NEW PATIENT CHECK LIST

☐ Arrive 30 minutes PRIOR to your appointment time
   For New Patients Only

☐ Bring or Fax All Necessary Medical Records from your OBGYN regarding Infertility
   Records are not required in order to be seen

☐ Locate our Practice prior to your appointment day, Please do not use Mapquest or a GPS
   Using a GPS or MAPQUEST may take you to a residential area if you do so.

☐ Please Call 48 Hours PRIOR to your appointment to cancel or reschedule.
   Not calling at least 48 hours prior to your appt. time will lead to a $50 No show fee

☐ Bring your license and Insurance Card the day of your appointment
   Please make sure our office has your insurance information prior to your appointment
day so that they may obtain coverage information.

☐ If your Partner or Spouse will be attending the appointment with you please bring
   New Patient forms for your partner or spouse as well.

☐ If you are being referred by another physician's office please bring or have them fax the
   referral by the day of your appointment.

☐ For our Male Patients, please note we do not accept Walk ins for Semen Analysis.
   You must have a scheduled appointment even for drop offs.

☐ New Patients for HSG procedure, please note you will be the only one allowed
   in the xray room.
**Carolina Conceptions**  
2601 Lake Drive  
Suite 301  
Raleigh, NC 27607  
www.carolinaconceptions.com  
Dr. Grace Couchman, Reproductive Endocrinologist  
Dr. William Meyer, Reproductive Endocrinologist  
Dr. John Park, Reproductive Endocrinologist  
Dr. Meaghan Bowling, Reproductive Endocrinologist

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**Date** / / (mm/dd/yy)

**Dr. Couchman**  
**Dr. Meyer**  
**Dr. Park**  
**Dr. Bowling**  
**Patient ID #**

<table>
<thead>
<tr>
<th><strong>PATIENT INFORMATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name:</strong> PRINT (First/MI/ Last)</td>
</tr>
<tr>
<td><strong>Name you prefer to be called:</strong></td>
</tr>
</tbody>
</table>
| **Partner or Spouse Name:** (First/MI/Last)  
Married__ Divorced__ Other__ |
| **Street Address (of person filling out this form):** |
| **City:**  
**State:**  
**Zip:** |
| **Phone:** (h) (w) (mobile/cell) |
| **May we leave messages for you on the numbers listed above? Yes_ or NO_ If NO, please check ___(h) ___(w) ___(m/c)** |

| **EMAIL:** |
| **Date of Birth:** (mm/dd/yy) / /  
**Social Security Number:** - - |
| **Occupation:** |
| **If you have children, Please list their ages:** |
| **Your local pharmacy:**  
**Pharmacy phone #:** |
| **Emergency contact:**  
**Relationship to Patient:**  
**Phone #:** |

**How Did You Hear About Us? (Please put an "x" by one and provide additional information):**

| Internet____ when I searched for  
**Friend____ Friends Name____ Radio____ Print Ad____ Other____.** |
| **By Referral____ Name of Referring Physician/Practice:** |
| **Physician Phone #:** ______________________ Fax#:________________________. |

**Insurance Information:**

| **Policy Holder's Name**  
**Sex:** _____Male _____Female |
| **Is the contact information for the Policy Holder same as the Patient contact information above? _Y_ _N**  
(if the answer is "no", please fill out Policy Holder Contact Information below) |
| **Relationship to Patient:** |
| **Date of Birth:** (mm/dd/yy) / /  
**Social Security Number:** - - |

**Ethnic/Racial History:**

| Jewish____ Black/African American____ Asian____ Caucasian____ American Indian____ |
| French-Canadian_____ Mediterranean ( Greek, Italian, Other)________________ |

(PLACE SCAN LABEL HERE)
### Family History of Birth or Genetic Defects:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Club Foot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deafness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open spine (spina bifida)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cleft Palate</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blindness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Down Syndrome</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Intellectual Impairment</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Background Information:

- Have you or your partner undergone testing to rule out carrier status of Cystic Fibrosis?  __Yes__ __No__
- Have you ever seen another fertility specialist?  __Yes__ __No__

**Reason for Today's Visit:** Infertility _____ Miscarriage _____ Donor Sperm/Egg _____ Other _____

### Pregnancies (include miscarriages, ectopic pregnancy, abortions and still births)

<table>
<thead>
<tr>
<th>Date</th>
<th>Type and duration</th>
<th>Father</th>
<th>Prior or Current Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Previous Gyn Surgery (Laparoscopy, Hysteroscopy, Myomectomy, Leep, Freezing of Cervix)

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
<th>Physician</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Your Medical History:

**Allergic to:**
- Medication(s):  
- Reaction(s):  
- Environmental:  
- Reaction(s):  

**Current medications/ dosage:**

**Current medical conditions:**
- Smoke?  __Yes__ __No__  
- if so how much:  
- how long:  
- Prior Smoker?  __Yes__ __No__  
- if so how much:  
- how long:  

**Fertility Medication:**
- Current:  
- Dates:  
- Prior:  

**Age at first menstrual period:**  
**How many days in cycle:**  
**Days Flow:**  
**Painful periods?**  __Yes__ __No__  
**Please rate pain on a scale of 1-10; 1=No pain, 10=severe pain:**  
**Dates of last three periods:**  

**If you've had any of the following test, please provide date and results if possible:**

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sperm count</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSG (Hysterosalpingogram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TSH, Prolactin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progesterone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 3 FSH, Estradiol, AMH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Your Medical History, continued:**

**Previous Treatments:**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number of Cycles</th>
<th>Location</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clomid/Timed intercourse (Coitus)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clomid/Insemination (IUI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letrozole (Femara)/ Coitus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letrozole (Femara)/ IUI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable/IUI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IVF/ICSI</td>
<td></td>
<td></td>
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</tbody>
</table>

**Questions and Concerns:**

1. What is the question you are primarily hoping to answer today?

2. Are you confused about any specific infertility treatments that you have read about or experienced yourself?

3. Other?

(PLACE SCAN LABEL HERE)
**Carolina Conceptions**

Authorization for Release of Information – Compound Release

Name of Patient ___________________________________________ Date of Birth ________

**Carolina Conceptions** is authorized to release protected health information about the above named patient in the following manner and to the identified persons.

<table>
<thead>
<tr>
<th>Entity to Receive Information.</th>
<th>Description of information to be released. Check each that can be given to person/entity on the left in the same section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Voice Mail</td>
<td>☐ Results of lab tests/x-rays</td>
</tr>
<tr>
<td></td>
<td>☐ Other ____________________________________________________________________________________</td>
</tr>
<tr>
<td>☐ Other person(s) (provide name and phone number)</td>
<td>☐ Financial</td>
</tr>
<tr>
<td></td>
<td>☐ Medical</td>
</tr>
<tr>
<td>☐ Email communication - Provide email address*</td>
<td>☐ Financial</td>
</tr>
<tr>
<td></td>
<td>☐ Medical</td>
</tr>
<tr>
<td></td>
<td>☐ Appointment reminders</td>
</tr>
<tr>
<td></td>
<td>☐ Breach notification</td>
</tr>
<tr>
<td></td>
<td>☐ Carolina Conceptions Newsletter</td>
</tr>
</tbody>
</table>

*For email communication to occur, please accept the disclosure below:

<table>
<thead>
<tr>
<th>Text communication – Provide number *</th>
<th>☐ Appointment reminder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Other: ____________________________________________________________________________________</td>
</tr>
</tbody>
</table>

*For text communication to occur, accept the disclosure below:

☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ Birth Announcements/Baby Photos ☐ May be posted in office

☐ Personal/Video Testimonials ☐ May be posted on website

☐ Other ____________________________ ☐ Other ____________________________

**Patient Rights:**
- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

__________________________________________ Date ________________

Signature of Patient or Personal Representative*

*Description of Personal Representative’s Authority (attach necessary documentation)

Revised November 2015
Authorization for the Use and Disclosure of PHI

Use and Disclosure of Health Information

I hereby authorize the use or disclosure information as follows:

X All health information pertaining to insurance payment, treatment, medical history, and mental or physical condition.

Purpose of request use or disclosure: Continuation of treatment.

Expiration

This Authorization expires one year from the date of signing.

Notice of Rights and other information

I may refuse to sign this Authorization.

Understanding that by doing so, Carolina Conceptions will not be responsible for filing any claims to my insurance provider on my behalf. I may revoke this authorization at any time.

My revocation must be in writing, signed by me or on my behalf; and delivered to the following address: 2601 Lake Dr., Suite 301, Raleigh, NC 27607

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

Neither treatment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law. (HIPAA).

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Signature ____________________________ Date __________

CONSENT TO TREATMENT

I hereby voluntarily consent to outpatient care at Carolina Conceptions. Such care includes routine diagnostic procedures, which includes but is not limited to routine laboratory work (such as blood, urine and other studies) and ultrasounds. Such care also includes examination and medical treatment with administration of medications. Routine laboratory testing may include testing for HIV, the virus that causes AIDS. I understand that I have the option to decline testing for HIV and will notify the staff if I choose to decline testing.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Carolina Conceptions.

Signature: ____________________________

If signature is not that of the Patient, indicate below the relationship of the person signing for the (e.g., Parent, Guardian):

If patient or patient's personal representative does not sign, indicate the reasons why signature could not be obtained:

Name of Practice Staff Member __________________ Date ________
Insurance Disclaimer/Office Information

Insurance Coverage. The health insurance and medical industry is becoming increasingly complex. Each patient has a unique bundle of insurance coverage (HMO versus PPO, copays, lab copays, deductibles, exam coverage, etc…). We are happy to assist you in understanding your specific insurance benefits and responsibilities. Any changes in your insurance plans or benefits can affect your coverage for your visits as well as any pending visits or diagnostic tests. Please be aware that due to the large variety of medications offered we are unable to verify coverage for prescriptions, as we are a medical services provider not a pharmacy. You may contact your insurance plan to obtain benefit coverage for medication. We encourage you to notify the office of any insurance changes. With out notification we are unable to verify coverage and benefits. Ultimately, you are responsible.

Proof of insurance coverage is required at the time of the office visit. Without confirmation of benefits, you will be charged full price for the office visit. Insurance benefits will not be applied retroactively.

Referrals. It is your responsibility to make certain that the referral is obtained prior to your specialist appointment if one is required by your insurance. Without the proper referral paperwork, you may be 100% responsible for your specialist visit. All referrals must be completed prior to a specialist visit.

Billing. We expect full payment of copayments, deductibles and non-covered expenses prior to leaving the office visit. Insurance claims will be filed to your primary insurance; we do not file to secondary. The insurance company will send you a detailed EOB (explanation of Benefits) after they have processed the claim. The EOB explains the charges, the discounts, the insurance payment to the doctor and the patient’s responsibility for all coinsurance, deductible or copays. We will bill you for any outstanding patient balance. Services may be terminated if outstanding balances are not rendered within 30 days.

No Show: If you do not call to cancel your appointment at least 24 hours prior to your scheduled time, you will be charged a No-Show fee of $50. This payment must be submitted before you can schedule another appointment. If you have any questions, please contact the Practice Manager, Nikki Duncan, at 919-782-5911 x 105.

Refunds: We will issue a refund check once all insurance claims have been processed/paid. Refund checks are issued at the middle of each month.

Thank you for choosing Carolina Conceptions for your infertility needs. We hope this provides a better understanding of our financial department.

Print Name: ______________________________

Signature: _______________________________ Date: _______________________________
Which ethnic groups have an increased risk of genetic disorders and what carrier screening tests are offered to these groups?

People from certain ethnic groups have an increased risk of passing on certain genetic disorders. For this reason, The American College of Obstetricians and Gynecologists recommends carrier screening to certain groups as follows:

- Non-Hispanic white individuals should be offered cystic fibrosis carrier screening.

- People of Eastern European Jewish descent (Ashkenazi Jews) should be offered screening for Tay-Sachs disease, Canavan disease, familial dysautonomy, and cystic fibrosis. Individuals can ask about screening for other disorders. Carrier screening is available for mucolipidosis IV, Niemann-Pick disease type A, Fanconi anemia group C, Bloom syndrome, and Gaucher disease.

- People of African, Mediterranean, and Southeast Asian heritage should be offered screening for thalassemias and sickle cell disease.

The American College of Obstetricians and Gynecologists' Committee on Genetics recommends testing for fragile X syndrome as follows:

- Women with a family history of fragile X–related disorders, unexplained mental retardation or developmental delay, autism, or premature ovarian insufficiency are candidates for genetic counseling and fragile X premutation carrier screening.
- I understand that I should ask my doctor if I want to get the above testing.