We are required to:

- Maintain the privacy of your health information
- Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Where required by law, notify you in the event that there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all Protected Health Information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at **fcionline.com** as well as at our offices and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which we receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect, except where we have already relied upon your authorization.

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Permitted Uses and Disclosures

We will use and disclose your health information for ***treatment****.* For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. That way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

We will use your health information for ***payment****.* For example: A bill may be sent to you or a third-party payer, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

We will use and disclose your health information for our ***health care operations****.* For example: Members of the clinical staff, the risk or quality improvement manager or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and the reproductive medicine service we provide.

Other Uses or Disclosures of Protected Health Information

Business Associates: There are some services provided at Fertility Centers of Illinois through contacts with business associates. For example: The management services of US Fertility. and certain laboratories for testing. When these services are contracted, we may disclose your health information to our business associate, so they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. So, your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member or any other person you identify health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.

Public Health: As required by law, your health information may be used or disclosed for public health activities, such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTE: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable state and federal laws. Any disclosures of these types of records will be subject to these special protections.

For More Information or to Report a Problem/Complaint

If you believe your privacy rights have been violated, immediately contact Fertility Centers of Illinois Privacy Officer at **847.729.2188.**

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

If you have any questions or would like further information about this notice, contact Fertility Centers of Illinois Privacy Officer at **847.729.2188** or visit **fcionline.com**.

This notice is effective as of September 23, 2013.

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NEW PATIENT INFORMATION

Our goal at Fertility Centers of Illinois is to provide you with the most sensitive, comprehensive and technologically advanced fertility care. In order to make the most of your time at the first appointment, we respectfully request that you prepare ahead of time by following the steps listed below:

1. Review the **Fertility Centers of Illinois Notice of Privacy Practices.**
2. Complete the following applicable form(s) or portions of forms for your individual circumstances:
   - **Female New Patient Packet (to be completed by any female patient who will receive medical services)**
   - **TRANS Male New Patient Packet (to be completed by any male patient who will receive medical services)**
3. If you have Aetna or Humana Insurance, refer to the following requirements from your insurer: **Aetna and Humana Insurance Form.**
4. In order for us to determine which test(s) and treatment(s) may be best for you, **it is important to bring any pertinent medical records with you.** Be sure to contact the health care provider that retains these records and ask for a copy to be provided. To allow time for the authorization, copying and mailing processes, request the records as soon as possible.
5. For questions about our locations, visit **http://www.fcionline.com/locations/**.
   For travel and lodging information as well as local attractions and activities, visit **http://www.fcionline.com/out-of-town/**.
6. Bring your insurance card(s) and photo identification (i.e. driver's license, state ID) with you; copies will be needed for our files.
7. In order to complete the registration process, please arrive 20 minutes prior to your appointment time.
8. We love children; however, because our staff is dedicated to providing their undivided attention to our patients, we are not able to monitor patients' children during office visits. Please be sure that young children are secured in a stroller for their safety. Whenever possible, have someone come with you to provide care for your child while you spend time with your physician and health care team.

We look forward to meeting you. Contact your Fertility Centers of Illinois

Patient Services Team with any questions, concerns or feedback.

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Informed Consent Area

1. Email Consent:

The physicians and staff of Fertility Centers of Illinois offer patients the opportunity to communicate by email for general questions or concerns. Because email has certain risks and your privacy and security are of paramount importance to us, patients should carefully consider before giving email consent. Email risks include, but are not limited to:

1. Circulating, forwarding and storing in numerous paper and electronic files
2. Broadcasting to both intended and unintended recipients
3. Misaddressed email
4. Easier falsification than handwritten or signed documents
5. Backup copies existing even after the sender or the recipient has deleted his or her copy
6. Altering, forwarding or use without authorization or detection
7. Introduction of viruses into computer systems

The physicians and staff of Fertility Centers of Illinois will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of email communication, and therefore, you should never include your social security number or date of birth in any email communications to us.

In addition, email should never be used to communicate acute and/or urgent clinical problems, such as pain or abnormal bleeding. Our physicians and staff always try to respond to emails in a timely manner; however, for any clinical problems, follow proper guidelines by calling our office or the answering service after hours. In a medical emergency, call 911.

_____ I authorize Fertility Centers of Illinois to communicate with me by email in regard to my medical care and associated financial charges (we will use the email address provided on the first page of this form).
Initial here

2. Authorization for Use and Disclosure of Health Information to Spouse or Partner (if applicable):

I hereby authorize Fertility Centers of Illinois to disclose the health information described below to:

_____
Spouse/Partner (please print)

_____ I authorize the following information to be disclosed:
Initial here

☐ All health information, including (if available) any results and/or information regarding HIV, genetics, psychotherapy/mental health, and substance and/or alcohol abuse

☐ Other:_____

Fertility Centers of Illinois will only disclose the health information you have authorized above, except as otherwise required by law.

_____ I authorize Fertility Centers of Illinois to disclose my health (and associated financial) information as designated above.
Initial here

_____ I acknowledge that I have received a copy of the Joint Notice of Privacy Practices.
Initial here

You may revoke this authorization in writing at any time. If you do, it will not affect any previous actions already taken in reliance upon your authorization. Once health information is disclosed pursuant to this authorization, it may be redisclosed and may no longer be protected by privacy laws.

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3. Patient Financial Responsibility Notice - Payment & Information Release Consent & HIPAA Acknowledgment: U.S. Patients

The goal of Fertility Centers of Illinois is to offer you the most sensitive, comprehensive and technologically advanced care. If you have insurance coverage, Fertility Centers of Illinois will make our best effort to coordinate your care in a cost-effective manner within the limits of your insurance benefit and to minimize the expense for which you are responsible. Fertility benefits vary widely by state, insurer and specific plan. The coverage available to you depends on the insurance choices you made with your employer or by purchasing independently.

You are responsible for understanding the details of your insurance plan and we rely on you to keep Fertility Centers of Illinois up to date with correct information about your coverage. Please note we are not a party to your insurance contract. Your insurance coverage is specified in a contract between you and the insurance company. Fertility Centers of Illinois is not responsible for incorrect information given by your insurance company or failure of your employer to provide accurate information to your insurer about your employment status.

If you are covered by one of our accepted insurance plans and provide a valid insurance card or other evidence of coverage at the time of service, we will bill your insurance carrier for covered services. Covered services are those services for which benefits are available under your health care plan; all services are not covered benefits in all insurance contracts. Additionally, some insurance companies may deem certain covered services as medically unnecessary – despite your physician having good clinical reasons for the required service. Common examples are PGD testing, management of ovulation and cryopreservation/storage of gametes (sperm, oocytes and embryos). Finally, some insurance companies may take up to 30 days to obtain authorization.

In turn, you grant us permission to bill your insurance company for covered services rendered and authorize payments of medical benefits to the practice. Covered services are subject to deductibles, copayments, coinsurance or denied payment– in which case, it will be your financial responsibility. Prior authorization from an insurance company is not a guarantee of payment. All insurance payments are subject to review of claims submitted. Fertility Centers of Illinois will not be responsible if your insurance should deny payment. Payments to Fertility Centers of Illinois by insurance plans are subject to audits and may require refunds that make you responsible for the charges. The staff of Fertility Centers of Illinois work with patient(s) to determine possible insurance reimbursement for care rendered, but the ultimate responsibility for payment rests with the patient(s), not their insurance company.

We are sensitive to the cost of infertility treatment and the variability of insurance coverage. As a courtesy to our patients and to provide you with the most effective use of your fertility benefits, we offer financial coordinators to discuss your needs and treatment concerns as it relates to out-of-pocket costs. We strongly recommend scheduling a consultation with a financial coordinator after your physician has determined your treatment plan and/or prior to starting any treatment.

The following may apply depending on the details of your insurance plan:

- Please note that we do not bill services your insurance company has communicated are not covered unless a specific circumstance warrants it.
- In cases where your insurance requires your bloodwork to be processed by an external lab, you will receive a separate bill from your insurance's preferred lab, and it is your responsibility to pay them directly.
- You may be asked to pay a deposit if your coverage has a monetary maximum and you are close to the maximum; if your plan has a deductible greater than $1,000; or if your estimate for services exceeds $1,000.
- Insurance plans may require a written referral prior to you receiving service from Fertility Centers of Illinois. If this is the case, you must have the referral with you at the initial appointment, or the appointment may be rescheduled. If you choose to proceed without a valid referral, you will be responsible for all charges.
- Some insurance plans are "diagnostic only," which means they only cover certain tests to determine the cause of infertility but no treatment.
- Some insurance plans place a lifetime maximum on what they will pay toward fertility testing and/or treatment.

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Medication Coverage:

Please check with your insurance company about:

- How much of the fertility drug costs will they cover?
- Is there a specific pharmacy that must be used for fertility drugs?
- Is prior authorization required for fertility testing?

Payments:

- Payment should be made at the time of service for services not covered by insurance. For services covered by insurance, please submit payment within 30 days upon receipt of your statement for patient balance owed.
- **You can pay using the following two options:**
  1. **Online:** www.fcionline.com/billpay (also accessed through patient portal; see Embryo Options below for storage billing)
  2. **Calling our billing department directly at 847.729.2188**
- In cases where your patient balance exceeds 90 days, your account balance will be turned over to a collection agency. Additionally, services provided will be affected, and you may not be able to continuetreatment.
- Excluding packages, payments and credits are applied in the order from oldest to most recent balance owed.
- All treatment packages must be purchased 48 hours or more prior to initiating treatment.
- All past due accounts must be paid in full prior to starting a new cycle.
- We will only submit for rendered services using the physician-documented diagnosis.
- If you are unable to keep a new patient physician appointment, we ask that you kindly provide us with a minimum of two (2) business days' notice. In the event that you are unable to give us such notice, you will incur a no-show or last-minute cancellation fee for physician appointments of $50 during the weekday or $100 during the weekend. This is done as a courtesy to other patients on waiting lists.
- In the event you would like to speak with medical staff outside of routine business hours (Monday-Friday, between 8am-4pm) for a nonemergency situation, you will be charged $50 to speak with a physician and $25 to speak with the on-call nurse.
- We may require that you maintain a valid credit card in our PCI (Payment Card Industry Data) compliant database 48 hours to initiating a treatment plan. Alternatively, you may provide a $150 deposit per visit.
- Fertility Centers of Illinois has partnered with Embryo Options to provide you cryopreservation billing and disposition education services. It is required that you pre-enroll into Embryo Options to cryopreserve embryos, eggs or sperm at https://fcionline.embryooptions.com/enroll/.

For Illinois residents: The Family Building Act requires many, but not all, insurers in Illinois to offer coverage to Illinois residents for infertility treatments. Your Fertility Centers of Illinois financial coordinator or office manager can give you a copy of the Act, or you can view it at http://insurance.illinois.gov/healthinsurance/infertility.asp. You may also call the Office of Consumer Health Insurance toll free at 877.527.9431. If you have any questions about coverage, you should seek clarification from your employer and about your insurance plan in writing before you begin treatment.

I have read and understand the policy outlined above and agree to accept full financial responsibility as described. I authorize payment to Fertility Centers of Illinois of insurance benefits for claims submitted on my behalf, and I also authorize Fertility Centers of Illinois to release any medical information necessary for claim payments. Patients who are married or in a legal union are jointly responsible for all charges incurred.

Patient's printed name_____ Date _____

Patient's signature _____