



# THE FERTILITY CENTER *of Charleston*

Dear Prospective Patient,

Welcome! We are grateful that you have chosen The Fertility Center of Charleston to help grow your family!

Our dedicated team understands the importance of this decision and we will make every effort to guide, encourage, and support you on the journey from evaluation to treatment and pregnancy. Some of the treatment options available are ovulation induction (OI) with intrauterine insemination (IUI), in vitro fertilization (IVF), egg freezing, pre-implantation genetic testing (PGS), and donor eggs.

We are well aware of the emotional strain this process can bring to a family, so please know that our staff will make every effort to make each step as comfortable and easy for you as possible. You are in competent and caring hands and we promise to provide the best possible care to help you achieve success.

We also understand that fertility treatments can be financially challenging. We participate in and offer many unique programs and financing options which can aid in offsetting the costs of treatment.

In the following pages, we have provided some additional details about The Fertility Center of Charleston and your new patient visit. Please complete all demographic, financial, and medical history forms. Please return these forms by email or fax, as well as copies/pictures of your driver's license and insurance cards.

Again, thank you so much for choosing The Fertility Center of Charleston. We look forward to meeting you at your new patient visit!

Sincerely,

*Stephanie D. Singleton, MD*

Dr. Stephanie Singleton and the staff of The Fertility Center of Charleston



# THE FERTILITY CENTER *of Charleston*

## WHAT TO EXPECT DURING YOUR FIRST VISIT

Welcome to The Fertility Center of Charleston. We hope your first visit here will enable you to get a chance to meet our staff and see our facility. To make the most out of your first visit, we feel it is important that we receive any fertility-related medical records that you may have from your current or past physicians or your partner's physicians.

We request that you arrive fifteen (15) minutes prior to your initial consultation so that you can complete and finalize any remaining paper work. A member of our staff will check your blood pressure, height, and weight, and record allergies and current medications. You will then start with a one hour evaluation with Dr. Singleton. She will conduct a comprehensive medical history to identify possible causes of infertility and will discuss the possible etiologies of your infertility and the tests we use to establish a diagnosis. She may also discuss treatment options, along with the advantages and disadvantages of each treatment. The next step is typically a transvaginal ultrasound of the uterus and ovaries. This is the first step in determining if there is an abnormality of the reproductive tract.

Please remember that 20% of all couples have more than one cause of infertility and therefore, even if you are currently suspicious about or know a current cause of your infertility, a thorough evaluation is necessary to identify other causes. It is also important to remember that approximately 40% of all cases of infertility are from a male factor cause. The evaluation for male factor infertility starts with a semen analysis and we therefore strongly recommend that this test be performed during your initial visit so we can discuss the presence or absence of a male factor component.

Following this consultation, you will meet with one of our nurse coordinators, who will help to coordinate your care. She will be in charge of scheduling your diagnostic tests and starting your treatment plan. After your nursing visit you will then have an opportunity to meet with our financial coordinator to discuss your insurance coverage, typical cost associated with your evaluation and treatment plan, and financial programs we have in place.

Please be reassured that you will receive all of the information and guidance necessary to make informed and appropriate treatment decisions together with our clinical team. Your satisfaction is very important to us. We look forward to seeing you soon!



# THE FERTILITY CENTER *of Charleston*

## TREATMENT OPTIONS

The Fertility Center of Charleston provides a wide range of treatment options, from basic to state of the art. We have a very specialized team of infertility professionals focused on providing you with all the information and guidance needed to make informed and appropriate treatment decisions.

After your initial consultation and completion of your infertility evaluation, your treatment plan will be tailored and customized according to your needs and cause of your infertility. Here are some of the treatment options we are able to offer.

### OVULATION INDUCTION AND INTRAUTERINE INSEMINATION (IUI)

Fertility medications are used to stimulate the ovaries to produce 1-3 mature eggs and enhance the pregnancy rates per cycle. Blood tests and ultrasounds are used to monitor the progress of follicular growth and eventually determine the best time to perform the insemination. Semen is then processed to maximize the number of healthy motile sperm available to fertilize the mature egg(s). A catheter is used to deposit the processed sperm past the cervix and into the uterus. The concentration of sperm available to fertilize the egg(s) is of greater magnitude with IUI than would be found after intercourse, thus increasing the chance that fertilization will occur. This is a painless, in-office procedure.

Candidates for IUI include patients with infertility related to cervical factors, slight male factor infertility, and unexplained infertility. Success rates vary and depend on the age and diagnosis of the patient.

### IN-VITRO FERTILIZATION (IVF)

In-Vitro fertilization is an option for those in which other basic treatment options (like IUI) are not an option. It is a more aggressive and involved treatment but yields the highest success rates. This treatment utilizes fertility medications to stimulate the ovaries to produce multiple mature eggs per treatment cycle. Several blood tests and ultrasounds are used to monitor the progress of the cycle and egg growth. At the optimal time, the eggs are then retrieved from the ovary and fertilized in the embryology laboratory. After 5 days of incubation in the IVF laboratory, quality embryo(s) will be frozen. In a subsequent cycle, the uterus is prepared, using hormones, for optimal implantation. When ultrasound evaluation shows that the uterine lining is optimal, an embryo will be transferred into the uterus.

Candidates for IVF treatment are patients with failed tubal-reversal or tubal blockage, moderate to severe male factor infertility, failed treatment with ovulation induction and IUI, endometriosis, recurrent pregnancy loss, and those wishing genetic screening of embryos to prevent inheritable diseases.



# THE FERTILITY CENTER *of Charleston*

## **PREIMPLANTATION GENETIC DIAGNOSIS (PGD)**

Preimplantation Genetic Diagnosis is a test developed to help couples with a family history of genetically transmitted diseases to prevent this disease in their child. It is a procedure used in conjunction with in vitro fertilization (IVF) to screen embryos for a known chromosomal abnormality and a specific genetic disorder. Using PGD we can then transfer only chromosomally unaffected embryos (without the genetic disorder) into the uterus.

## **PREIMPLANTATION GENETIC SCREENING**

Preimplantation Genetic Screening is a similar test to PGD but is not used to detect specific diseases. This test is a more general evaluation of the chromosomes of embryos to select chromosomally normal embryos for transfer. In standard IVF, we select embryos based on their level of appropriate development and appearance. This test actually allows us to determine which embryos are chromosomally normal. It can increase pregnancy rates and live births per transfer and help to reduce recurrent pregnancy loss.

## **DONOR EGGS**

We provide donor egg services through the use of frozen donor oocytes available from My Egg Bank®. The use of a donor egg bank allows potential recipients a wider selection of donor oocytes ready for immediate use. After patient selection of a donor, the frozen eggs are shipped to our laboratory and then, when the patient's uterine lining is appropriate, they are thawed and fertilized creating embryos which are then transferred into the patient's uterus. If more embryos are available than selected for transfer, they may be cryopreserved for future use if the recipient so desires.

Candidates for the use of donor eggs are those patients who are not able to use their own eggs due to age, diminished ovarian reserve, or genetic disease.

## **EGG FREEZING**

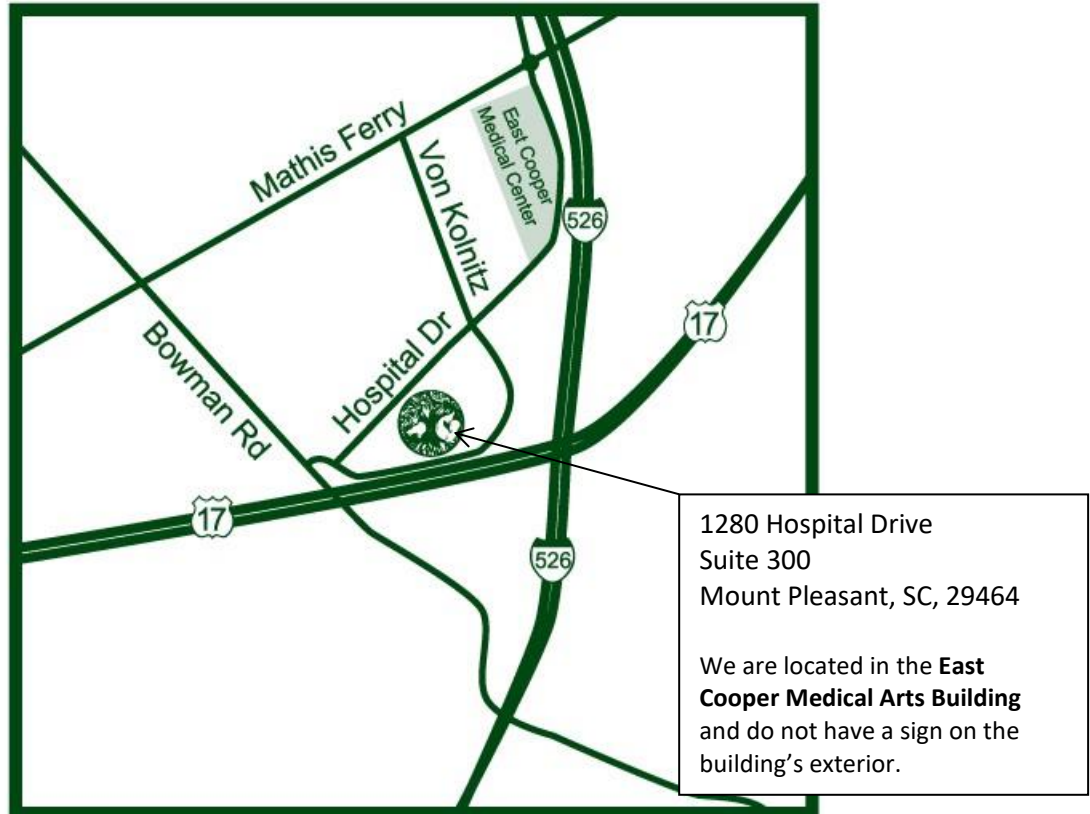
Improvements in freezing technologies have allowed those who wish to freeze eggs for fertility preservation or other reasons to do so. Ultra-rapid freezing, called vitrification, is used after eggs are obtained from stimulated ovaries similar to an IVF cycle, without having to be fertilized.

Candidates for egg freezing are those who wish to delay pregnancy but want to preserve or bank their best quality eggs while they are young. Other candidates are those who may need treatments that could potentially affect future fertility, like chemotherapy or removal of the ovaries. Egg freezing success rates depend on the age and diagnosis of the patient.



# THE FERTILITY CENTER *of Charleston*

## Mount Pleasant Office



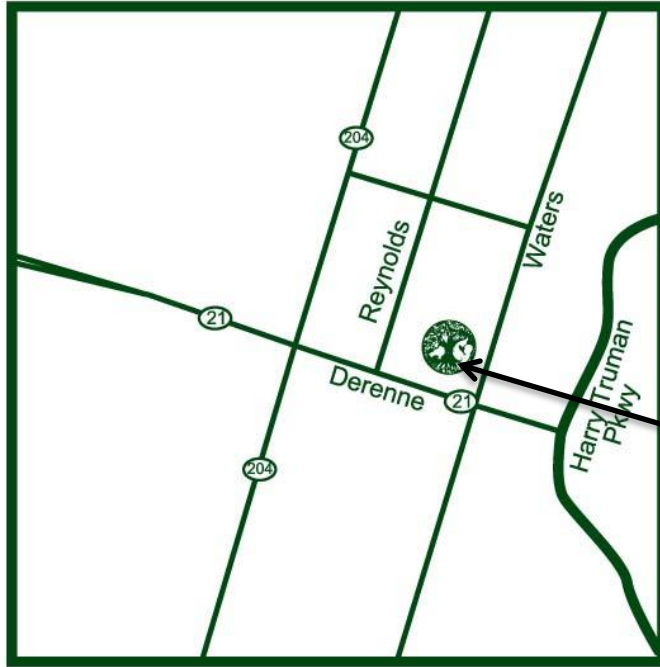
1280 Hospital Drive, Suite 300 • Mount Pleasant, SC 29464 • (843) 881-7400 • Fax (843) 881-7444  
5354 Reynolds Street, Suite 416 • Savannah, GA 31405 • (912) 228-8909 • Fax (912) 228-8912

[www.fertilitycharleston.com](http://www.fertilitycharleston.com)



# THE FERTILITY CENTER *of Charleston*

## Savannah Office



SAVANNAH

5354 Reynolds St, #416  
Savannah, GA 31405

We are located on the 4<sup>th</sup> floor of the Candler Professional Office Building, which is on the campus of Candler Hospital. Please note that The Candler Professional Building is located near the Emergency Room and faces DeRenne Avenue.



1280 Hospital Drive, Suite 300 • Mount Pleasant, SC 29464 • (843) 881-7400 • Fax (843) 881-7444  
5354 Reynolds Street, Suite 416 • Savannah, GA 31405 • (912) 228-8909 • Fax (912) 228-8912

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Please print and return this form as soon as possible. All information will remain confidential. Thank you!

Patient Name \_\_\_\_\_  
(Last) (First) (Middle) (Maiden) (Name Called)

Home address to include Apt #, City, State, and Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_

ARE YOU FLUENT IN ENGLISH? SPEAKING?  Yes  No WRITING?  Yes  No READING?  Yes  No IF NO, PREFERRED LANGUAGE \_\_\_\_\_  
May we contact you via email?  YES  NO If so, email address: \_\_\_\_\_

Have you or your spouse/partner been here before?  YES  NO Physician Who Referred You? \_\_\_\_\_

Physician's Address \_\_\_\_\_  
At least City/State \_\_\_\_\_ Phone Number \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Work Telephone \_\_\_\_\_ Are We Able To Contact You There? \_\_\_\_\_ **WE DO NOT SAY THE NAME OF OUR FACILITY**

How did you hear about our practice?  Doctor  Friend  Print Advertisement  Radio  Internet  Our Web Site  Fertility Network  Other

Emergency Contact: Name \_\_\_\_\_  
(Last) (First) (Relationship) Best Phone # \_\_\_\_\_

Partner's Name \_\_\_\_\_  
(Last) (First) (Middle) (Name Called)

SSN \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_ Gender \_\_\_\_\_

Employed By \_\_\_\_\_ Work Number \_\_\_\_\_ Cell Phone \_\_\_\_\_

Insurance Coverage(Primary)	Insurance Coverage(Spouse/Partner)
<b>Are you currently a Medicare and / or Medicaid beneficiary?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Are you currently a Medicare and/or Medicaid beneficiary?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Insurance _____	Name of Insurance _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Telephone _____	Telephone _____
Policy# _____	Policy# _____
Group# _____	Group# _____
Policy Holder _____	Policy Holder _____
Partner Covered <input type="checkbox"/> YES <input type="checkbox"/> NO	Partner Covered <input type="checkbox"/> YES <input type="checkbox"/> NO

I HEREBY MAKE ASSIGNMENT OF ALL SURGICAL, MEDICAL AND MAJOR MEDICAL INSURANCE BENEFITS TO STEPHANIE D. SINGLETON, MD, AND TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO EXECUTE AN ASSIGNMENT OF BENEFITS. I UNDERSTAND THAT REGARDLESS OF ANY INSURANCE COVERAGE I MIGHT HAVE, I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES TO THIS ACCOUNT. I FURTHER AGREE IN THE EVENT OF NON PAYMENT TO BEAR THE COST OF COLLECTION AND/OR COURT COSTS AND REASONABLE LEGAL FEES SHOULD THIS BE REQUESTED.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Partner Signature \_\_\_\_\_ Date \_\_\_\_\_



# THE FERTILITY CENTER of Charleston

## QUESTIONNAIRE FOR FEMALE PATIENT

Name \_\_\_\_\_ Partner's Name \_\_\_\_\_  
Length of time attempting pregnancy \_\_\_\_\_ Length of time not using contraceptives \_\_\_\_\_

### MENSTRUAL HISTORY

Age at first period \_\_\_\_\_ Date of first day of last period \_\_\_\_\_ Usual duration of bleeding \_\_\_\_\_  
Shortest number of days from beginning of one period to the beginning of the next \_\_\_\_\_  
Longest number of days from the beginning of one period to the beginning of the next \_\_\_\_\_  
Amount of flow  Light  Moderate  Heavy Any cramping with period?  Yes  No

### OBSTETRICAL HISTORY

Children?  Yes  No Ages \_\_\_\_\_ Number of Vaginal Deliveries (include date, sex of baby, and weight): \_\_\_\_\_  
Any difficulty becoming pregnant previously?  Yes  No \_\_\_\_\_  
Number of previous pregnancies \_\_\_\_\_ Number of C-Section (include date, sex of baby, and weight) \_\_\_\_\_  
Number of deliveries at term(40 weeks) \_\_\_\_\_  
# of premature deliveries(less than 37 weeks) \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_ Were there complications with previous pregnancies?  Yes  No  
How many weeks along \_\_\_\_\_ If yes, explain complications, including dates \_\_\_\_\_  
Number of living children \_\_\_\_\_  
Number of therapeutic abortions \_\_\_\_\_  
How many weeks along \_\_\_\_\_

### PREVIOUS INFERTILITY TESTING

	Yes	No	Year	Results (if known)
Ovulation Testing	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hysterosalpingogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hormone Studies	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

### PREVIOUS INFERTILITY TREATMENT

	Yes	No	Date	Type
Procedures on Cervix/Uterus/Tubes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Procedures on Ovaries	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Procedures for Adhesions	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Treatment for Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Treatment with Medication	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Artificial Insemination	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____





# THE FERTILITY CENTER *of Charleston*

## MEDICAL –SURGICAL HISTORY

	Yes	No	Date	Comments
Elevated Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver or Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Urinary Tract Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Autoimmune Disease(i.e Lupus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other Serious or Chronic Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Any Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Genital Warts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV 1 or 2	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HSV (Herpes)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
History of X-ray or Cancer treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

List any allergies to medications: \_\_\_\_\_  
\_\_\_\_\_

List medications you are taking now: \_\_\_\_\_  
\_\_\_\_\_

List medications you have taken in the past: \_\_\_\_\_  
\_\_\_\_\_



# THE FERTILITY CENTER *of Charleston*

## PARTNER QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_  
Occupation \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Partner's Name \_\_\_\_\_

### MEDICAL –SURGICAL HISTORY

	Yes	No	Date	Comments
Elevated Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver or Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Urinary Tract Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Autoimmune Disease(i.e Lupus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other Serious or Chronic Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Any Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Genital Warts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV 1 or 2	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HSV (Herpes)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
History of X-ray or Cancer treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

List any allergies to medications: \_\_\_\_\_  
\_\_\_\_\_

List medications you are taking now: \_\_\_\_\_  
\_\_\_\_\_

List medications you have taken in the past: \_\_\_\_\_  
\_\_\_\_\_



# THE FERTILITY CENTER *of Charleston*

## If Partner is Male Please Complete

	Yes	No	Comments
Have you ever fathered a child	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been told you are infertile	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is there any difficulty maintaining an erection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you ejaculate into the vagina without difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has a semen analysis ever been performed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a history of undescended testes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have an injury to the testes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had surgery on the testes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had a hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any history of treatment to improve fertility	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been treated for infection of testicles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for infection of seminal vesicles	<input type="checkbox"/>	<input type="checkbox"/>	_____

## If Partner is Female Please Complete

### Menstrual History

Age at first period \_\_\_\_\_ Date of first day of last period \_\_\_\_\_ Usual duration of bleeding \_\_\_\_\_  
 Shortest number of days from beginning of one period to the beginning of the next \_\_\_\_\_  
 Longest number of days from the beginning of one period to the beginning of the next \_\_\_\_\_  
 Amount of flow  Light  Moderate  Heavy Any cramping with period?  Yes  No

### For Female Partner Only to Complete

### Obstetrical History

Children?  Yes  No Ages \_\_\_\_\_  
 How long to conceive \_\_\_\_\_  
 Any difficulty becoming pregnant previously?  Yes  No  
 Number of previous pregnancies \_\_\_\_\_  
 Number of deliveries at term(40 weeks) \_\_\_\_\_  
 # of premature deliveries (less than 37 weeks) \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
     How many weeks along \_\_\_\_\_  
 Number of living children \_\_\_\_\_  
 Number of therapeutic abortions \_\_\_\_\_  
     How many weeks along \_\_\_\_\_

Number of Vaginal Deliveries (include date, sex of baby, and weight): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Number of C-Section (include date, sex of baby, and weight) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Were there complications with previous pregnancies?  Yes  No  
 If yes, explain complications, including dates \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# THE FERTILITY CENTER *of Charleston*

## ZIKA Questionnaire

The CDC and ASRM continue to update information and recommendations regarding the risk of ZIKA and pregnancy. Please answer the following questions so that we can take these risks into consideration when providing care.

YES      NO

- Have you or your partner been diagnosed with ZIKA infection in the last 6 months?
- Have you had sexual intercourse in the last 6 months with a male who is known to have either been diagnosed with ZIKA or traveled to one of the areas with active ZIKA transmission (listed below) within the last 6 months?

Please indicate any areas which you or your spouse have visited during the last 6 months or plan to visit during your treatment or pregnancy.

- The Caribbean:     Anguilla                       Antigua and Barbuda                       Aruba                       Barbados                       Bonaire  
 British Virgin Islands     Cuba                       Curaçao                       Dominica  
 Dominican Republic     Grenada                       Haiti                       Jamaica                       Montserrat  
 Commonwealth of Puerto Rico     Saba                       Saint Kitts and Nevis  
 Saint Lucia                       Saint Martin                       Saint Vincent and the Grenadines  
 Saint Eustatius                       Saint Maarten                       Trinidad and Tobago  
 Turks and Caicos Islands                       US Virgin Islands
- North America:     Mexico
- Central America:     Belize                       Costa Rica                       El Salvador                       Guatemala                       Honduras  
 Nicaragua                       Panama
- South America:     Argentina                       Bolivia                       Brazil                       Colombia                       Ecuador  
 French Guiana                       Guyana                       Paraguay                       Peru                       Suriname  
 Venezuela
- Africa:                       Angola                       Benin,                       Burkina-Faso                       Burundi                       Cameroon  
 Cape Verde                       Central African Republic                       Chad                       Congo (Congo-Brazzaville)  
 Côte d'Ivoire                       Democratic Republic of the Congo (Congo-Kinshasa)  
 Equatorial Guinea                       Gabon                       Gambia                       Ghana                       Guinea  
 Guinea-Bissau                       Kenya                       Liberia                       Mali                       Niger  
 Nigeria                       Rwanda                       Senegal                       Sierra Leone                       South Sudan  
 Sudan                       Tanzania                       Togo                       Uganda
- Asia:                       Bangladesh                       Burma (Myanmar)                       Cambodia                       India                       Indonesia  
 Laos                       Malaysia                       Maldives                       Pakistan                       Philippines  
 Singapore                       Thailand                       Timor-Leste (East Timor)                       Vietnam
- The Pacific Islands:     Papua New Guinea                       Solomon Islands                       Fiji                       Samoa                       Tonga



# THE FERTILITY CENTER *of Charleston*

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This form needs to be sent to your Physician(s) so that The Fertility Center of Charleston may obtain your medical records. Please send this form to any physicians (OB/GYN, Urologist, Infertility Specialist, etc) who have participated in your fertility related care ASAP.

Patient Name: \_\_\_\_\_  
(First) (Middle/Maiden) (Last)

SSN# \_\_\_\_\_ DOB: \_\_\_\_\_

INFORMATION RELEASED FROM :	INFORMATION RELEASED TO:
PRACTICE NAME:	THE FERTILITY CENTER OF CHARLESTON
PHYSICIAN NAME:	<b>ATTN: NEW PATIENT COORDINATOR</b>
ADDRESS:	1280 HOSPITAL DRIVE, SUITE 300 MOUNT PLEASANT, SC 29464
PHONE:	PHONE: 843-881-7400
FAX:	FAX: 843-881-7444

Dear Dr. \_\_\_\_\_

I am considering treatment at The Fertility Center of Charleston. Please forward a summary letter, this sheet and the below listed information to The Fertility Center of Charleston. All records need to be submitted prior to appointment date: \_\_\_\_\_

Please include the following if applicable:

- All semen analysis
- Hysterosalpingogram(HSG) reports and films
- Any operative notes and pathology
- All lab results
- Any other pertinent records related to infertility including notes on IUI or IVF

I request and authorize the above named physician or health care provider to release information to The Fertility Center of Charleston . I certify this request has been made voluntarily and that the information given above is accurate. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Copies of medical records may be mailed or faxed to the above address.

A copy of this authorization with my signature thereon may be utilized with the same effectiveness as the original.

Thank you for your assistance.

Sincerely,

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

PLEASE ENCLOSE THIS LETTER WITH THE RECORDS

1280 Hospital Drive, Suite 300 • Mount Pleasant, SC 29464 • (843) 881-7400 • Fax (843) 881-7444  
5354 Reynolds Street, Suite 416 • Savannah, GA 31405 • (912) 228-8909 • Fax (912) 228-8912  
[www.fertilitycharleston.com](http://www.fertilitycharleston.com)



# THE FERTILITY CENTER *of Charleston*

## CONSENT AND AUTHORIZATION FOR ELECTRONIC COMMUNICATION (EMAIL)

E-mail and communication provides for a fast and easy way to communicate with your healthcare provider for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

### General Considerations

- E-mail communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard e-mail services, such as Gmail, AOL, Yahoo and Hotmail are not secure. This means that the e-mail messages are not encrypted and can be intercepted and read by unauthorized individuals.
- Transmitting e-mail that contains protected health information through an email system that is not encrypted does not meet the security guidelines as required by the Health Information Protection and Accountability Act (HIPAA).
- Your e-mail address will not be used for external marketing purposes without your permission. You may receive a group mailing from the practice, however, the recipients e-mail addresses will be hidden.

### Provider Responsibilities

- The provider will attempt to electronically confirm your e-mail address by requesting a return response to all email messages.
- Your provider may route your e-mail messages to other members of the staff for informational purposes or for expediting a response.
- Designated staff may receive and read your e-mail.
- The provider will make every attempt to respond to your e-mail message within 2 business days. If you do not receive a response from the provider within 2 business days, please contact the office.
- Copies of e-mails sent and received from and to you will be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.
- All e-mail communication with patients is sent via a **SECURE** e-mail messaging system.

### Patient Responsibilities

- E-mail messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should contact 911. For emergent or time sensitive situations, you should contact your healthcare provider through the office.
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via e-mail.
- Please key in your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the e-mail.
- Please acknowledge that you received and read the provider's message by return e-mail to the provider.

I have read and understood the above description of the risks and responsibilities associated with the electronic communication with my healthcare provider.



# THE FERTILITY CENTER *of Charleston*

I acknowledge that commonly used e-mail services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

I have been given the opportunity to discuss electronic communication with my healthcare provider and have had all my questions answered.

**In consideration of my desire to use electronic communication as a supplement to in-person office visits with my provider, I hereby consent to electronic communication via secure e-mail services.**

I understand that I may revoke my consent to communicate electronically at any time by notifying The Fertility Center of Charleston in writing, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance on my consent.

I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a secured network.

I further agree to be held accountable for the patient responsibilities as outlined above.

PATIENT \_\_\_\_\_

Patient Authorized E-mail Address \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

PARTNER (if applicable) \_\_\_\_\_

Partner Authorized E-mail Address \_\_\_\_\_

Partner Signature \_\_\_\_\_ Date \_\_\_\_\_



# THE FERTILITY CENTER *of Charleston*

## Patient Financial Policy

1. **The Fertility Center of Charleston (TFCOC) is not a Medicare or Medicaid provider.** Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

2. I am ultimately responsible for the payment of all medical services. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

3. I understand that it is my responsibility to supply TFCOC with any current insurance information and/or any referral authorization forms (pre-authorization forms). Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

4. I understand I am (or guarantors) responsible for payment of co-pays, co-insurance, deductibles, supplemental fees, and all other fees not covered by my insurance plans and that payment must be made at the time services are rendered. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

5. **Private Insurance Authorization for Assignment of Benefits/Information Release:** I authorize that the payment of medical benefits be made on my behalf directly to The Fertility Center of Charleston for any services furnished me by the physician (s). I understand that I am financially responsible for any amount not covered by my contract. I authorize the release to my insurance company information concerning health care, advice and/or treatment provided to me necessary for processing of insurance claims. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

I hereby assign all medical and surgical benefits to which I am entitled (assignment of benefits) to TFCOC. I authorize and direct my insurance carrier(s) to issue payment check(s) directly to TFCOC for rendered services. If I receive payment check(s) from my insurance carriers, I will promptly forward them to TFCOC. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

6. **Insurance Coverage:** TFCOC will bill my insurance plans if the patient provides the required insurance information and signs and Assignment of Benefits statement. TFCOC may submit claims for covered services to non-contracted insurance plans as a courtesy; however, the services must be paid in full at the time services are rendered. If the patient has dual coverage and we do not participate with the primary insurer, services must be paid in full at the time services are rendered. Patients with a contracted insurance plan that covers only a portion of the services must pay the difference between the charges and the anticipated insurance payment at the time the services are rendered. All patients receiving medical services are required to prove their social security number prior to services being rendered. A pre-treatment deposit is required to initiating certain services. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

- We will file a claim for services rendered with the insurance carrier and allow 45 days for a payment in full. If payment is not received within 45 days, the balance due will become the obligation of the patient or guarantor(responsible party) and must be paid within 45 days. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

- Fertility services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventative, pre-existing, or non-covered, you will be responsible for your balance. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

7. If you do not have insurance or we are non-participating providers with your insurance carrier, payment is expected at the time services are rendered. Patients receiving services at our Savannah monitoring facility may be required to pre-pay for all services to be rendered. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_





# THE FERTILITY CENTER *of Charleston*

8. I understand payments may be made by cash, check, cashier check or credit card (Visa, MasterCard, Discover, or American Express). No personal checks over \$2,500. Returned checks will be handled in accordance with the Patient Financial Services Department NSF procedures. A \$35.00 administration fee will be assessed for each returned check. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_
9. **Phone Consults:** Our office does offer follow up phone consultations for out of town patients, however the cost is \$120.00 and is not covered by insurance. Our no show /no contact policy does apply. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_
10. **No show/Cancellation Policy:** I understand if I cannot keep my appointment, I will contact the office at least 48 hours in advance to cancel or reschedule my appointment. If I do not cancel or reschedule 48 hours in advance, I will be charged a no show/cancellation fee of \$60.00. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_
11. **Cryopreservation and Storage:** Our frozen storage system at TFCOC was established to provide our patients with a safe and convenient method to store frozen specimens for use in future treatments. Storage fees not paid upon receipt of statement within 90 days are subject to a collection process that may result in reporting the storage debt to an outside collections agency and may jeopardize the patient's credit rating. The patient will continue to accrue a yearly storage fee without notice until legal documentation is received releasing TFCOC as legal custodian. Cryopreservation fees that become delinquent will enter the same collection process as above. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_
12. **Cancellation of Cycle:** I understand if a cycle is cancelled for any reason, I will be charged for the actual procedures performed according to the standard fee schedule utilized by TFCOC. If I am undergoing an IVF cycle and convert to an IUI cycle, I will only be charged for the actual procedures performed. Any difference between cost of the actual procedures performed and the deposit amount will be refunded to me/guarantor once I have been released from care and any insurance payments due have been received. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_
13. **Refunds:** Overpayments of credit balances greater than \$10.00 will be refunded to the appropriate party after review of the account. Patient refunds will not be processed until the patient is released from care and any insurance payments due have been received. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_
14. **Collections:** I agree to reimburse TFCOC for the fees of any collection agency, which may be based on the percentage of the debt at a minimum of 30% to a maximum of 50%, and of all cost and expenses, including reasonable attorneys' fees, TFCOC incurred in such collection efforts. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_
15. **Additional Information requests:** I understand there is a \$25.00 charge per request for additional forms other than standard HFCA 1500 billing forms and any additional dictated letters required by Dr. Singleton. Ten (10) business days are allowed for these forms to be completed. Payment for these will be made in advance. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_
16. I understand that this authorization will remain on file for future rendered services. Patient Initials \_\_\_\_\_ Partner Initials \_\_\_\_\_

I UNDERSTAND THE ABOVE FINANCIAL RESPONSIBILITIES AND AGREE TO THEIR TERMS. I ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS INSURANCE CLAIMS.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Partner

\_\_\_\_\_  
Date



# THE FERTILITY CENTER *of Charleston*

## Additional Authorizations

### HIPPA Notice of Privacy Practices Acknowledgement

I have been made aware of The Fertility Center of Charleston's Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of TFCOC. I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions. **Patient initials** \_\_\_\_\_ **Partner initials** \_\_\_\_\_

### Authorization to Release and/or Obtain Medical Records

I hereby authorize my primary care physician, my referring physician, and TFCOC physicians, the release, use, and disclosure of my entire medical record by mail, phone, and fax, to carry out my treatment, payment, and healthcare operations.

**Patient initials** \_\_\_\_\_ **Partner initials** \_\_\_\_\_

### Authorized Methods of Communication (Please check all that apply)

- 1. Permission is given to leave call back phone number only:     Home     Cell     Work
- 2. Permission is given to leave detailed message on answering machine/voice mail:     Home     Cell     Work
- 3. Permission is given to discuss my healthcare treatment with:     Spouse     Family Member     Friend     Other

**Patient initials** \_\_\_\_\_ **Partner initials** \_\_\_\_\_

**This authorization will remain on file for future rendered services.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Partner

\_\_\_\_\_  
Date