SOUTHERN CALIFORNIA CENTER FOR REPRODUCTIVE MEDICINE

Robert E. Anderson

361 Hospital Road, Suite 333
Newport Beach, CA 92663
Tel: (949) 642-8727 Fax: (949) 642-5413

Initial Consultation Checklist

Please Review This Checklist Carefully
The items listed below MUST be completed PRIOR to your New Patient Consultation

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☐ **New Patient Portal: <u>Please use the assigned Primary Patient and Partner Portal ID's provided when you scheduled your appointment.</u>**
Please log into our website: www.socalfertility.com and click on the Green **NEW PATIENT PORTAL button** 

to fill out the Patient and Partner Medical History. **This must be done prior to your New Patient Consult with Dr. Anderson (WITHOUT EXCEPTION)**.

☐ **Medical Record Release Form: <u>RETURN SIGNED COPY TO US ASAP. WE WILL REQUEST YOUR MEDICAL RECORDS FROM ANY PREVIOUS PHSYCIANS ON YOUR BEHALF. (Please print additional copies if necessary)</u>**
Dr. Anderson must have copy/copies of your previous medical records prior to your **New Patient Consultation.**

☐ **Insurance Card/s: <u>RETURN COPY OF CARD (front and back) TO OUR OFFICE ASAP.</u>**
As a courtesy, our office will verify your insurance benefits prior to your appointment; HOWEVER, we cannot verify your benefits without your insurance card. If your card is not received, you will be charged the cash fee for the New Patient Consultation of $250. Note: In order to fully understand your insurance coverage, we suggest that you contact the carrier to determine your **infertility benefits** and to find out which labs and hospitals are covered by your plan.

☐ **Referral or Authorization（HMO Plans only）**
It is necessary for you to have a copy of the referral authorization prior to scheduling your new patient appointment. Please provide your Authorization Confirmation number and provide a copy of the Authorization prior to your appointment.

☐ **Carrier Screening Acknowledgement, Financial Policy, Patient Agreement & HIPPA Form/ Email Consent/Physician Disclosure: (SCCRM & Ovation Fertility)**
Please be sure to read over these forms carefully. Please sign and date each form and keep a copy of your records. **Return via email or fax prior to your appointment.**

Please send the above information to the office as soon as possible, but no later than 3 business days before your appointment. **If you are unable to scan or fax the patient forms, OR if you do not complete the PATIENT PORTAL, please arrive 20 minutes early, and bring the completed information with you to the appointment. Remember, it may be necessary for you to pay for your consultation at the time of service, if benefits cannot be verified in advance.**

Thank you very much!

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Medical Records Release Request

(To be filled out by patient and returned to Southern California Reproductive Medicine via fax or email.)

Date:

To: (Name and address of your Physician)

Address:

Office Phone #

Office Fax#

I hereby authorize you to release my record to:

Robert E. Anderson, M.D.

Please send to: ☐ **361 Hospital Road, # 333**
Newport Beach, CA 92663
Ph: (949) 642-8727
Fax: (949) 642-5413

Records to be Included:

Records to be excluded:

Expiration Date of Authorization
This authorization is effective through: s revoked or terminated by the patient or
the patient's personal representative.

Potential for Re-disclosure
Information that is disclosed under authorization may be disclosed again by the person or organization to which
it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (Print or Type) D.O.B. Social Security #

Signature of Patient Date

Signature of Patient Representative Name of Patient Representative and Relationship (Print or Type)

NOTE: If you wish to fill out and sign this form electronically, you must have Adobe XI.
Revised 4.18.14 AS

Email and SMS (text) Correspondence Consent

I understand that unencrypted Email and SMS (text) messaging is not a secure form of communication. There is some risk that any identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. I understand that SCCRM and OVATION FERTILITY will use the minimum necessary amount of protected health information when corresponding via email or text message.

I hereby consent to the following: (**choose one only**)

☐ I **consent to and accept** the risk of receiving information as it pertains to future treatment. This may also include appointment confirmations, general correspondence, and information regarding SCCRM and OVATION FERTILITY. I can withdraw my consent at any time.

My email address is: _____

☐ I consent **only** to receiving appointment reminders via email or SMS messaging. I understand I can withdraw my consent at any time.

My email address is: _____

☐ I **do not** consent to receiving any information via email or SMS messaging. I understand that I can change my mind and provide consent later.

Patient Name: _____

Signature: _____

Partner Name: _____

Signature: _____

SOUTHERN CALIFORNIA CENTER FOR REPRODUCTIVE MEDICINE

Robert E. Anderson, M.D.

Carrier Screening

Recent developments in genetic research have revealed that there are many diseases that have as their cause an abnormal gene carried by one or both parents. These genetic abnormalities are detectable by a technology called Carrier Screening. Currently there are hundreds of diseases that can be detected by a simple blood test. For most diseases, the abnormal gene must be carried by both parents. If one parent carries the abnormal gene but the other does not, at worst their offspring will be carriers but not affected with the disease. If both parents are carriers of the abnormal gene, the offspring have an increased likelihood of being affected by the disease in question.

Because we have the ability to identify whether or not an individual is a carrier of these abnormal genes and the cost of the testing has become more reasonable, we strongly suggest that one individual be tested prior to starting infertility treatment. If an abnormal gene is detected then the other member of the couple should be tested as well.

This will be discussed in more detail at your first new patient appointment. Costs and the implications of the effect that this may have on your treatment will be addressed as well.

Robert E. Anderson, M.D.

I have read the above statement regarding Carrier Screening:

X _____ Date _____
Patient Signature

X _____ Date _____
Partner Signature

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Financial Policy

All fees for procedures and treatment are due and payable at the time services are rendered. If you are enrolled in a health plan that is contracted with Dr. Anderson, all services that are a ***covered benefit*** will be billed directly to your health plan. Any treatment that is a *non-covered benefit* will be due at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We bill your insurance as a courtesy for you; however, you are the responsible party if your insurance fails to pay.

Members of Greater Newport Physicians, Memorial Care, and/or Monarch Medical Groups (HMO'S) are required to obtain a referral to our office for the initial consultation. Subsequently, all future services need to be pre-authorized by your IPA. Any services that have not received prior authorization, or are a non-covered benefit, ***will be the financial responsibility of the member.*** Please communicate with the office staff prior to beginning new treatment to ensure that proper authorization has been obtained.

It is your responsibility to be aware of your infertility benefits.

Monthly statements will be mailed to all patients with an outstanding balance, and are due upon receipt. Outstanding balances that go beyond 90 days are subject to collections.

Our office accepts payments in the form of cash, personal checks, Visa, MasterCard, American Express and Discover. A $25.00 fee will be charged for all returned checks. We also provide options for financing through Prosper Healthcare Lending. Please contact the billing department for details.

Fee schedules are available upon request.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I understand and agree to this financial policy.

X _____ Date: _____

Signature of Patient or Responsible Party

X _____ Date: _____

Signature of Co-Responsible Party

OVATION FERTILITY
THE NEXT GENERATION
361 Hospital Road, Suite 433
Newport Beach, CA 92663
Phone: (949) 642-5954 Fax (949) 642-2954

Financial Policy

Please note: **Ovation Fertility is a NON-CONTRACTED Fertility Laboratory.** All fees for procedures and treatment are due and payable at the time services are rendered. If you are enrolled in a health plan that provides **Out-Of-Network Benefits**, all services that are a ***covered benefit*** will be billed directly to your health plan. You are responsible for any Co-Insurance and/or deductible amounts. Since we are non-contracted provider, there is no provider write-off, and you are financially responsible for these amounts.
****Patients with Blue Cross/Blue Shield policies will be required to pay for services up front, as Blue Cross/Blue Shield pays the subscriber on the policy directly. ****

Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We bill your insurance as a courtesy for you, however, you are the responsible party if your insurance fails to pay. **It is your responsibility to be aware of your infertility benefits.**

Monthly statements will be mailed to all patients with an outstanding balance, and are due upon receipt. Outstanding balances that go beyond 90 days are subject to collections.

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X _____ Date: _____

Signature of Patient or Responsible Party

X _____ Date: _____

Signature of Co-Responsible Party

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HIPAA Notice of Privacy Practices

Southern California Center for Reproductive Medicine

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment; Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations; We may use or disclose, as-needed, your protected healU1 information in order to support the business activities of your physician'spractice. These activities include. but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may u se or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in U1e following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures : Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however. you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Yon have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. lf we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Yon have the right to receive an accounting of certain disclosures we have made. if any. of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of. and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at or Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature: _____ Date:_____

OVATION FERTILITY
THE NEXT GENERATION

361 Hospital Road, Suite 433
Newport Beach, CA 92663
Ph: (949) 642-5954 Fax (949) 642-2954

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Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment; Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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We may use or disclose your protected health information in U1e following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures : Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Yon have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information . lf we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Yon have the right to receive an accounting of certain disclosures we have made , if any, of your protected health information.

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Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date:_____

OVATION FERTILITY
THE NEXT GENERATION

PHYSICIAN / PATIENT DISCLOSURE FORM

Robert E. Anderson, M.D.
The "Physician"

During the course of your physician/patient relationship with the Physician, the Physician may refer you to FPG Labs of Newport, LLC d/b/a Ovation Fertility, which operates an assisted reproductive technology laboratory located at 361 Hospital Road, Suite 433, Newport Beach, CA 92663.

In connection with any such referral, the Physician hereby advises you that the Physician has an investment interest in FPG Services, LLC, which provides management services to FPG Labs of Newport, LLC d/b/a Ovation Fertility and its assisted reproductive technology laboratory.

Please be advised that you have the right to obtain the health care items and services for which the Physician refers you, at any location or from any lab, ambulatory surgery center, hospital, provider or supplier of your choice, including FPG Labs of Newport, LLC d/b/a Ovation Fertility.

* * *

I, the undersigned patient (the "Patient"), received this Physician/Patient Disclosure Form from the above-referenced Physician, and I read and understood the information contained in this Physician/Patient Disclosure Form. The Physician furnished me with this Physician/Patient Disclosure Form prior to the Physician's referral of me to FPG Labs of Newport, LLC d/b/a Ovation Fertility.

Date: _____, 20___

_____
(Signature of Patient)

_____
(Printed Name of Patient)

_____
(Home Street Address of Patient)

_____
(City, State, Zip of Patient)

_____
(Telephone Number of Patient)

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IMPORTANT!!
STATE REQUIRED

Infectious Disease Screening

It is mandated by the State of California that we have infectious disease screening results for you and your partner in your chart prior to beginning your treatment cycle**.**

Therefore, we do ask that you and your partner have blood drawn for infectious disease screening on the day of your New Patient visit. This will enable you to begin treatment as soon as possible.

Thank you for your cooperation,

Annamarie Santana
Practice Manager

Acupuncture for Women's Health

- PMS
- Infertility
- Low libido
- Endometriosis/painful menstruation
- Delayed menstruation
- Polycystic Ovarian Syndrome
- Depression
- Mood swings
- Anxiety and/or panic attacks
- Insomnia
- Headaches and Migraines
- TMJ pain
- Neck and shoulder tension
- Constipation
- Fibromyalgia
- Diabetes
- Peri-menopausal and menopausal conditions
- Thyroid dysfunction
- Hormonally-related acne and skin conditions
- Irritable Bowel Syndrome and other digestive disorders

Acupuncture benefit in enhancing fertility

Regulate menstrual cycle.
Improve sperm count and motility.
Reduce stress and anxiety associated with infertility.
Normalize hormone and endocrine systems.
Improve blood flow in the uterus.
Decrease chance of miscarriage.
Increase the chance of pregnancy for women undergoing in vitro fertilization (IVF).



Please call 949-642-8727 to schedule your appointment

Nutrition and Fertility

Erin MacDonald, Registered Dietician

Those who take medicine and neglect their diet waste the skill of the physician.
--Chinese proverb

Let food be thy medicine and thy medicine shall be thy food
--Hippocrates

The importance of a fertility diet and a preconception diet plan

The foods you eat (or choose not to) can have an impact on your fertility. Nutrition is extremely important for balancing the hormones. A good diet will support and nourish the organs that produce hormones that are essential for reproduction. A study conducted by the University of Surrey showed that couples with a previous history of infertility who made changes in their lifestyle, diet, and took nutritional supplements had an 80 percent success rate.

Although it goes without saying that a healthy diet is crucial to a successful pregnancy and a healthy baby, many people are unaware of the fact that diet can help to correct hormone imbalances that may affect your ability to conceive. There are also certain foods and drinks that are known to lower fertility.

Treating the cause, not just the symptoms

If we treat just the symptoms of infertility (hormone imbalance, amenorrhea, overweight, underweight, PCOS, etc.), it's like putting a bandage on a gaping wound. The holistic approach to infertility is to look to the causes of these symptoms and make lifestyle changes that will heal the body and decrease or eliminate the symptoms, increasing your odds of conception. To do that, nutrition is crucial. Everything that you eat can be turned into the fuel that your body uses to produce hormones, enzymes, blood, bone - in fact, every single cell in your body, and all the processes that take place, are determined by what goes into your mouth. Your diet is the foundation of your health, so it is important that your food contains the right nutrients to keep you balanced and healthy and to prevent health conditions from cropping up in the future.

Our Nutrition Program educates you on what food and lifestyle habits to include and what to avoid, improving your chances of conceiving as well as a successful pregnancy. Based on the most recent nutrition research, our Registered Dietitian, **Erin Macdonald, R.D.,** uses an integrative approach that includes relaxation, exercise, and food to nourish your body on all levels. By optimizing your weight, ensuring adequate vitamin intake from food and supplementation, and suggesting healthy lifestyle habits, our Nutrition Program will help you enhance your fertility and promote a health pregnancy.

During your initial consultation, you will have the opportunity to discuss your individual goals for health and current lifestyle habits. Erin will make specific recommendations based on your diagnosis. After your first consultation, you will receive a customized plan that includes: meal ideas, recipes, lifestyle suggestions and supplement recommendations.

A fertility-friendly diet can help you:

1. Improve absorption and distribution of nutrients
2. Balance blood sugar levels to address PCOS and gestational diabetes
3. Detoxify from environmental toxins
4. Balance hormones
5. Optimize weight to attain an ideal BMI (body mass index) for conception (19-25)

Who can benefit from a nutrition consultation?

Men or women looking to improve their chances of conceiving by optimizing their weight, supporting sperm and egg quality and resolving conditions like PCOS can benefit greatly from a nutrition consultation.

How many nutrition sessions should I sign up for?

While some people need a jumpstart to their program with a single nutrition consult, others benefit greatly from ongoing support with meal plans and recipes. During your initial consultation, your nutrition consultant will help you determine a protocol that best supports your personal goals.

If you are interested in scheduling a consult with Erin to discuss your nutritional needs, please call 949-542-7171.