NEW PATIENT AGENDA

Welcome to the ART Fertility Program of Alabama. We would like to provide you with an outline of what you can expect on your initial visit. Your visit will include the following:

1. A meeting with the physician to discuss:
   - Detailed patient history
   - Treatment plan
   - Risk and benefits
   - Statistics

2. Physical exam performed by the physician or the nurse practitioner. Exam includes:
   - Pap smear
   - Cervical Cultures
   - Blood work

3. A meeting with the nurse to include:
   - Details of your treatment plan
   - Office policies
   - Prescriptions/medications

4. A meeting with the financial counselor will include:
   a. Costs associated with your treatment plan
   b. Review of insurance coverage

5. The partner will have a semen analysis and blood drawn for required screening.
New Patient Checklist

The following is a checklist of paperwork that you must have completed and returned before your initial visit with the physician. We request that you *fax the signed and completed* paperwork to Angie Champion at (205) 803-1980 or bring it with you the day of your appointment; your visit may be delayed if these forms are not completed and received prior to your arrival.

It is extremely important that we receive this paperwork as early as possible prior to your appointment.

**Please do Immediately**
- Medical Release Form *(mail to your current physician*[s])*

**Please Complete and Sign and Return**
- General Information
- Designation of Partnership
- Assignment and Instructions
- Female Patient History
- Male Patient History
- Preconception Questionnaire
- Answering Machine Consent
- Release of Results
- HIPAA Privacy Notice (send only signed pages 5 and 6, both partners must sign)

**Please bring to your appointment**
- Insurance Card *(Patient and Partner)* *(we would prefer you send copies of front and back of all cards along with your paperwork)*
- Driver’s License *(Patient and Partner)*
- Information regarding your last three menstrual cycles, if applicable

**Please Remember**
- Discontinue smoking
- Limit/decrease your caffeine intake to one cup *(coffee, tea, cola, etc. ) per day*
- Begin a multi-vitamin, which contains at least 0.4 mg folic acid *(females)*
- Abstain from intercourse 2-3 days prior to your initial appointment

*Our weekend patients come from all locations to the Birmingham office for their care. Generally, the patients are scheduled at approximately 9:00 am for IUI. The IUI procedure will then be performed based on completion of the sperm prep; therefore, the time in the office may range from 1-2 hours for the patient receiving the IUI. Please be aware and plan your schedule accordingly.*
MEDICAL RELEASE FORM

Date of Initial Appointment: __________________________________________________________

Patient Name: __________________________________________________________________________

Patient DOB: ____________________ Patient SS#: _______________________

Referring Physician: ______________________________________________________________________

Address: ______________________________________________________________________________

I hereby authorize the physician listed above to disclose my health information to:

Honea, Houserman, Long and Allemand, P.C.
2006 Brookwood Medical Center Drive, Suite 508
Birmingham, Alabama 35209
Fax: 205-870-0698

Please send the following information:

☒ Dates of service: From __________________ to _________________

☒ Specific Records: _____________________________________________

☒ Entire OB/GYN and pertinent medical history records related to infertility care.

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.

2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.

3. I understand that I may revoke this Authorization at any time by notifying the referring physician listed above in writing, but if I do, it will not have any effect on uses or disclosure prior to the receipt of the revocation.

4. I understand that this Authorization will expire on _____/_____/____(DD/MM/YR). Date must be entered!

________________________________________  __________________________________________
Signature of Patient                  Date

After completing this release, please forward to your physician(s) for your medical records to be sent to our office prior to your appointment.
Date of Appointment:__________________________

**Patient:**
Name: ________________________________________ Preferred Name: ______________________
Email: _______________________________________ SS# __________________________
Address: _______________________________________ City: __________________________
State: _______ Zip: ___________ Home Phone: (          )____________________ Cell: (          )_________
DOB: __________________ Age: _______ Sex: M    F  Race: _______ Marital Status: M    D    S    W    Other: _______
Employer: ___________________________________________ Phone: (          )___________
Address: _______________________________________ Occupation: ______________________
 Preferred Pharmacy: ______________________________________ Phone: (          )___________

**Partner:**
Name: ________________________________________ Preferred Name: ______________________
Email: _______________________________________ SS# __________________________ Cell Phone: (          )____________________
Date of Birth: __________________ Age: _______ Sex: M    F  Race: _______ 
Employer: ___________________________________________ Phone: (          )___________
Address: _______________________________________ Occupation: ______________________

**General:**
Contact person for emergency (other than spouse): __________________________________________
Relationship to patient: ___________________________ Phone Number(s): ___________________________

Who is your current OB/GYN? ________________________________________________________________

May we send an update regarding your treatment to your current physician? □ Yes □ No

What other doctor(s) would you like Honea, Houserman, Long & Allemand to update regarding your treatment plans?
1. ______________________________________________________ 2: ________________________________________

**INSURANCE INFORMATION**

**Primary Insurance:**
Insurance Company: ___________________________________________ Phone: (          )___________
Address: ___________________________________________
Name of Insured: ___________________________ Contract #: ______________________ Group #: ______________________

**Secondary Insurance:**
Insurance Company: ___________________________________________ Phone: (          )___________
Address: ___________________________________________
Name of Insured: ___________________________ Contract #: ______________________ Group #: ______________________

The above information is complete and accurate to the best of my knowledge.

_________________________________________________________  ______________________________________
Patient’s Signature                                Date
DESIGNATION OF PARTNERSHIP

I, ______________________________________, the undersigned patient, am pursuing operations or procedures as are considered therapeutically necessary for fertility treatment on the basis of findings during the course of said treatment.

I understand that procedures and testing will be recommended specific to me and my partner, if applicable, during the course of treatment. I am providing below the current status of my partnership, if any:

_____ Married

Partner – Name______________________________ DOB________________

_____ Single, with single

Partner – Name______________________________ DOB________________

_____ Single, no partner

I understand that I must notify Drs. Honea, Houserman, Long & Allemand, PC should the status of my partnership change during the course of said treatment.

Signed this ____________ day of _________________________, 20__________.

________________________________________________________

Patient’s signature _______________________________ DOB

________________________________________________________

Witness
ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

AUTHORIZATION FOR TREATMENT

I (we), the undersigned patient(s) and responsible party(s), consent to necessary treatment by Honea, Houserman, Long and Allemand, P.C., physicians; physicians taking call for Honea, Houserman, Long and Allemand, P.C., and/or any of the employees of Honea, Houserman, Long and Allemand, P.C. Treatment to include venipuncture, medication, ultrasound, X-rays or other studies, and to perform any operations and/or procedures after discussion of the risks and benefits and consent to undergo other procedures deemed necessary or advisable in the judgment of the attending physician employee of Honea, Houserman, Long and Allemand, P.C., or his/her associates or assistants in the diagnosis and treatment of my condition(s).

In the course of this treatment should it be necessary to consult with others, I hereby give my permission and consent for this organization to obtain and release medical records and other pertinent information on the undersigned patients, to/from other healthcare providers or agencies (including but not limited to Blue Cross/Blue Shield Infosolutions).

__________________________________________________  ____________________________________________________
Patient (Female)                                      Responsible Party
Date                                                   Date

__________________________________________________
Partner                                               Date

RESPONSIBILITY FOR NON-COVERED SERVICES

The physicians of Honea, Houserman, Long and Allemand, P.C. may determine that there are certain routine services that are necessary for your treatment and/or for the maintenance of good health and standard medical care that are not covered by your insurance, including Blue Cross and Blue Shield Preferred Care contracts. For example, in vitro fertilization is generally a non-covered service under most insurances and Blue Cross and Blue Shield Preferred Care contracts. In addition, there may be other services which are performed by the physicians of Honea, Houserman, Long and Allemand, P.C., in conjunction with your treatment which may be deemed to be non-covered. If you have any questions regarding whether a certain service is covered by your insurance, you should raise these directly with your private insurance carrier or agent.

I (we) agree to be fully responsible for all charges by Honea, Houserman, Long and Allemand, P.C. for non-covered services under our insurance and Blue Cross and Blue Shield Preferred Care contracts. Honea, Houserman, Long and Allemand, P.C. will order only tests and procedures that are deemed medically necessary for the patient's treatment and care. I (we) hereby agree that I (we) have read this non-covered services policy and agree to pay for any and all services not covered by our insurance, including Blue Cross and Blue Shield Preferred Care contracts, which may include, but not be limited to, the following:
Exhibit A

1. **In vitro fertilization.** This involves "in glass" fertilization and is the process of placing sperm and eggs together in the laboratory to facilitate fertilization. Services, which may be routinely covered by health insurance, may be non-covered services when rendered as part of IVF treatment. Estimated charges range from $7200.00 to $10,000.00. The following is included in this estimate:
   a. Ultrasounds.
   b. Nursing services.
   c. Ultrasound retrieval.
   d. Egg identification.
   e. Semen analysis.
   f. Semen prep for insemination.
   g. Lab monitoring embryo development.
   h. Embryo assessment and prep for transfer.
   i. Ultrasound for transfer.
   j. Procedure room cost.
   k. Physician services.
   l. Blood work.

2. **Inseminations.** Artificial insemination is insemination of a woman using sperm from her partner or donor performed in the office setting. Estimated charge is $375.00. Charges for donor semen samples and shipping are additional and depend on the source of samples. The following is included in this price:
   b. Insemination $215.
   c. Services related to the insemination procedure, such as ovulation inducement, diagnostic tests to determine ovulatory status, and office visits may not be covered. These non-covered charges can range from $500-$2000.

3. **Cryopreservation.** Estimated charge is $770. Cryopreservation is the method used to preserve excess embryos for a future cycle.
   a. Lab monitoring of embryos for cryopreservation.
   b. Preparation and storage of embryos cryopreserved.

   A separate $890.00 charge is incurred for embryo thawing, embryo assessment and preparation for transfer.

   The following procedures and services may also be considered non-covered under certain insurance contracts. I (we) hereby agree to pay for all charges for such services if determined to be not covered by my (our) insurance or Blue Cross and Blue Shield Preferred Care contract, which may include, but not be limited to, the following services:
1. Initial consultation $237  
   Follow-up consultation $ 90  
   Comprehensive history and physical $155  
   Ultrasounds $184-240 each.  

2. Endocrine assays $1315  
   BhCG, estradiol, LH, progesterone, may include screening evaluation, FSH, prolactin, DHEAS (depending on patient).

3. Medications $3,000 – $6,000  

I understand that prices are subject to change without notice.

__________________________________________  ______________________   ______________________
Patient                              Date                              Responsible Party          Date

__________________________________________  ______________________
Partner                               Date
AGREEMENT TO PAY

The patient(s) and responsible party(s) acknowledges that it is difficult to project the full cost of medical services and treatments in advance, since it is impossible to know what services, tests, procedures, and/or treatments will be required in the course of medical care. The patient(s) and responsible party(s) agree to pay in full all charges submitted by Honea, Houserman, Long and Allemand, P.C., which may include, but shall not be limited to, one of the standard procedure charges set forth on Exhibit A (attached) for services rendered by Kathryn L. Honea, M.D., Virginia L. Houserman, M.D., Cecil A. Long, M.D., M. Chris Allemand, M.D., or any other physician who becomes associated with Honea, Houserman, Long and Allemand, P.C. in the future, or any other agents, employees or contractors of Honea, Houserman, Long and Allemand, P.C. during the patient's treatment, including hospitalization, unless Honea, Houserman, Long and Allemand, P.C., its agents, employees, or contractors, are otherwise obligated to accept payment solely from a third party. The patient(s) and the responsible party(s) hereby agree to be financially responsible to Honea, Houserman, Long and Allemand, P.C., even though the charges may exceed the amount reimbursed by insurance, and agree that failure to make payment when requested is the basis for legal action and agree to pay any and all costs of collection, including a reasonable attorney's fee. The patient(s) and the responsible party(s) agree that their obligations are joint and severable and that Honea, Houserman, Long and Allemand, P.C. may pursue either or both parties for payment. The patient(s) understands that there is no written or oral contract, which designates by name or description the individual physician who will treat the patient.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Date</th>
<th>Responsible Party</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner</td>
<td>Date</td>
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</table>

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I (we), the undersigned patient(s) and responsible party(s), hereby authorize Honea, Houserman, Long and Allemand, P.C., its agents, employees, or contractors, to release and disclose all or any part of the patient's medical records to any person, corporation, or entity, which is, or may be, liable for all or part of the provider charges, or to any professional review organization associated therewith, and to release and disclose all or any part of my medical records to any health care provider, which may be of assistance in the opinion of Honea, Houserman, Long and Allemand, P.C., in providing for or continuing the medical care and treatment of the patient and/or for assisting in any reimbursement or benefits to which I (we) may be entitled. All releases and/or disclosures will be made in accordance with HIPAA guidelines as outlined in our Privacy Notice.

I (we) authorize and request that payment of any and all authorized insurance benefits be made on my behalf to Honea, Houserman, Long and Allemand, P.C. for services furnished the patient(s) by any of the providers set forth herein. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above any insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. The signatures shall suffice for all insurance forms on a continuing basis.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Date</th>
<th>Policy Holder of Insurance Contract</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FEMALE PATIENT HISTORY -- CONFIDENTIAL – FOR OFFICE USE ONLY

Administrative Information

Social Security #: ____________________________ Date: ____________________________

Full Name: ____________________________ Your Age: ____________________________

Address: ____________________________ Date of Birth: ____________________________ Blood Type: ____________________________

Country: ____________________________ Marital Status: M S D W Other: ____________________________

Telephone: (H)_______________________(W)_______________________(C)_______________________

Partner’s Full Name: ____________________________ DOB: ____________________________ Sex: M F Social Security #: ____________________________

Reproductive and Gynecologic History

Reproductive:

Total # of pregnancies you have achieved

Full term pregnancies: _______ Pre-term pregnancies: _______ Miscarriages: _______ Therapeutic Abortions: _______

# living children: _______ # adopted children: _______

Please complete the following information regarding your pregnancies beginning with most recent:

Preg # Date Ectopic (Y/N) Abortion /Miscarriage (Y/N) Liveborn (Y/N) Stillborn (Y/N) Term (Y/N) IVF Pregnancy (Y/N)

1) ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________

2) ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________

3) ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________

Age at first pregnancy: ____________________________ # pregnancies with current partner: ____________________________

# deliveries by C-Section: ____________________________ # infant deaths (past live birth): ____________________________

Please mark “Y” or “N” in the following blanks regarding past pregnancies:

Exposure to Rubella: ____________________________ Radiation Exposure: ____________________________

Toxemia: ____________________________ Prolapsed Cord: ____________________________

Pregnancy Diabetes: ____________________________ Uterine Dysfunction: ____________________________

Incompetent Cervix: ____________________________ Vaginal Bleeding: ____________________________

Placenta Over Cervix: ____________________________ Infection: ____________________________

Increased Amniotic Fluid: ____________________________ Placenta Separation: ____________________________

Premature Labor: ____________________________ Water Broke Prematurely: ____________________________

Congenital Abnormalities

Specify: ____________________________

Has anyone in your family had an infant with a congenital abnormality? ____________________________

Specify: ____________________________

Chromosomal Abnormalities?

Specify: ____________________________

Do any chromosomal abnormalities run in your family? ____________________________

Specify: ____________________________
Gynecologic:

Have you ever had an abnormal Pap Smear? __________________________
If yes, give treatment: ____________________________________________________________

Contraception:

<table>
<thead>
<tr>
<th></th>
<th>Y/N</th>
<th>1st year use</th>
<th>Last use</th>
<th>Duration (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Control Pills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Spermicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubal Ligation</td>
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</tbody>
</table>

Please mark a “Y” in the space provided if you have been diagnosed with any of the following:

DES Exposure (Did your mother take DES while pregnant with you?)
Primary Infertility (Always infertile?)
Secondary Infertility (Infertile past previously achieving pregnancy?)
Unexplained Infertility
Ovarian Cyst
Abnormal Shaped Uterus
Luteal Phase Defect (Abnormal progesterone level in late cycle?)
Abnormal Uterine Bleeding
Recurrent Miscarriage

Have you had an artificial insemination? __________________________ If so, how many?

If you have taken any of the following medications, please list the number of months in which you took them:

- Clomid/Serophene
- HCG/Pregnyl/Profasi
- Danazol/Danocrine
- Progestrone
- Pergonal/Repronex/Humgon
- Lupron
- Metrodin/Fertinex/Follistim/Gonal
- Parlodel

Any other medications in past or currently? Yes □ No □
If yes, please list medication and number of months taken:

Age at first menstrual period? __________________________
# days from beginning of period to beginning of next period? __________________________
Are your periods regular? __________________________
Duration of menstrual flow? __________________________
Do you experience menstrual cramping? __________________________
Do you bleed or spot between periods? __________________________
Do you use lubricants for intercourse? __________________________ If so, what? __________________________
Do you douche before or after intercourse? __________________________
Do you experience pain with intercourse? __________________________
How long have you tried to conceive? __________________________
Have you ever had a mammogram? __________________________ Results? __________________________
III. Medical and Surgical History

Height:  
Weight:  
Blood Type:  

Are you allergic to any medications?  

Current medications or supplements:  

Current herbal or homeopathic therapies:  

Hospitalizations:

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
<th>Surgery</th>
<th>Type Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes □</td>
<td>No □</td>
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<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes □</td>
<td>No □</td>
</tr>
</tbody>
</table>

Have you lost or gained 20 or more pounds in the past year?  
If yes, explain:  

Have you ever had anorexia or bulimia?  

Serious/Chronic Illness:

Please mark "Y" or "N" in the following blanks:

Heart Attack | Endometriosis | Rheumatic Fever | Asthma
Blood Clots  | Breast Soreness | High Blood Pressure | Neurologic Problems
Stroke       | Breast Discharge | Gallbladder Disease | Pneumonia
Valve Disease| Hirsutism      | Liver Disease     | Anemia
Depression   | Thyroid Problems | Ulcers           | German Measles
Anxiety      | Kidney Disease | Diabetes          | Regular Measles
Psychosis    | Bladder Infection | Arthritis        | Blood Transfusion
Hepatitis    | Scarlet Fever  | Seizures          | Tuberculosis
Bronchitis   | Changes in cognition, speech, gait | Exposure to tissues suspected of harboring transmissible spongiform encephalopathies: (yourself) (family member)

Cancer |  
Type:  
Chemotherapy? | Radiation? | Surgery?  

Please mark "Y" or "N" in the following blanks:

Gonorrhea | Treatment:  
Syphilis  | Treatment:  
Chlamydia | Treatment:  
Mycoplasma| Treatment:  
Herpes    | Treatment:  
AIDS      | Treatment:  
Other     | Treatment:  

Explain  

If you have any other serious illnesses we should know about, please list below:
Social History/Habits

Occupation

Are you exposed to any hazards in your job (i.e., chemicals, toxic fumes, radiation?)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Exercise Habits:

<table>
<thead>
<tr>
<th>Type</th>
<th># hours per week</th>
</tr>
</thead>
</table>

Have you ever been physically or sexually abused?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### HABITS

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Usage*</th>
<th>Amt/Week</th>
<th>Years</th>
<th>Years Since Stopping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reg. Coffee (cups)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decaf. Coffee (cups)</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Tea (cups)</td>
<td></td>
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</table>

**SOFT DRINKS**

| Regular (glass) Caffeinated | | | | |
| Decaffeinated | | | | |
| Diet (glass) Caffeinated | | | | |
| Decaffeinated | | | | |
| Art Sweeteners (# pkts) | | | | |
| Beer (glass) | | | | |
| Wine (glass) | | | | |
| Liquor (drinks) | | | | |

**RECREATIONAL DRUGS**

| Marijuana | | | | |
| Cocaine | | | | |
| Others | | | | |

* Usage = C-Current; P-Past

### Family History:

**Reproductive:**

<table>
<thead>
<tr>
<th>Congenital Defects</th>
<th>Relation*</th>
<th>Description</th>
<th>Psychiatric:</th>
<th>Relation*</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chromosomal Abnor.</td>
<td></td>
<td></td>
<td>Depression</td>
<td></td>
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<tr>
<td>Uterus Abnormalities</td>
<td></td>
<td></td>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td></td>
<td></td>
<td>Psychosis</td>
<td></td>
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<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
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</tbody>
</table>

**Cardiovascular:**

<table>
<thead>
<tr>
<th>Heart Attack</th>
<th>Relation*</th>
<th>Description</th>
<th>Psychiatric:</th>
<th>Relation*</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Clots</td>
<td></td>
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<tr>
<td>Stroke</td>
<td></td>
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<tr>
<td>Valve Disease</td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
<td></td>
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</table>

**Other Illnesses:**

| Cancer (type) | | | | |
| Diabetes | | | | |
| Liver Disease | | | | |
| Kidney Disease | | | | |
| AIDS | | | | |

**Relation** = M-Mother; F-Father; B-Brother; S-Sister; C-Child; O-Other; PGM-Paternal Grandmother; PGF-Paternal Grandfather; MGM-Maternal Grandmother; MGF-Maternal Grandfather

**Relation** = M-Mother; F-Father; B-Brother; S-Sister; C-Child; O-Other; PGM-Paternal Grandmother; PGF-Paternal Grandfather; MGM-Maternal Grandmother; MGF-Maternal Grandfather
## Administrative Information

<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Social Security #:</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Full Name:</td>
<td>Your Age:</td>
<td>Blood Type:</td>
</tr>
<tr>
<td>Address:</td>
<td>Date of Birth:</td>
<td>Race:</td>
</tr>
<tr>
<td>Country:</td>
<td>Marital Status: M S D W Other:</td>
<td></td>
</tr>
<tr>
<td>Telephone: (H) (W) (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner’s Full Name:</td>
<td>DOB:</td>
<td>Sex: M F</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Security #:</td>
</tr>
</tbody>
</table>

## Male Reproductive History

### Have you had a vasectomy?

- What year?
- Was this reversed? What year?

### Have you ever been diagnosed with any of the following (Y or N):

- Exposure to DES
- Hypospadias
- Testicular Cancer
- Chromosome Abnormalities
- Testicular Surgery
- AIDS
- Exposure to Chemotherapy
- Prostatitis
- Exposure to Radiation
- Testes Injury
- Exposure to Excessive Heat
- Testes Tumor
- Endocrine Disorders
- Testes Infection
- Mumps
- Bladder Infection
- Venereal Disease
- Gonorrhea
- Infection
- Syphilis
- Varicocele
- Herpes
- Ductal Obstruction
- Mycoplasma
- Ejaculatory Disorders
- Chlamydia

### Other Disorders

- Explain:

### Are there any hereditary/genetic illnesses that run in the family?

If yes, explain:

### Has anyone in your family had a child with a congenital abnormality?

If yes, explain:

### Does anyone in your family have a history of infertility?

If yes, explain:

### Have you undergone previous treatment, surgery, or taken medication to improve the quality of your semen?

If yes, please describe:

### Have you previously obtained a pregnancy with another partner?

If yes, outcome of pregnancy:

### Have you ever had a discharge from your penis or a urinary tract infection?

If yes, when?

Name of personal physician:
Medical History – MALE

Height: _______________  Weight: _______________  Blood Type: _______________

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

<table>
<thead>
<tr>
<th>Disease</th>
<th>Disease</th>
<th>Disease</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>Tuberculosis</td>
<td>Measles (German)</td>
<td>Emotional Disorders</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Colitis</td>
<td>Measles (Regular)</td>
<td>Blood Transfusion</td>
</tr>
<tr>
<td>Gallbladder Disease</td>
<td>Diabetes</td>
<td>Neurologic Problems</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>Anemia</td>
<td>Ulcers</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Thyroid Problems</td>
<td>Epilepsy</td>
<td>Other</td>
</tr>
</tbody>
</table>

Have you lost or gained 20 or more pounds in the past year? _______________
If yes, explain: ___________________________________________________________

Are you taking any medications (over the counter or prescription) on a regular basis? _______________
If yes, please list: __________________________________________________________

Allergies to medicine: _______________________________________________________
Current supplements: _______________________________________________________
Current herbal or homeopathic therapies: _______________________________________

Hospitalizations:

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
<th>Surgery</th>
<th>Type Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2)</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Social History/Habits

Occupation: _______________________________________________________________
# of years: _______________
Are you exposed to any hazards in your job (i.e., chemicals, toxic fumes, radiation)? Yes [ ]  No [ ]
If so, please list: _________________________________________________________

Do you use tobacco? _______________ If so, how many cigarettes per week? _______________
Do you drink alcohol? _______________ If so, how many glasses per week? _______________
Do you use recreational drugs such as marijuana or cocaine? _______________
If yes, please list: _________________________________________________________

Do you use saunas or hot tubs? How often?
Exercise habits: Type: ____________________________ Hours per week: _______________

Family History

Do any members of your family have:

<table>
<thead>
<tr>
<th>Illness</th>
<th>Illness</th>
<th>Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Seizures</td>
<td></td>
</tr>
<tr>
<td>Other Serious Illness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**PRECONCEPTION GENETIC SCREENING QUESTIONNAIRE**

Patient’s Name: ___________________________________________  DOB: _____________________________________

Partner’s Name: ___________________________________________ DOB: _____________________________________

Doctor/Clinic: _____________________________________________ Today’s Date: _______________________________

In the event you become pregnant while in our Program, the following questionnaire will help evaluate the potential risks for your unborn baby. Your answers may indicate that certain tests would be appropriate. Please answer all questions as completely as possible. All information will be kept confidential.

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<tr>
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<th>ORDERS</th>
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</thead>
<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td>1. Are you 35 or older?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>N/A, if male</td>
<td>Your due date is <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>CVS</td>
<td>Amnio</td>
<td>AFP, hCG, UE3</td>
</tr>
</tbody>
</table>

| 2. Are you OR your partner from any of these ethnic backgrounds? | |        |
| Yes | No | Southern Chinese, Asian Indian, Taiwanese, Filipino or Southeast Asian |
| Italian, Greek, Middle Eastern or Spanish | If yes, have you or your partner been tested to see if you are a carrier of thalassemia or other hemoglobin abnormality? |
| Yes | Don’t know | If yes, who was tested and what were the results? |
| CVS | Amnio |AFP, hCG, UE3 |
| CBC and Hgb Electrophoresis |

| 3. Have you or your partner or any relative had a neural tube defect (such as open spine, spina bifida, anencephaly)? | |        |
| Yes | No |        |
| If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby’s father? |
| FM CPF | Fetal Echocardiogram 18-20 weeks |

| 4. Have you or your partner or anyone in your families been born with a heart defect? | |        |
| Yes | No |        |
| If yes, please write the diagnosis or describe the defect. How is this person related to you or your partner? |
| CVS | Amnio |AFP, hCG, UE3 |

| 5. Have you or your partner or anyone in your families had a pregnancy or a child diagnosed with Down syndrome? | |        |
| Yes | No |        |
| If yes, how is this person related to you or your partner? |
| CVS | Amnio |AFP, hCG, UE3 |
| Ash Kenazi Jewish Carrier Testing and Gaucher Disease |

| 6. Are you or your partner Jewish? | |        |
| Yes | No |        |
| If yes or don’t know, have either you or your partner been tested to see if you are carriers of Tay-Sachs disease, cystic fibrosis, or Canavan disease? |
| Yes | Don’t know | If yes, who was tested and what were the results? |
| CVS | Amnio |AFP, hCG, UE3 |
| Ash Kenazi Jewish Carrier Testing and Gaucher Disease |

| 7. Are you or your partner French Canadian? | |        |
| Yes | No |        |
| If yes or don’t know, have either you or your partner been tested to see if you are carriers of Tay-Sachs disease? |
| Yes | Don’t know | If yes, who was tested and what were the results? |
| Tay-Sachs |

<p>| 8. Are you or your partner African American or of African descent? | |        |
| Yes | No |        |
| If yes or don’t know, have either you or your partner been tested to see if you have sickle cell trait (are a carrier of sickle cell anemia or Thalassemia)? |
| Yes | Don’t know | If yes, who was tested and what were the results? |
| CBC and Hgb Electrophoresis | | |</p>
<table>
<thead>
<tr>
<th><strong>9.</strong> Do you or your partner or anyone in your families have hemophilia or another bleeding disorder?</th>
<th>□ Yes</th>
<th>□ No</th>
<th>If yes, please write the diagnosis or describe the disorder. How is this person related to you or your partner?</th>
<th>____ Preconception Genetic Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10.</strong> Do you or your partner or anyone in your families have a neuromuscular disease or muscular dystrophy?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, please write the diagnosis or describe the disease. How is this person related to you or your partner?</td>
<td>____ Preconception Genetic Counseling</td>
</tr>
<tr>
<td><strong>11.</strong> Do you or your partner or anyone in your families have cystic fibrosis?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, how is this person related to you or your partner?</td>
<td>____ CF Screen</td>
</tr>
<tr>
<td><strong>12.</strong> Do you or your partner or anyone in your families have Huntington’s disease?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, how is this person related to you or your partner?</td>
<td>____ Preconception Genetic Counseling</td>
</tr>
<tr>
<td><strong>13.</strong> Do you or your partner or anyone in your families have autism or mental retardation?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, please write the diagnosis or describe the problem. How is this person related to you or your partner?</td>
<td>____ Preconception Genetic Counseling (FragileX, inherited chromosome rearrangement)</td>
</tr>
<tr>
<td><strong>14.</strong> Do you or your partner or anyone in your families have an inherited disorder or chromosome abnormality not listed above?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, please write the diagnosis or describe the problem. How is this person related to you or your partner?</td>
<td>____ Preconception Genetic Counseling</td>
</tr>
<tr>
<td><strong>15.</strong> Do you or your partner have insulin dependent diabetes, PKU, lupus, or another chronic condition?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, please write the diagnosis :</td>
<td>____ Preconception Genetic Counseling</td>
</tr>
<tr>
<td><strong>16.</strong> Do you or your partner or anyone in your families have a birth defect not listed above?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, please write the diagnosis or describe the defect. How is this person related to you or your partner?</td>
<td>____ Preconception Genetic Counseling</td>
</tr>
<tr>
<td><strong>17.</strong> Have you or your partner had a stillborn child or two or more pregnancy losses in this or any other relationship?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, please describe:</td>
<td>____ POC Chromosomes ____ Peripheral Blood Chromosomes ____ CVS or Amnio</td>
</tr>
<tr>
<td><strong>18.</strong> Have you or your partner taken any medications, recreational drugs, or had any alcoholic drinks since your last menstrual period, or had any rashes or infectious diseases?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, please describe:</td>
<td>____ Counseling re: Teratogenic Exposure ____ CVS or Amnio</td>
</tr>
<tr>
<td><strong>19.</strong> Did you or your partner or anyone in your families have any other serious medical condition in infancy or childhood?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>If yes, please describe. How is this person related to you or your partner?</td>
<td>____ Preconception Genetic Counseling</td>
</tr>
</tbody>
</table>

I have answered these questions to the best of my knowledge.

______________________________________________________________

Patient Signature

For office use only: Reviewed by:_____________________________ Date:_____________________________
RELEASE OF RESULTS

I, _____________________________, DOB_____________________________, the undersigned patient, authorize Honea, Houserman, Long and Allemand, P.C., and/or any of the employees or staff of Honea, Houserman, Long and Allemand, P.C., to release laboratory test results and procedure results and to share treatment plans with my partner, _____________________________,
DOB______________________________, or ________________________________
DOB_____________________________ (i.e., mother, sister, etc.). Hepatitis and HIV screening results are excluded from this release. The consent for release of Hepatitis and HIV results is a separate consent.

___________________________________________  ___________________________________
Patient’s Signature                         Date
RELEASE OF RESULTS

I, ______________________________, DOB__________________________, the undersigned patient, authorize Honea, Houserman, Long and Allemand, P.C., and/or any of the employees or staff of Honea, Houserman, Long and Allemand, P.C., to release laboratory test results and procedure results and to share treatment plans with my partner, ______________________________, DOB______________________, or ______________________________, DOB__________________________, (i.e., mother, sister, etc.). Hepatitis and HIV screening results are excluded from this release. The consent for release of Hepatitis and HIV results is a separate consent.

__________________________________________  ______________________________________
Patient's Signature                           Date
PRIVACY NOTICE

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

Honea, Houserman, Long and Allemand, P.C.
Suite 508, 2006 Brookwood Medical Center Drive
Birmingham, Alabama 35209
(205) 870-9784

We are required under the federal health care privacy rules (the “Privacy Rules”), to protect the privacy of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history (collectively, "Health Information"). We are also required to provide you with this Privacy Notice regarding our legal duties, policies and procedures to protect and maintain the privacy of your Health Information. We are required to follow the terms of this Privacy Notice unless (and until) it is revised. We reserve the right to change the terms of this Privacy Notice and to make the new notice provisions effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of this Privacy Notice change, we will make a revised copy of the notice available to you. Revised Privacy Notices will be available at our office for individuals to take with them and we will post a copy of revised Privacy Notices in a prominent location in our office. Privacy Notices will also be posted and available electronically on our web site.

PERMITTED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION.

General Uses and Disclosures. Under the Privacy Rules, we are permitted to use and disclose your Health Information for the following purposes, without obtaining your permission or Authorization:

➤ **Treatment.** We are permitted to use and disclose your Health Information in the provision and coordination of your health care. For example, we may disclose your Health Information to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment.

➤ **Payment.** We are permitted to use and disclose your Health Information for the purposes of determining coverage, billing, and reimbursement. This information may be released to an insurance company, third party payor, or other authorized entity or person involved in the payment of your medical bills and may include copies or portions of your medical record which are necessary for payment of your bill. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

➤ **Health Care Operations.** We are permitted to use and disclose your Health Information during our health care operations, including, but not limited to: quality assurance, auditing, licensing or credentialing activities, and for educational purposes. For example, we can use your Health Information to internally assess our quality of care provided to patients.

➤ **Uses and Disclosures Required by Law.** We may use and disclose your Health Information when required to do so by law, including, but not limited to: reporting abuse, neglect and domestic violence; in response to judicial and administrative proceedings; in responding to a law enforcement request for information; or in order to alert law enforcement to criminal conduct on our premises or of a death that may be the result of criminal conduct.

➤ **Public Health Activities.** We may disclose your Health Information for public health reporting, including, but not limited to: child abuse and neglect; reporting communicable diseases and vital statistics; product recalls and adverse events; or notifying person(s) who may have been exposed to a disease or are at risk of contracting or spreading a disease or condition.

➤ **Abuse and Neglect.** We may disclose your Health Information to a local, state, or federal government authority, if we have a reasonable belief of abuse, neglect or domestic violence.

➤ **Regulatory Agencies.** We may disclose your Health Information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs, and compliance with civil rights.

➤ **Judicial and Administrative Proceedings.** We may disclose your Health Information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.
Law Enforcement Purposes. We may disclose your Health Information to law enforcement officials when required to do so by law.

Coroners, Medical Examiners, Funeral Directors. We may disclose your Health Information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

Research. Under certain circumstances, we may disclose your Health Information to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your Health Information.

Threats to Health and Safety. We may use or disclose your Health Information if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.

Specialized Government Functions. If you are a member of the U.S. Armed Forces, we may disclose your Health Information as required by military command authorities. We may also disclose your Health Information to authorized federal officials for national security reasons and the Department of State for medical suitability determinations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your Health Information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety, or the health or safety of others; or for the safety and security of the correctional institution.

Workers' Compensation. We may disclose your Health Information to your employer to the extent necessary to comply with Alabama laws relating to workers' compensation or other similar programs.

Fundraising. We may use or disclose your Health Information to make a fundraising communication to you, for the purpose of raising funds for our own benefit. Included in such fundraising communications will be instructions describing how you may ask not to receive future communications.

Marketing. We may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.

Appointment Reminders/Treatment Alternatives. We may use and disclose your Health Information to remind you of an appointment for treatment and medical care at our office or to provide you with information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.

Business Associates. We may disclose your Health Information to business associates who provide services to us. Our business associates are required to protect the confidentiality of your Health Information.

Other Uses and Disclosures. In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by the Privacy Rules.

Uses and Disclosures Which Require Patient Opportunity to Verbally Agree or Object. Under the Privacy Rules, we are permitted to use and disclose your Health Information: (i) for the creation of facility directories, (ii) to disaster relief agencies, and (iii) to family members, close personal friends or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. Except in emergency situations, you will be notified in advance and have the opportunity to verbally agree or object to this use and disclosure of your Health Information.

Uses and Disclosures Which Require Written Authorization. As required by the Privacy Rules, all other uses and disclosures of your Health Information (not described above) will be made only with your written Authorization. For example, in order to disclose your Health Information to a company for marketing purposes, we must obtain your Authorization. Under the Privacy Rules, you may revoke your Authorization at any time. The revocation of your Authorization will be effective immediately, except to the extent that: we have relied upon it previously for the use and disclosure of your Health Information; if the Authorization was obtained as a condition of obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself; or where your Health Information was obtained as part of a research study and is necessary to maintain the integrity of the study.
PATIENT RIGHTS.

You have the following rights concerning your Health Information:

Right to Inspect and Copy Your Health Information. Upon written request, you have the right to inspect and copy your own Health Information contained in a designated record set, maintained by or for us. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you. However, we are not required to provide you access to all the Health Information that we maintain. For example, this right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding. Where permitted by the Privacy Rules, you may request that certain denials to inspect and copy your Health Information be reviewed. If you request a copy or summary of explanation of your Health Information, we may charge you a reasonable fee for copying costs, including the cost of supplies and labor, postage, and any other associated costs in preparing the summary or explanation.

Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your Health Information for treatment, payment and health care operations, as well as disclosures to persons involved in your care or payment for your care, such as family members or close friends. We will consider, but do not have to agree to, such requests.

Right to Request an Amendment of Your Health Information. You have the right to request an amendment of your Health Information. We may deny your request if we determine that you have asked us to amend information that: was not created by us, unless the person or entity that created the information is no longer available; is not Health Information maintained by or for us; is Health Information that you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement, and a description of how you may file a complaint.

Right to an Accounting of Disclosures of Your Health Information. You have the right to receive an accounting of disclosures of your Health Information made by us within six (6) years prior to the date of your request. The accounting will not include: disclosures related to treatment, payment or health care operations; disclosures to you; disclosures based on your Authorization; disclosures that are part of a Limited Data Set; incidental disclosures; disclosures to persons involved in your care or payment for your care; disclosures to correctional institutions or law enforcement officials; disclosures for facility directories; or disclosures that occurred prior to April 14, 2003.

Right to Alternative Communications. You have the right to receive confidential communications of your Health Information by a different means or at a different location than currently provided. For example, you may request that we only contact you at home or by mail.

Right to Receive a Paper Copy of this Privacy Notice. You have the right to receive a paper copy of this Privacy Notice upon request, even if you have agreed to receive this Privacy Notice electronically.

If you want to exercise any of these rights, please contact our Privacy Officer. All requests must be submitted to us in writing on a designated form (which we will provide to you), and returned to the attention of our Privacy Officer at the address below.

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION.

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Address: 2006 Brookwood Medical Center Dr., Suite 508
          Birmingham, Alabama 35209
          Attn: Privacy Officer
Telephone: (205) 870-9784
Fax: (205) 870-0698

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The Effective Date of this Privacy Notice is February 1, 2003.
BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE

<table>
<thead>
<tr>
<th>Printed Name of Patient</th>
<th>Date</th>
<th>Date of Birth</th>
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Signature of Patient or Patient's Representative

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<tr>
<th>Printed Name of Patient's Representative (if applicable)</th>
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</table>

Representative's Relationship to Patient (if applicable)

To be completed by Office Representative:

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

<table>
<thead>
<tr>
<th>Reason(s)</th>
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Honea, Houserman, Long and Allemand, P.C. Representative

<table>
<thead>
<tr>
<th>Date</th>
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</thead>
</table>
BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE

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<th>Date</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Signature of Patient or Patient's Representative

Printed Name of Patient's Representative (if applicable)

Representative's Relationship to Patient (if applicable)

To be completed by Office Representative:

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s)

Honea, Houser, Long & Allemand, P.C. Representative | Date
CONSENT TO UTILIZE AUTOMATED VOICE MAIL SYSTEMS OR ANSWERING MACHINES

Due to your activities, lifestyle and work schedules, as well as our patient visits and clinics, it is often difficult for the nursing staff to be readily accessible for all patient phone calls. Therefore, it may be necessary or convenient to utilize your answering machine, voice mail system or any other automated system to leave results, instructions and responses to your telephone calls. This consent form outlines how we will most effectively communicate with you.

I, ______________________________, understand the necessity of being in (constant) contact with the nursing staff at the ART Fertility Program of Alabama, Honea, Houseran, Long and Allemand, P.C.

In order to facilitate communication between the nursing staff and myself, I give permission for the nurses to leave detailed messages of a personal and confidential nature on my voice mail, answering system or any other automated system at ____________________________. I will have a greeting that confirms this telephone number is my message system. Messages from the ART Fertility Program may include lab results and cycle instructions. I agree that I will be responsible for picking up these messages daily.

I also understand that I must call during office hours if I need clarification of the message. Current office hours are Monday-Thursday, 8:00 a.m. - 4:00 p.m.; Friday, 8:00 a.m. - 2:00 p.m., Central Time.

I understand if I page the on-call nurse after office hours, she will not have access to my chart and may not be able to answer questions regarding the messages that were left.

________________________________________  __________________________
Signature                                      Date

*******************************************************************************

I, ________________________________, do not want detailed messages left on my answering machine.

________________________________________  __________________________
Signature                                      Date
HUNTSVILLE OFFICE OVERVIEW OF SERVICES

The ART Fertility Program of Alabama is pleased to be part of the Northeast Alabama community with a permanent office in Huntsville, Alabama. The office is located at 401 Lowell Drive, Suite 24, Huntsville.

The Huntsville office is limited in its scope of services. Monday through Friday the office is open from 7:00 a.m. to noon. The Huntsville office is not available for weekend and holiday services. The Birmingham office; however, is open on weekends and certain holidays to accommodate patient care.

New patient visits as well as return visits are performed by a physician in the Huntsville office.

Additionally, Nancy Scott, CRNP, provides services in Huntsville such as physical exams, cultures, ultrasounds, etc. Ms. Scott is a Certified Registered Nurse Practitioner (CRNP) and lives in the Huntsville area. She has received infertility training at our Birmingham clinic and is the primary nurse practitioner for the Huntsville office. Ms. Scott is in constant communication with the Birmingham office and the physicians. Ms. Scott works under physician direction to provide services such as monitoring, ultrasounds, intrauterine inseminations (IUI) with non-frozen sperm, injection instructions, counseling and venipuncture. Medications and supplies are also available for purchase in Huntsville.

We can provide “same-day results” for estradiol, progesterone and BhCG tests for Huntsville patients in our care. Patients who have blood drawn and prepared before the courier picks up (10:00 a.m.) will have results available between 4:00 and 5:00 p.m. on the same day. Patients expecting “same-day results” should call their personal voice mailbox (1-800-338-0765) for results and instructions. There will still be certain situations in a treatment cycle when Huntsville-area patients will have to travel to Birmingham for their services.

We also offer on-site Andrology services, which include semen analysis and semen prep for inseminations. A separate collection area is available in the Huntsville office.

For patient convenience, the Birmingham office is the primary communication channel for the ART Fertility Program’s offices. All inquiries, appointments, requests for the physicians or nurses and LH surges, including those for the Huntsville office, are to be scheduled through the Birmingham office. Questions about treatment and lab results, including after-hours calls to our answering service, are to be handled through the Birmingham office.

We request that all payments for services be paid by personal check or credit card. Cash cannot be accepted at the Huntsville office.

Please call our toll free number 1-800-476-9784 with all questions and concerns. Thank you for your continued support.
MONTGOMERY OFFICE OVERVIEW OF SERVICES

The ART Fertility Program of Alabama is pleased to be part of the South Alabama community with a permanent office in Montgomery, Alabama. The office is located at 7209 Copperfield Drive, Montgomery.

The Montgomery office is limited in its scope of services. Monday through Friday the office is open from 7:00 a.m. to 2:00 p.m. The Montgomery office is not available for weekend and holiday services. The Birmingham office; however, is open on weekends and certain holidays to accommodate patient care.

New patient visits as well as return visits are performed by a physician in the Montgomery office.

Additionally, Sarah Shoemaker, CRNP, provides services in Montgomery such as physical exams, cultures, ultrasounds, etc. Ms. Shoemaker is a Certified Registered Nurse Practitioner (CRNP) and lives in the Wetumpka area. She has received infertility training at our Birmingham clinic and is the primary nurse practitioner for the Montgomery office. Ms. Shoemaker is in constant communication with the Birmingham office and the physicians, and works under physician direction to provide services such as monitoring, ultrasounds, intrauterine inseminations (IUI) with non-frozen sperm, injection instructions, counseling and venipuncture. Medications and supplies are also available for purchase in Montgomery.

We can provide “same-day results” for estradiol, progesterone and BhCG tests for Montgomery patients in our care. Patients who have blood drawn and prepared before the courier picks up at 10:30 a.m. will have results available by 4:00 p.m. on the same day. Patients expecting “same-day results” should call their personal voice mailbox (1-800-338-0765) for results and instructions. There will still be certain situations in a treatment cycle when Montgomery-area patients will have to travel to Birmingham for their services.

We also offer on-site Andrology services, which include semen analysis and semen prep for inseminations. A separate collection area is available in the Montgomery office.

For patient convenience, the Birmingham office is the primary communication channel for the ART Fertility Program’s offices. All inquiries, appointments, requests for the physicians or nurses and LH surges, including those for the Montgomery office, are to be scheduled through the Birmingham office. Questions about treatment and lab results, including after-hours calls to our answering service, are to be handled through the Birmingham office.

We request that all payments for services be paid by personal check or credit card. Cash cannot be accepted at the Montgomery office.

Please call our toll free number 1-800-476-9784 with all questions and concerns. Thank you for your continued support.
TUSCALOOSA OFFICE OVERVIEW OF SERVICES

The ART Fertility Program of Alabama is pleased to be part of the Tuscaloosa, Northport and western Alabama community with a permanent office in Tuscaloosa/Northport, Alabama. The office is located at 650 Energy Center Blvd., Suite 1703, Northport, AL 35473.

The Tuscaloosa office is limited in its scope of services. Tuesdays and Thursdays the office is open from 7:00 a.m. to 2:30 p.m. The Tuscaloosa office is not available for weekend and holiday services. The Birmingham office; however, is open on weekends and certain holidays to accommodate patient care.

New patient visits as well as return visits are performed by a physician in the Tuscaloosa office.

Additionally, a CRNP provides services in Tuscaloosa such as physical exams, cultures, ultrasounds, etc. The CRNP is in constant communication with the Birmingham office and the physicians, and works under physician direction to provide services such as monitoring, ultrasounds, intrauterine inseminations (IUI) with non-frozen sperm, injection instructions, counseling and venipuncture.

We can provide “same-day results” for estradiol, progesterone and BhCG tests for Tuscaloosa patients in our care. Patients who have blood drawn and prepared before the courier picks up at 10:30 a.m. will have results available by 4:00 p.m. on the same day. Patients expecting “same-day results” should call their personal voice mailbox (1-800-338-0765) for results and instructions. There will still be certain situations in a treatment cycle when Tuscaloosa-area patients will have to travel to Birmingham for their services.

We also offer on-site Andrology services which include semen prep for inseminations. A separate collection area is available in the Tuscaloosa office.

For patient convenience, the Birmingham office is the primary communication channel for the ART Fertility Program’s offices. All inquiries, appointments, requests for the physicians or nurses and LH surges, including those for the Tuscaloosa office, are to be scheduled through the Birmingham office. Questions about treatment and lab results, including after-hours calls to our answering service, are to be handled through the Birmingham office.

We request that all payments for services be paid by personal check or credit card. Cash cannot be accepted at the Tuscaloosa office.

Please call our toll free number 1-800-476-9784 with all questions and concerns. Thank you for your continued support.