Patient Demographics

First Name: _____ **MI:** _____ **Last Name:** _____ **Sex:** ☐ Female ☐ Male

Preferred Name: _____ **Maiden Name:**_____

DOB: _____/_____/_____ **SSN:** _____- _____ - _____

Race: (choose one) ☐ African American/Black ☐ American Indiana/Alaskan Native ☐ Caucasian/White ☐ Nat Hawaiian/Pacific Islander ☐ Asian ☐ Decline ☐ Other: _____

Ethnicity: (choose one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated

Address: _____ **Apt. #:** _____

City: _____ **State**: _____ **Zip Code:** _____

Home Phone: _____**Work:** _____ **Cell:** _____

Primary Phone: (choose one) ☐ Home ☐ Work ☐ Cell **Email:**_____

Emergency Contact #1 (First & Last Name): _____ **Relationship:** _____ **Phone Number:** _____

Preferred Pharmacy Name: _____ **Location:** _____

Family Doctor (First & Last Name): _____ **City:** _____ **State:** _____

Employer: _____ ☐ Full Time ☐ Part Time

Primary Insurance Coverage: _____

Policy Holder Name: _____ **Relationship to patient:** _____

DOB: _____/_____/_____ **SSN:** _____- _____ - _____ **Sex:** ☐ Female ☐ Male

Address: _____ **Zip Code:** _____

Contact Phone Number: _____ **Employer:** _____

Secondary Insurance Coverage: _____

Policy Holder Name: _____ **Relationship to patient:** _____

DOB: _____/_____/_____ **SSN:** _____- _____ - _____ **Sex:** ☐ Female ☐ Male

Address: _____ **Zip Code:** _____

Contact Phone Number: _____ **Employer:** _____

Tertiary Insurance Coverage: _____

Policy Holder Name: _____ **Relationship to patient:** _____

DOB: _____/_____/_____ **SSN:** _____- _____ - _____ **Sex:** ☐ Female ☐ Male

Address: _____ **Zip Code:** _____

Contact Phone Number: _____ **Employer:** _____

Fertility & Midwifery Care Center

CONSENT FOR TREATMENT OF ADULT

I (the patient) hereby consent to the administration of health care (including care, treatment, services, examinations, tests, consultations or procedures to maintain, diagnose or treat me (the patient) by Fertility & Midwifery Care Center, LLC (FMCC). This Consent for Treatment shall specifically include tests for the presences/absence of alcohol or controlled substances. By my signature below, I acknowledge that I am giving my consent to the administration of health care by FMCC voluntarily, and that I hereby knowingly and voluntarily enter into this Consent for Treatment. I have been informed and acknowledge that I may withdraw my consent hereunder at any time upon written notice to FMCC.

CONSENT FOR TREATMENT OF MINOR

I am the (circle one) parent/guardian/custodian/legally authorized representative/other _____ (describe) of _____, an un-emancipated minor child who is _____ years of age (hereafter the "Patient") and I have authority to execute this Consent for Treatment on behalf of the Patient. I hereby consent to the administration of health care (including care, treatment, services, examinations, tests, consultations or procedures to maintain, diagnose or treat the patient's condition) by Fertility & Midwifery Care Center, LLC (FMCC) for the Patient. The conditions or limitations, if any, on my consent and the authority delegated to FMCC hereunder include: _____. The consent for Treatment shall specifically include tests for the presence/absence of alcohol or controlled substances. By my signature below, I acknowledge that I am giving my consent to the administration of health care by FMCC for the Patient voluntarily, and that I hereby knowingly and voluntarily enter into the Consent for Treatment. Due to the Patients' inability to sign this Consent for Treatment, I hereby agree on behalf of the Patient, to sign for the Patient, and to bind the patient to the terms of this Consent for Treatment. I have been informed and acknowledge that I may withdraw my consent hereunder at any time upon written notice of FMCC.

AGREEMENT TO PAY

I agree that I am responsible for payment for all services provided to me by Fertility & Midwifery Care Center, LLC (FMCC), subject to limitations set forth in any applicable insurance or other third-party benefits contract. I agree that I will pay all applicable insurance co-payments and deductibles. I further agree that I will pay all other outstanding balances for which I am responsible. Specifically, I will be responsible for any services: which Medicare, Medicaid, Medigap or my insurance or other third-party benefits plan determines are not covered; for which the benefits have been exhausted; for which I fail to obtain any required authorization from my primary care physician; for which any spend down amount has not been met. I will also be responsible for any out-of-network fess and for any other amounts which are due and are not required to be written off by the contract FMCC has with my insurance or other third-party benefits carrier. I agree to pay such amounts within 30 days of being notified by FMCC of the balance due. *I understand that if I fail to pay my balance, my account may turned over to a collections agency or attorney. In such an event, I agree that I will be responsible for all collection fees (including reasonable legal fees, interest, and court costs).*

ASSIGNMENT OF BENEFITS

I hereby assign to Fertility & Midwifery Care Center, LLC (FMCC) all rights I have to be reimbursed for medical expenses generated by FMCC with respect to Medicare, Medigap, Medicaid and/or any other insurance carrier, including any plan or policy of insurance (group or individual), flexible spending account, health savings account, health reimbursement arrangement or similar plan or reimbursement mechanism. This assignment includes all rights that I may have under ERISA, including but not limited to all rights concerning obtaining copies of plan/policy documents, rights to reasonable and customary fee schedules and rights to appeal any full or partial claim denial for treatment by FMCC. In addition, I hereby request that payment of any authorized Medicare benefits, Medigap benefits, Medicaid benefits and/or insurance or third-party benefits be made directly to Fertility & Midwifery Care Center, LLC. If said benefits are not paid directly to FMCC, I agree to forward to FMCC all payments that I receive immediately upon my receipt. To assist in this process, I authorize any holder of medical information about me to release to CMS, my Medigap insurer, Indiana health Coverage Programs/Medicaid and/or any other insurances or third-party payor and their respective agents any information needed to determine the benefits payable for the services rendered to me.

ACKNOWLEDGEMENT AND RELEASE

I hereby authorize Fertility & Midwifery Care Center, LLC. (FMCC) and all physicians and providers involved with my care to release information from my medical records as may be required to any person, corporation, or agency which is legally responsible or which FMCC has good cause to believe is legally responsible, for processing and/or paying all or any part of FMCC charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize FMCC and any affiliated physician or provider involved with my care to release information to any physician or provider to which I may be transferred for further medical care.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been offered the opportunity by Fertility & Midwifery Care Center, LLC (FMCC) to receive a copy of the Notice of Privacy Practices.

PRINTED NAME OF RESPONSIBLE PARTY: _____ DATE: _____

SIGNATURE OF RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____

Fertility & Midwifery Care Center

MRN# _____

Limited Patient Authorization for Disclosure of Protected Health Information
Please print all information.

Patient Name Printed: _____

Social Security Number: XXX-XX- __ __ __ __ **Date of Birth:** _____
Purpose of request (who will be authorized to receive information) – I authorize the practice to disclose or provide protected health information about me.
Who will provide or disclose information:

Fertility and Midwifery Care Center LLC
10228 Dupont Circle Drive, Suite 100
Fort Wayne, Indiana 46825-1611

Who will be authorized to receive information (family, friends, others):

Name: _____ Relationship: _____ Phone: ( ) _____

Name: _____ Relationship: _____ Phone: ( ) _____

Name: _____ Relationship: _____ Phone: ( ) _____

Description of the Information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire record, including every category listed below
☐ Office notes, labs and x-rays only
  ☐ office notes ☐ lab results ☐ x-rays; hospital ☐ pregnancy test results
  ☐ nursing home, home health, hospice, and other physician records
  ☐ record of HIV and communicable disease testing, including testing for sexually transmitted diseases
  ☐ financial history report (previous, 3 years only)
  ☐ only disclose the following _____

Purpose of disclosure (please check the purpose of the disclosure or check patient request):

☐ Patient Request
☐ Other (please specify): _____

Expirations or termination or authorization: This authorization will expire upon the termination of your physician/patient relationship with FMCC, unless you specify an earlier termination. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.
Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.
Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature _____ **Date**_____
(You have the right to receive a copy of signed authorizations upon request)

Fertility & Midwifery Care Center

Cancellation/No Show Policy for Appointments and Surgery

1. Cancellation/ No Show Policy for Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can occur, however, we must do our best to keep our providers on schedule.

If a patient arrives 15 minutes past their scheduled time we may have to reschedule the appointment out of respect for our other patients.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations impose considerable hardships for the office and other patients waiting to have surgery.

If surgery is not cancelled at least 14 days in advance* you will be charged a one hundred and fifty dollar ($150) fee; this will not be covered by your insurance company.

_____	_____	___/___/___
Print Patient Name	**Signature Patient/Guardian**	**Date**

*Effective 9/22/21

Fertility & Midwifery Care Center

A#_____

FMLA & Disability Policy Notification

The Family and Medical Leave Act (FMLA) is a federal law passed in 1993 that entitles eligible employees to job protection and unpaid leave for up to 12 weeks per year. Most people use their FMLA time as a continuous leave after the birth of their child, as mothers and fathers are both allowed to take this time away from work. Disability insurance provides compensation to an employee, usually at a percentage of their regular pay, during time away from work related to an illness. Both FMLA and disability should be discussed with a medical provider prior to requesting the leave.

We are happy to manage the FMLA/disability paperwork that your employer may require. We charge a **$20.00 fee for the completion and maintenance of this documentation**. This one-time fee covers any documentation required during/after your pregnancy or surgery recovery. FMLA and disability insurance are two separate entities and usually require separate paperwork. Your employer will help you understand your eligibility for FMLA and/or disability leave due to pregnancy/surgery. If for any reason you need to be away from work prior to your birth/surgery, please discuss this with a provider.

Should you elect to begin your FMLA leave before your birth/surgery date without a documented medical reason to do so, we will complete your FMLA forms as needed. However, disability paperwork (as opposed to FMLA) cannot be completed prior to the date of your actual disability. Disability insurance provides compensation to policy holders and employers require documentation of the nature of the specific disability by a medical provider.

Please understand that FMLA and disability coverage can be complex and confusing topics for all involved and we will do our best to assist you throughout the process.

Name (print): _____ Date: _____

Signature: _____

Fertility & Midwifery Care Center

G#_____

Patient Health History

Patient Name: _____ **Age:** _____ **DOB:** _____

Family Doctor: _____ **Referred By:** _____

Reason for visit: _____ **Date:** _____

Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Abnormal PAP Smear				Hypertension			
Anemia				Infertility			
Anesthesia Complication				Kidney Stone			
Anxiety				Liver Disease			
Asthma				Lupus			
Blood Clots in Leg or Lungs				Migraine			
Blood Transfusion				Miscarriage			
Breast Disorder				MTHFR			
Cancer of the Breast				Mitral Valve Prolapse			
Cancer , other				PAI-1			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Depression				PCOS			
Diabetes				Seizures/Convulsions			
Endometriosis				Sexually Transmitted Diseases, STD's			
Epilepsy				Stroke			
Factor 5				Thyroid Disorder			
Fibromyalgia				Tuberculosis			
Heart Murmur				Ulcer			
Herpes				Von Willebrand's Disease			

Date of Last Pap Smear: / / ☐ Normal ☐ Abnormal Date of Last Mammogram: / / ☐ Normal ☐ Abnormal

Date of Last Dexa Scan: / / ☐ Normal ☐ Abnormal Date of Last Colonoscopy: / / ☐ Normal ☐ Abnormal

Other:

Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

Medications

(Include prescriptions, over the counter, herbals & vitamins)

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		

SEE BACK

Medication Allergies

Do you have any drug allergies? ○ NO ○ YES (if yes, please list below)

MEDICATION	REACTION
1)	
2)	
3)	

Family Medical History

(Do any of your children, siblings, or parents have any of the following?)

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHP
None			Cardiovascular Disease		
Adopted			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Colon			Osteoporosis		
Cancer, Ovarian			Polyp – anal/rectal/colon		
Cancer, Uterine			Stroke		
Cancer, Other			Thyroid Disorder		

Genetic History / Screening

(Self, partner, or other family member)

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats – do you have exposure?			Diabetes – self only		
Chickenpox			Down Syndrome		
Congenital Heart Defect			Infertility		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		

REPRODUCTIVE HISTORY

Age of first menses:	Cycle Interval (Number of days from start to start):
Menses duration (Number of days of bleeding):	Flow (circle): Light Medium Heavy
Number of Tampons per day:	Number of Pads per day:
Last Menstrual Period (date): / /	Certain of LMP date? (circle) YES NO
Menopause Status (circle): Pre Peri Post	Age at Menopause:
Method of Family Planning:	Sexually Active: (circle) YES NO
Bleeding between periods: (circle) YES NO	Pain with menses: (circle) YES NO

Pregnancy History

Total Pregnancies: _____ / Full Term: _____ / Preterm: _____ / Miscarriage: _____ / Abortion: _____ / Ectopic: _____ / Multiple: _____ / Living: _____

DATE	GESTATIONAL AGE	HOURS IN LABOR	BIRTH WEIGHT	GENDER	TYPE OF DELIVERY	ANESTHESIA	COMMENTS/ COMPLICATIONS	FACILITY/ PROVIDER

Social History

Marital Status (circle): Single Married Widowed Divorced Spouse/Partner Name:_____

Occupation:

Religious Preference: Willing to receive blood products, if necessary? ☐ Yes ☐ No

Alcohol: _____Never _____Current _____Former _____Amount per week

Drugs: _____Never _____Current _____Former _____Type

Smoking: _____Never _____Current _____Former _____Amount per day

Amount of Exercise? Active Heavy Medium Minimal None (Sedentary)