IVFLA Fertility

Steven C. Presser, M.D.

Reproductive Endocrinology & Infertility

BEVERLY HILLS
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Beverly Hills, CA 90211
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Fax:424 – 320-5798

MURIETTA
25109 Jefferson Ave. #210
Murietta, CA 92562
Ph:951- 677-5338
Fax: 424-320-5798

Patient's Name: Last, First, Middle Initial	S.S.#	Marital Status M / S / D / W / Sep	Birth Date
Street Address	City, State, Zip	Home Phone (preferred) □	
Patient's Employer	Occupation	Business Phone	Cell Phone (preferred) □
Employer's Address	City, State, Zip	Personal Fax	
Drug Allergies, If Any	Are you Diabetic? □ Yes □ No	Driver's License #	Email Address
Spouse/Partner's Name: Last, First, Middle Initial	S.S.#	Birth Date	
Address (If different)	City, State, Zip	Home Phone	
Spouse / Partner's Employer	Occupation	Business Phone	
Employers Address	City, State, Zip	Alternate Phone	
In Case of Emergency, Notify	Relationship	Phone	
Name of Person Insured	Effective Date	Certificate / Policy #	Group #
Name of Insurance Company	HMO Yes / No	Subscriber #	
Insurance Address	City, State, Zip		

How did you learn about IVFLA Fertility /Dr. Presser? Please Check all that apply

□ Friend Name:		□ Mailer	□ Advertisement	□ Website
□ Seminar Date:	□ Radio Station:	□ TV Station:	Referring Physician	Physician Phone

IVFLA Fertility /Dr. Presser is committed to safeguarding your confidentiality. We are also committed to educating the community on issues concerning infertility. May we include you on future mailings?

□ YES □ NO

AUTHORIZATION OF TREATMENT ASSIGNMENT OF BENEFITS, REALEASE OF MEDICAL INFORMATION FINACIAL RESPONSIBILITY

I understand that I am financially responsible of charges incurred at the time of service or for any charges not covered by an approved contractual provider insurance or insured benefits. I am also responsible for any collection fees or legal cost incurred should costs be necessary because of non-payment. I hereby authorize the release of any medical records or other information necessary for the processing of insurance benefits of medical and/or surgical services rendered.

I hereby authorize payment of benefits directly to IVFLA Fertility / Steven C. Presser, M.D. for the procedural, surgical, and/or medical benefits if any, otherwise payable to me for their service.

HMO patients should be aware that you are financially responsible for all the unauthorized services.

I hereby authorize treatment by IVFLA Fertility / Steven C. Presser, M.D.

Signature of Patient, Guarantor, or Guardian Date

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

Request Limitation of PHI

This form is for our own internal purposes only and is in compliance with the HIPAA Act. We need documentation to verify the most successful ways of communicating with you.

PLEASE NOTE: If we are not able to reach you at the numbers below, we may need to try alternate numbers.

Name: _____ Date of Birth: _____

What are the best number to contact you? Please provide 2 options in case we are not able to reach you at one of the numbers:

- ☐ Home phone #: _____
  Is it ok to leave a message? ☐ Yes ☐ No
- ☐ Work phone #: _____
  Is it ok to leave a message? ☐ Yes ☐ No
- ☐ Cell phone #: _____
  Is it ok to leave a message? ☐ Yes ☐ No
- ☐ Fax home #: _____
- ☐ Fax work #: _____
- ☐ Email (Personal): _____
- ☐ Email (Work): _____

Comments:

_____

_____

- ☐ I give permission for my partner to receive my test results.

_____ _____
SIGNATURE OF MALE PARTNER DATE

_____
PRINTED NAME

_____ _____
SIGNATURE OF PATIENT DATE

_____
PRINTED NAME

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

Female Patient History

Today's Date:_____

Please complete all pages of this form and either email before or bring to initial consultation. If downloading, print and fill out by hand using a pen.

IDENTIFYING INFORMATION

Name: _____ _____ Age: _____ DOB: _____
Last First

Occupation: _____ Marital Status: □ Single □ Separated □ Divorced □ Married ____ years

Partner's Name: _____ _____ Age: _____ DOB: _____
Last First

Referring Physician: _____ Primary Care Physician: _____

Address: _____ Address:_____

Ph: _____ Ph: _____

Reason for Visit: _____

Trying to conceive: ☐ No ☐ Yes If so, how long without protection? ___ Years ___ Months Comments: _____

TRAVEL/WORK AND GENERAL BACKGROUND

All present employment title(s), location, brief description, and number of years employed.

_____ _____ _____ ___

_____ _____ _____ ___

Are you or have you ever been exposed to any of the following during employment or military service:

□ Heat □ Toxic Fumes □ Other

(Specify):_____

□ Chemicals □ Radiation (chest x-ray, CAT scan, MRI)

_____

MEDICAL HISTORY

Weight: _____lbs. Height: ____ft. ____in.

Have you ever lost/ gained greater than 20 pounds of weight in the last year? □Yes □No

Do you follow a particular food diet or have any special dietary needs? □Yes □No

List the forms and frequency of regular vigorous exercise (e.g. swimming, cycling, running) and age you began:

Exercise: _____ Hrs./Week: _____ Age: ____ Exercise: _____ Hrs./Week: _____ Age: ____

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

□ Acne	□ Colitis	□ Kidney Infection	□ Ovarian Cysts	□ Ulcers
□ Anemia	□ Cystic Fibrosis	□ Liver Problems	□ Parasitic Infection	□ Vaginitis (Trichomoniasis, Yeast)
□ Appendicitis	□ Diabetes	□ Loss of Balance	□ Parathyroid Problems	# of episodes: _____
□ Arthritis	□ Dizziness	□ Lung Disease	□ Pelvic Infection	□ Varicose Veins
□ Blood Transfusion	□ Endometriosis	□ Measles: German	□ Pituitary Problems	□ Visual Disturbances
□ Bowel Disease/Stomach Problems	□ Epilepsy	□ Measles: Regular	□ Pneumonia	Other Medical Problems:
□ Breast Discharge	□ Gallbladder Problems	□ Mental Illness	□ Poor Sense of Smell	_____
□ Breast Soreness	□ Gonorrhea	□ Mitral Valve Prolapse	□ Rheumatic Fever	_____
□ Breast Tenderness	□ Heart Disease	□ Mumps	□ Scarlet Fever	_____
□ Bronchitis	□ Hepatitis	□ Muscle and Joint Disease	□ Seizures	_____
□ Cancer	□ Herpes	□ Neurological Problems	□ Syphilis	_____
□ Chlamydia	□ Hirsutism (excess hair growth)	□ Nongonococcal Urethritis	□ Thrombophlebitis	_____
□ Chronic Bronchitis	□ Immunization: German measles, Hep B, Tuberculosis	□ Obesity	□ Thyroid Problems	_____
□ Chronic Headaches	□ Irregular bleeding	□ Osteoporosis	□ Tuberculosis	_____

If you answered yes to any, please give specific details regarding who and how diagnosis was made, as well as treatment given (if any). Use the back of this page, if necessary.

_____

_____

Have you ever had a high fever (over 102˚F) during the past 3-4 months? □ Yes □ No

Comments:_____

MENSTRUAL HISTORY

Comments

Age you started to have periods ____ _____

Are your periods regular? □ Yes □ No _____

If cycles irregular, number of cycles/years ____ _____

On average, how many days between periods? ____ _____

How long do your periods last? ____ Days _____ Weeks _____

Menstrual flow: □Normal □Light □Heavy

Pain with periods? □None □Mild □Moderate □Severe

Comments

Pain not associated with your periods? □Yes □No _____

_____

Bleeding between periods? □Yes □No _____

_____

Date of last menstrual period? ____/____/_____

GYNECOLOGICAL HISTORY

Birth Control (Presently)	□Yes	□No	Type: _____	Mom took DES	□Yes	□No
Vaginal Lubricants (Presently)	□Yes	□No	Type: _____	Douche	□Yes	□No
Sexual Abuse	□Yes	□No		Physical Abuse	□Yes	□No
Abnormal Pap	□Yes	□No	When: _____	Mammogram	□Yes	□No

Treatment: _____ Date of last Mammogram: _____/_____/_____

Date of last Pap ____/____/_____ Normal: □ Yes □ No If yes, results for mammogram:

_____ Findings: _____

Prior IUD use □Yes □No Type: _____

OBSTETRIC HISTORY

Date (mo./yr.) Outcome (circle one) Comments/ Complications

_____/ _____ Miscar/ Nml deliv/ C-sec/ Tubal/Abortion _____

_____/ _____ Miscar/ Nml deliv/ C-sec/ Tubal/Abortion _____

_____/ _____ Miscar/ Nml deliv/ C-sec/ Tubal/Abortion _____

_____/ _____ Miscar/ Nml deliv/ C-sec/ Tubal/Abortion _____

_____/ _____ Miscar/ Nml deliv/ C-sec/ Tubal/Abortion _____

INFERTILITY HISTORY

Comments

How often do you have intercourse? Per week ____ Per month ____ _____

Do you douche before or after intercourse? □Yes □No _____

Is intercourse painful? □Yes □No _____

Do you have problems with arousal or lubrication? □Yes □No _____

Any change in sexual frequency or enjoyment? □Yes □No _____

PRIOR INFERTILITY EVALUATION (if applicable)

			Year	Result		Comments
Day 3 Blood Tests and Ultrasound	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Urine Ovulation Kits	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Endometrial Biopsy	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Semen Analysis	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Hysterosalpingogram	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Postcoital Test	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Laparoscopy	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Hysteroscopy	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Clomid Challenge Test	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Hysterosonogram (Sono- HSG)	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____
Other Blood Tests	□ Yes	□ No	_____	□ Normal	□ Abnormal	_____

PRIOR INFERTILITY TREATMENTS (if applicable)

			Year		Comments
Clomid/ Letrozole	□ Yes	□ No	_____	# of cycles _____	_____
Follistim, Gonal, Menopur	□ Yes	□ No	_____	# of cycles _____	_____
Lupron/ Ganirelix	□ Yes	□ No	_____	# of cycles _____	_____
Intrauterine Insemination (IUI)	□ Yes	□ No	_____	# of cycles _____	_____
IVF or GIFT	□ Yes	□ No	_____	# of cycles _____	_____
Egg Donor IVF	□ Yes	□ No	_____	# of cycles _____	_____

MEDICATIONS

Do you take medication? Comments (names and doses): _____

□ Yes □ No _____

Do you take vitamins? Comments (names and doses): _____

□ Yes □ No _____

Do you take herbal remedies/other supplements? Comments (names and doses): _____

□ Yes □ No _____

ALLERGIES **(to medicines or dyes)**

□Yes □No If yes, describe: _____

_____

BLOOD TYPE □ Unknown □ Blood Type _____

PAST SURGERIES □ Yes □ No

Date	Hospital	MD	Operation	Findings	Complications

SOCIAL HISTORY

(If you answer yes to any of the following questions, please describe details, amounts, and frequency)

						Comments
Smoke (Cigarettes)	□ Yes	□ No	Alcohol	□ Yes	□ No	_____
Cocaine	□ Yes	□ No	Marijuana	□ Yes	□ No	_____
IV Drugs	□ Yes	□ No	Weight change	□ Yes	□ No	_____
Caffeine	□ Yes	□ No				_____

(If you feel more comfortable discussing illicit or recreational drug use (e.g. cocaine, marijuana, IV drugs) with the doctor instead of writing anything down, simply check this box □)

FAMILY/ GENETIC HISTORY

Has anyone in your family had one or more infants with serious birth defects? □ Yes □ No
Has anyone in your family had two or more miscarriages? □ Yes □ No

Do you or anyone in your family have one or more of the following? (check all that apply)

Club Foot	□ Yes	□ No	Schizophrenia	□ Yes	□ No
Kidney Malformation	□ Yes	□ No	Bladder Malformation	□ Yes	□ No
Pyloric Stenosis	□ Yes	□ No	Polycystic Ovaries	□ Yes	□ No
Congenital Heart Disease	□ Yes	□ No	Cleft Lip or Palate	□ Yes	□ No
Neural Tube Defect	□ Yes	□ No	Loss of Muscle Function	□ Yes	□ No
Diabetes (adult)	□ Yes	□ No	Early Senility	□ Yes	□ No
Premature Death	□ Yes	□ No	Huntington's Disease	□ Yes	□ No
Early Menopause	□ Yes	□ No	Breast Cancer	□ Yes	□ No
Ovarian Cancer	□ Yes	□ No	Muscular Dystrophy	□ Yes	□ No
Stillbirth	□ Yes	□ No	Sickle- Cell Anemia	□ Yes	□ No
Cystic Fibrosis	□ Yes	□ No	Mental Retardation	□ Yes	□ No
Tay- Sachs	□ Yes	□ No	Spina Bifida	□ Yes	□ No
Down's Syndrome	□ Yes	□ No	Tuberous Sclerosis	□ Yes	□ No
Birth Defects	□ Yes	□ No	Heart Attack (<50 yrs.)	□ Yes	□ No
Thyroid Disease	□ Yes	□ No	Diabetes (juvenile)	□ Yes	□ No
Blindness	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Chromosome Problem	□ Yes	□ No	Recurrent Mischarge	□ Yes	□ No
Hemophilia	□ Yes	□ No	Deafness	□ Yes	□ No
Polycystic Kidneys	□ Yes	□ No	Other Genetic Disorders	□ Yes	□ No
Bleeding Disorders	□ Yes	□ No	_____		

ANCESTRAL BACKGROUND

There are certain ancestral backgrounds that have an increased frequency of some genetic diseases. Please indicate if either your mother or father are of any of the following backgrounds.

□ African □ Caribbean □ Jewish □ Indian □ Native American □ French Canadian
□ Latin America □ Mediterranean □Asian

All answers will be kept in strict confidence and serve to assist in your care. We encourage any questions you may have in regards to this history inquiry or any aspect of your care.

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Reproductive Endocrinology & Infertility

Male Patient History

Please complete all pages of this form and either email it before or bring it to your initial consultation. If downloading, print and fill out by hand using a pen.

TRAVEL/WORK AND GENERAL BACKGROUND

All present employment title(s), location, brief description, and number of years employed.

_____ _____ _____ _____

_____ _____ _____ _____

Are you or have you ever been exposed to any of the following during employment or military service:

□ Heat □ Toxic Fumes □ Other (Specify):_____

□ Chemicals □ Radiation (chest x-ray, CAT scan, MRI) _____

MEDICAL HISTORY

Weight: _____lbs. Height: ____ft. ____in.

Have you ever lost/ gained greater than 20 pounds of weight in the last year? □Yes □No

Do you follow a particular food diet or have any special dietary needs? □Yes □No

List the forms and frequency of regular vigorous exercise (e.g. swimming, cycling, running) and age you began:

Exercise: _____ Hrs./Week: _____ Age: ____ Exercise: _____ Hrs./Week: _____ Age: ____

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

□ Acne	□ Colitis	□ Measles: German	□ Poor Sense of Smell	□ Visual Disturbances
□ Anemia	□ Cystic Fibrosis	□ Measles: Regular	□ Prostatitis	Other Medical Problems:
□ Appendicitis	□ Diabetes	□ Mental Illness	□ Rheumatic Fever	_____
□ Arthritis	□ Dizziness	□ Mitral Valve Prolapse	□ Scarlet Fever	_____
□ Blood Transfusion	□ Epilepsy	□ Mumps	□ Seizures	_____
□ Bowel Disease/Stomach Problems	□ Gallbladder Problems	□ Muscle and Joint Disease	□ Syphilis	_____
□ Breast Discharge	□ Gonorrhea	□ Neurological Problems	□ Testes Infection	_____
□ Breast Soreness	□ Heart Disease	□ Nongonococcal Urethritis	□ Testes Injury	_____
□ Breast Tenderness	□ Hepatitis	□ Obesity	□ Testes Tumor	_____
□ Bronchitis	□ Herpes	□ Osteoporosis	□ Thrombophlebitis	_____
□ Cancer	□ Kidney Infection	□ Parasitic Infection	□ Thyroid Problems	_____
□ Chlamydia	□ Liver Problems	□ Parathyroid Problems	□ Tuberculosis	_____
□ Chronic Bronchitis	□ Loss of Balance	□ Pituitary Problems	□ Ulcers	_____
□ Chronic Headaches	□ Lung Disease	□ Pneumonia	□ Varicose Veins	_____

If you answered yes to any, please give specific details regarding who and how diagnosis was made, as well as treatment given (if any). Use the back of this page, if necessary. _____

_____

Have you ever had a high fever (over 102˚F) during the past 3-4 months? □ Yes□ No

Comments: _____

SEXUAL HISTORY

When you were a child, were both testes descended into the scrotum? □ Yes □ No

Have you ever produced a child with another partner? □ Yes □ No

If yes, how long did it take you to produce a child? _____ When was this (date)? _____

Do you have trouble getting an erection? □ Yes □ No

Do you have trouble maintaining an erection? □ Yes □ No

Do you have trouble ejaculating? □ Yes □ No

If yes, □ Premature ejaculation □ Retrograde Ejaculation

Do you ever have orgasms without ejaculation during masturbation? □ Yes □ No

Do you have any discharge from the penis? □ Yes □ No

How many times do you have intercourse around ovulation? _____

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

Do you use lubricants for intercourse? □ Yes □ No

Do you know what a semen analysis is? □ Yes □ No

If yes, have you had one and what are the results? _____

_____

Have you ever had any urological surgery? □ Yes □ No

If yes, describe: _____

_____

Have you ever considered adoption? □ Yes □ No

What are your views on adoption? _____

_____

Please answer the following questions on the following pages. Make any comments on the section at the bottom of this page.

Number of pregnancies with current partner: _____ Number of years married: _____

Number of prior marriages: Husband _____ Wife _____ Number of pregnancies with previous partner(s): _____

Age(s) of children, if any: _____

Have you ever suffered an injury to the testicles? □ Yes □ No

Have you ever had a hernia repair? □ Yes □ No

Have you been diagnosed with a varicocele? □ Yes □ No

Have you had a vasectomy? □ Yes □ No

Have you ever had bladder or prostate surgery? □ Yes □ No

Have you had epididymitis? □ Yes □ No

Did you have early puberty (before 12 yrs)? □ Yes □ No

Comments: _____

_____

_____

MEDICATIONS

Do you take medication?

□ Yes □ No

Comments (names and doses): _____

_____

Do you take vitamins?

□ Yes □ No

Comments (names and doses): _____

_____

Do you take herbal remedies/ other supplements?

□ Yes □ No

Comments (names and doses): _____

_____

ALLERGIES **(to medicine or dyes)**

□Yes □No If yes, describe: _____

_____

BLOOD TYPE □ Unknown □ Blood Type _____

PAST SURGERIES □ Yes □ No

Date	Hospital	MD	Operation	Findings	Complications

SOCIAL HISTORY

(If you answer yes to any of the following questions, please describe details, amounts, and frequency)

						Comments
Smoke (Cigarettes)	□ Yes	□ No	Alcohol	□ Yes	□ No	_____
Cocaine	□ Yes	□ No	Marijuana	□ Yes	□ No	_____
IV Drugs	□ Yes	□ No	Weight change	□ Yes	□ No	_____
Caffeine	□ Yes	□ No				_____

(If you feel more comfortable discussing illicit or recreational drug use (e.g. cocaine, marijuana, IV drugs) with the doctor instead of writing anything down, simply check this box □)

FAMILY/ GENETIC HISTORY

Has anyone in your family had one or more infants with serious birth defects? □ Yes □ No

Has anyone in your family had two or more miscarriages? □ Yes □ No

Do you or anyone in your family have one or more of the following? (check all that apply)

Club Foot	□ Yes	□ No	Schizophrenia	□ Yes	□ No
Kidney Malformation	□ Yes	□ No	Bladder Malformation	□ Yes	□ No
Pyloric Stenosis	□ Yes	□ No	Polycystic Ovaries	□ Yes	□ No
Congenital Heart Disease	□ Yes	□ No	Cleft Lip or Palate	□ Yes	□ No
Neural Tube Defect	□ Yes	□ No	Loss of Muscle Function	□ Yes	□ No
Diabetes (adult)	□ Yes	□ No	Early Senility	□ Yes	□ No
Premature Death	□ Yes	□ No	Huntington's Disease	□ Yes	□ No
Early Menopause	□ Yes	□ No	Breast Cancer	□ Yes	□ No
Ovarian Cancer	□ Yes	□ No	Muscular Dystrophy	□ Yes	□ No
Stillbirth	□ Yes	□ No	Sickle- Cell Anemia	□ Yes	□ No
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Tay- Sachs	□ Yes	□ No	Spina Bifida	□ Yes	□ No
Down's Syndrome	□ Yes	□ No	Tuberous Sclerosis	□ Yes	□ No
Birth Defects	□ Yes	□ No	Heart Attack (<50 yrs.)	□ Yes	□ No
Thyroid Disease	□ Yes	□ No	Diabetes (juvenile)	□ Yes	□ No
Blindness	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Chromosome Problem	□ Yes	□ No	Recurrent Mischarge	□ Yes	□ No
Hemophilia	□ Yes	□ No	Deafness	□ Yes	□ No
Polycystic Kidneys	□ Yes	□ No	Other Genetic Disorders	□ Yes	□ No
Bleeding Disorders	□ Yes	□ No	_____		

ANCESTRAL BACKGROUND

There are certain ancestral backgrounds that have an increased frequency of some genetic diseases. Please indicate if either your mother or father are of any of the following backgrounds.

□ African □ Caribbean □ Jewish □ Indian □ Native American □ French Canadian

□ Latin America □ Mediterranean □Asian

All answers will be kept in strict confidence and serve to assist in your care. We encourage any questions you may have in regards to this history inquiry or any aspect of your care.

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Notice of Privacy Practices

As required by the Privacy of Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your individually identifiable health information.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose you PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. The following categories describe the different ways in which we may use and disclose your PHI:

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage, such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the service provided, and the medical condition being treated.

Health Care Operation: We may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

Appointment Reminders: We may use and disclose your PHI to contact you and remind you of an appointment.

Treatment Options: We may use and disclose your PHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services: We may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Anesthesia Services: We may contact you regarding financial matters involving anesthesia, and we may provide your information to the anesthesiologist, if applicable.

Release of Information to Family/ Friends: We may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

Deceased Patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Disclosure Required by Law: We will use and disclose your PHI when we are required to do so by federal, state, or local law.

USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

Public Health Risks: We may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths'
- Reporting child abuse or neglect

- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device that they may be using has been recalled
- Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient, including domestic violence; however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings: We may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Research: We may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

Serious Threats to Health or Safety: We may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military: We may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security: We may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign head of state, or to conduct investigations.

Inmates: We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Right to Provide an Authorization for Other Uses and Disclosures: We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards including:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to file a complaint- We will provide you with the address
- The right to inspect and copy your protected health information- Contact the front office receptionist for the form
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

HIPAA Acknowledgement Form

(Leah Weiss- Privacy Officer Contact: leah@ivflafertility.com)

I hereby acknowledge that I received a copy of this medical practice's **Notice of Privacy Practices.** I further acknowledge that a copy of the current notice will be posted in the reception area and that a copy of any amended **Notice of Privacy Practices** will be available at each appointment.

- I would like to receive a copy of any amended Notice of Privacy Practices by email at:

_____

Signed: _____ Date: _____

Print Name: _____

Telephone: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name and Address of Patient:

_____

_____

_____

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

HIPAA Notice of Privacy Practices- Acknowledgement Tracking Information

Name of Patient: _____

Address: _____

_____

_____

For Office Use Only:

Date Received: _____

Practice Follow-up: __ Yes __ No

Processed by: _____

Date of Practice Follow-up: _____

Complete the following only if the Patient refuses to sign the Acknowledgement:

Efforts to Obtain:

_____

_____

Reason for Refusal:

_____

_____

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

Medical Records Request

By signing this authorization, I authorize you to use and / or disclose certain protected health information (PHI) about me to: **IVFLA Fertility/ Steven C. Presser, M.D.**

□ **292 S. La Cienega Blvd Suite 100** **Beverly Hills, California 90211** **Ph: (424)320-5848** **Fax: (424)320-5798**	□ **25109 Jefferson Ave Suite 210** **Murrieta, CA, 92562** **Ph: (951)677-5338** **Fax: (424)320-5798**

Dear Dr._____

I, _____ authorize you to release a copy of my medical records

covering the period of _____ to _____

_____ _____

Date of Birth Social Security Number

Please mail or fax the records to the above address.

The purpose of the requested release is to obtain records related to infertility or gynecological medical problems. Dr. Presser will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

The specific information requested is office visits, labs, x-rays, surgeries, op reports, etc. The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

I release you from all legal responsibility or liability that may arise from this authorization.

Please release my medical records including: (circle appropriate number)

1. All my medical records (excluding HIV testing)
2. HIV
3. Please exclude the following_____

_____ _____

Signature of Patient Date

_____

Print Name of Patient

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

Authorization for the Release of Medical Information to the Patient's Insurance Company

There are occasions when the patient's insurance company may request information from our office. In order to establish if office or surgical procedures are payable under the patient's policy, by signing this document, the patient is giving our office permission to release the appropriate information.

_____
Name of Patient (print)

_____ _____
Signature Date

Authorization for Benefits to be Paid Directly to Physician

I authorize payment to be made directly to the physician.

_____
Name of Patient (print)

_____ _____
Signature Date

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

Authorization for the Release of Medical Information to the Patient's Insurance Company

There are occasions when the patient's insurance company may request information from our office. In order to establish if office or surgical procedures are payable under the patient's policy, by signing this document, the patient is giving our office permission to release the appropriate information.

_____
Name of Patient (print)

_____ _____
Signature Date

Authorization for Benefits to be Paid Directly to Physician

I authorize payment to be made directly to the physician.

_____
Name of Patient (print)

_____ _____
Signature Date

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding *arbitration* rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement, you are changing the place where your claim will be presented. You **may still call witnesses and present evidence**. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case.

This agreement generally helps limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course is to provide medical care in such a way as to avoid any such dispute. We have known that most problems begin with communication. Therefore, **if you have any questions about your care, please ask us.**

Dr. Steven Presser and the IVFLA Fertility Team

Note: The arbitration form must be signed in person and witnessed by an employee.

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

PHYSICIAN- PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary, unauthorized, or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse, heirs of the patient and any children, whether born or unborn, at the time of occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partner, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of an arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Codes Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary of adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If the patient intends for this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) the patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initial

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature — Date

By: _____ _____
Patient or Patient Representative's Signature — Date

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____
Print Patient's Name

A signed copy of this document is to be given to the patient.
Original is to be filed in patient's medical record.

_____
(If Representative, Print Name and Relationship to Patient)

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Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
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Patient's or Patient Representative's Initial

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By: _____ _____
Physician's or Authorized Representative's Signature — Date

By: _____ _____
Patient or Patient Representative's Signature — Date

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____
Print Patient's Name

A signed copy of this document is to be given to the patient.
Original is to be filed in patient's medical record.

_____
(If Representative, Print Name and Relationship to Patient

IVFLA Fertility
Steven C. Presser, M.D.
Reproductive Endocrinology & Infertility

Preconceptual Evaluation and Counseling

Dr. Presser and his staff are aware that we have a unique patient population that cares strongly about the health and well-being of their children. We are also mindful that we have a unique responsibility and opportunity to counsel our patients regarding ways to improve the health of their pregnancy and infant.

As such, we feel strongly that all individuals desiring conception should be offered preconceptual evaluation and relevant screening. To that effect, we carefully screen each patient's personal and family health history. We ask that you please inform us if there is any history of congenital or hereditary abnormality in your family. In certain cases, additional genetic counseling may be advised. We are also instituting a practice-wide policy of universal prenatal and genetic screening. No test is capable of predicting disease or diagnosing an abnormality 100% of the time. However, based on the recommendations of the National Institutes of Health (NIH), the American Society of Reproductive Medicine (ASRM) and the United States Public Health Service Expert Panel on the Content of Prenatal Care, we recommend the following basic screening tests that are attached to this document.

While we respect your right to refuse any of these recommendations, we believe that everyone should be routinely screened before attempting to conceive. We would be happy to discuss any of these tests with you.

Please sign below to indicate that you have received and understood our recommendations and discussion.

_____ _____

Patient Signature Date

_____

Printed Name

_____ _____

Partner Signature Date

_____

Printed Name

IVFLA Fertility
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Preconceptual Screening Labs

Test	Date	Comment (Initial if Declined)
Blood Type & Rh Factor		
Complete blood count with red cell indices		
COVID-19		
Cytomegalovirus Titer		
Genetic/ Hereditary Paternal: Cystic Fibrosis Tay-Sachs Hb Electrophoresis Hexosaminidase A Level		
Genetic/Hereditary Maternal: Cystic Fibrosis Tay-Sachs Hb Electrophoresis Hexosaminidase A Level		
Maternal ID Panel: Chlamydia and Gonococcus Hepatitis B Surface Antigen Hepatitis C Antibody Human T-Lymphotropic Virus 1 & 2 Human Immunodeficiency Virus RPR (Syphilis)		
Maternal: Rubella Titer		
Maternal: Varicella Titer		
Paternal ID Panel: Chlamydia and Gonococcus Hepatitis B Surface Antigen Hepatitis C Antibody Human T-Lymphotropic Virus 1 & 2 Human Immunodeficiency Virus (HIV) RPR (Syphilis)		
Serum Glucose Level		
Toxoplasmosis Titer		

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STD Blood Panel

For every patient who will go through an Assisted Reproductive Technology (ART) procedure or Intrauterine Insemination (IUI), the husband/partner is required by California State Law to have his blood panel done once a year. While this law does not make an exception for spouses, the bill does provide for waiver of a second or third screening of the same donor if the recipient is informed of the requirements for testing donors under California Law, and signs a written waiver (see attached.)

The tissue transplant (TTP) includes:

	CPT Code
• HIV 1,2 Antibody, Total (EIA)	86703
• HTLV 1,2 Antigen	86687
• Hepatitis B Antigen	86287
• Hepatitis C Antibody	86302
• Rapid Plasma Reagin (RPR)	86592
• Rubella (female only)	86762
• Varicella (female only)	86787

Since the Tissue Bank Licensure Law (AB 525, Chapter 659) became effective, section 1644-5(a) of the Health and Safety code on Tissue Banks, additional screening for infection to human immunodeficiency virus (HIV 1,2), agents of viral hepatitis (Hepatitis B Antigen, Hepatitis C Antibody), human T-lymphotropic virus (HTLV 1,2) and syphilis (RPR) is required. This is mandatory for the male partner, and we also recommend testing of the female patient.

Because it is California State requirement, we must ask that all male partners providing sperm for Intrauterine Insemination, IVF, or GIFT be tested immediately. If you have any questions, please ask any of the physicians or nurses. Thank you very much for your cooperation.