Care New England Medical Group | A MEMBER OF Care New England

Women & Infants Fertility Center

90 Plain Street | Providence, RI 02903
(401) 453-7500 | (401) 453-7598 fax
womenandinfants.org/fertility

Hello!

We would like to welcome you to the Women & Infants Fertility Center. Our office is located at 90 Plain Street, 4th Floor, Providence, RI.

Our physicians work as a team to enhance the care we provide. In addition, Women & Infants is one of Brown University School of Medicine's premier teaching hospitals, and as such, residents and medical students may be involved in your care under our direct supervision.

Enclosed please find some documents regarding treatment at our facility, including the following:

- Patient Questionnaire and Patient Demographic Sheet
  - Complete and hand carry these forms to your initial appointment
- Patient Checklist
  - Carefully review this form prior to your appointment so that your initial appointment is as productive as possible.
- Patient Insurance Coverage information
  - Carefully review this form; it is intended for you to use as a guideline to contact your insurance carrier to discuss coverage for potential treatment at our facility.
  - Please complete and carry the acknowledgement only to your initial appointment; the first two pages are for you to keep as reference.

Please arrive 15 minutes early for your initial visit to our office to facilitate registration. Directions to your appointment can be found on our website. Your partner is encouraged to attend this visit and all subsequent appointments.

If you need to cancel your visit, please call us at 401-453-7500 at least 72 hours prior to your appointment.

We look forward to participating in your care. If you have any questions, please call and our dedicated staff will be more than happy to assist you.

Sincerely,

The Physicians and Staff
Women & Infants Fertility Center

Fertility Center – Resources for Patients

Phone: (401) 453-7500 FAX: 401-453-7598

We are available Monday through Friday from 8 a.m. to 4:30 p.m. **Weekends & Holidays**: If you leave a message before noon, your call will be returned same day in the afternoon. All messages after 12pm on weekend or holidays will be returned the next business day.
Our office is closed for lunch from 12 noon to 1 p.m.

When calling the Fertility Center, please select from the following options (you may make your selection at any time during the call):

1 – Schedule an appointment other an insemination (IUI)
2 – Speak with a nurse regarding clinical questions or to schedule an insemination (IUI)
5 – Financial counseling
6 – IVF coordinator (fresh cycle) – if you are doing a frozen embryo transfer cycle, please contact the nurse line (option 2)
7 – Medical records
8 – IVF (embryology) Lab
0 – Operator

When leaving a message, please be sure to leave the **spelling of your name, your date of birth, and the best number to call you back.**

WEBSITE womenandinfants.org/fertility

Visit our website for information and resources, including:

- **Videos for injections** – At the top of the page, click on Treatment & Testing and then scroll down to Fertility Medication Injections.
- **Consent Forms –** At the top of the page, click on Patients and then scroll down to Consent Forms Selection Tool.

PHLEBOTOMY SERVICES

For your convenience, we offer phlebotomy services at 90 Plain Street, 4th floor.

Monday through Wednesday	6:30 a.m. to 12:30 p.m. and 1:30 to 3:15 p.m.
Thursday	6:30 a.m. to 12:30 p.m. and 1 to 3:15 p.m.
Friday	6:30 a.m. to 12:30 p.m. and 1 to 2:15 p.m.
Weekends and holidays	7 to 9:45 a.m.

(We are open every day except Christmas)

Women & Infants
A MEMBER OF CARE NEW ENGLAND

MEET OUR TEAM

Jennifer Eaton MD, MSCI

Dr. Eaton is Director of the Division of Reproductive Endocrinology and Infertility (REI) at Women & Infants Hospital of Rhode Island and The Warren Alpert Medical School of Brown University. She earned her medical degree from Columbia University in New York City. She completed her residency training in obstetrics and gynecology at Beth Israel Deaconess Medical Center in Boston. She stayed on as ob/gyn faculty for 3 years before moving to Chicago for fellowship training in reproductive endocrinology and infertility at Northwestern University. While at Northwestern, she also earned a Master of Science in Clinical Investigation. After fellowship, she joined the faculty at Duke University as Medical Director of Assisted Reproductive Technology and the Director of the Oocyte Donation Program. She served in these roles for seven years before coming to Women & Infants.

Dr. Eaton is nationally recognized as a leader in the field of reproductive endocrinology and infertility and currently serves on several national committees. She was elected Chair of the Research Committee of the Society for Assisted Reproductive Technology (SART) and currently serves on the SART Executive Council.

Gary Frishman MD

Dr. Frishman is program director of the fellowship in Reproductive Endocrinology and Infertility at Women & Infants Hospital of Rhode Island and The Warren Alpert Medical School of Brown University. He attended college at the University of Pennsylvania and then medical school at Columbia University in New York City. Following this, he completed his residency in ob/gyn at Pennsylvania Hospital in Philadelphia and his REI fellowship at the University of Connecticut in Farmington. Dr. Frishman joined the Division of REI at Women & Infants in 1991. He is board-certified in ob/gyn and REI.

Women & Infants

A MEMBER OF CARE NEW ENGLAND

Dr. Frishman's research interests include surgery and medical education. He is actively involved in medical education and research and served on the Review Committee for Obstetrics and Gynecology for the ACGME. He is the former Ob/Gyn Residency Program Director. He is well-known nationally and internationally for his leadership roles and has served as President of both the Society of Reproductive Surgeons and the AAGL. He is currently Deputy Editor of the *Journal of Minimally Invasive Gynecology*.

Virginia Mensah MD

Dr. Mensah received her medical degree from the University of Illinois College of Medicine. She completed her residency in ob/gyn at Johns Hopkins Hospital and her REI fellowship at Women & Infants/Brown. Following several years in private practice, Dr. Mensah joined the Division of REI at Women & Infants in February 2020.

Dr. Mensah is board-certified in both ob/gyn and REI. Her clinical and research interests include outcomes in in vitro fertilization, pre-implantation genetic testing, and the impact of stress on reproduction.

May-Tal Sauerbrun-Cutler MD

Dr. Sauerbrun earned her medical degree from Sackler School of Medicine-New York State/American Program, Tel Aviv University. She completed her residency training in obstetrics at Mount Sinai St. Luke's-Roosevelt Hospitals Icahn School of Medicine in New York and her fellowship training in reproductive endocrinology and infertility at Women & Infants Hospital.

Dr. Sauerbrun is the director of fertility preservation and is heavily involved in resident education. Her research interests include endometrial receptivity, embryo development, and fertility preservation, which is also a clinical focus.

Women & Infants
A MEMBER OF CARE NEW ENGLAND

Victoria Snegovskikh MD

Dr. Snegovskikh received her medical degree from I. P. Pavlov State Medical University of St. Petersburg and completed her residency in obstetrics and gynecology at Medical Academy of Postgraduate Education in St. Petersburg, Russia. Dr. Snegovskikh then moved to the United States and completed residency in ob/gyn at Yale University School of Medicine. She then proceeded with fellowship in REI at Women & Infants Hospital. She is board-certified in both ob/gyn and REI.

Dr. Snegovskikh's research interests include changes in cervical mucus and saliva in patients undergoing fertility treatments, cervical mucus as a barrier against infection during pregnancy, and recurrent pregnancy loss.

Carol Wheeler MD

Dr. Wheeler earned her medical degree from Jefferson Medical College in Philadelphia, PA. She did her residency training in obstetrics at Miami Valley Hospital in Dayton, Ohio, and her fellowship training in REI at the Hospital of the University of Pennsylvania. She practiced in New Orleans, Louisiana prior to coming to Women & Infants in 1990. She is board-certified in ob/gyn and REI.

Dr. Wheeler is director of the Third-Party Reproduction Program and the Pediatric and Adolescent Gynecology clinic, in which she holds focused practice designation. She is currently the medical director of the in vitro fertilization program. Active in teaching of trainees at all levels, Dr. Wheeler functions as a mentor for many future obstetricians and gynecologists and is happy to share her knowledge and experience.

Women & Infants
A MEMBER OF CARE NEW ENGLAND

Yimin Shu PhD, MD, HCLD

Dr. Shu is the director of the in vitro fertilization laboratory. He earned his medical degree from Tongji Medical University in Wuhan, China and his PhD from Sun Yat-sen University of Medical Sciences in Guangzhou, China. He is certified as a High Complexity Laboratory Director (HCLD) by the American Board of Bioanalysis. Before joining Women & Infants Hospital, he was the IVF laboratory director at Wake Forest Baptist Hospital and Fertility Associates of Memphis and a senior gamete biologist at Stanford Hospital & Clinics.

Dr. Shu has been serving as the earliest "babysitter" through culturing human oocytes and embryos since 1998. His goal is to offer infertility patients the highest quality of laboratory services and help them experience the joy of having a healthy baby. His research interests focus on improving the understanding of reproductive biology and new treatment for infertility.

Jacalyn Finerty, NS, APRN, WHNP-B

Jackie is a Women's Health Nurse Practitioner. She earned her Bachelors of Science in Nursing (BSN) from the University of Rhode Island. She then completed her Masters in Science from Boston College in 2019, where she assisted in the education of undergraduate nurses and continues to lecture graduate nursing students.

Jackie has been with Women & Infants Hospital since 1998 and has worked in many aspects of women's health including labor and delivery, the operating room (where she served as a clinical educator), high-risk obstetrics, and reproductive medicine. Her interests include education of patients and nurses and mentorship of students, along with pregnancy outcomes of ovulation induction agents, fertility care of PCOS patients, and those of the LGTBQ community.

Women & Infants
A MEMBER OF CARE NEW ENGLAND

Meghan C. H. Ozcan, MD is a fellow in Reproductive Endocrinology and Infertility (2019-2022). Dr. Ozcan earned her medical degree from Uniformed Services University of the Health Sciences F. Edward Hebert School of Medicine and completed her ob/gyn residency at Naval Medical Center in Portsmouth, Virginia.

Dr. Ozcan is board-certified in ob/gyn. Her research interests include ovarian reserve, ectopic pregnancy, and maintaining quality of life during infertility treatment. She is actively involved in research and serves on the Reproductive Endocrinology and Infertility Milestones Team for the ACGME.

Alexis Gadson, MD is a fellow in Reproductive Endocrinology and Infertility (2020-2023). Dr. Gadson earned her medical degree from Boston University School of Medicine and completed her ob/gyn residency at Boston University/Boston Medical Center.

Dr. Gadson's research interests include polycystic ovary syndrome (PCOS) and the impacts of health disparities on reproductive outcomes.

Karine Matevossian, DO is a fellow in Reproductive Endocrinology and Infertility (2021-2024). Dr. Matevossian earned her medical degree from Kansas City University of Medicine and Biosciences College of Osteopathic Medicine and completed her ob/gyn residency at Advocate Lutheran General Hospital in Illinois. Dr. Matevossian will be joining the Division in July 2021.

Women & Infants' Fertility Center
90 Plain Street, Providence RI 02903
mailing: 101 Dudley Street, Providence RI 02905
phone: 401-453-7500 | fax: 401-453-7598

Women & Infants
A MEMBER OF CARE NEW ENGLAND

40735

WOMEN & INFANTS HOSPITAL
Providence, RI 02905

PATIENT CONSENT FOR FERTILITY TREATMENT DURING COVID-19 AT WOMEN & INFANTS FERTILITY CENTER

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

C19-40735 (5-2020)

COVID-19 has been declared a worldwide pandemic by the World Health Organization. Although the exact mode of transmission is not entirely known, COVID-19 is contagious and is believed to spread by person-to-person contact. Despite taking reasonable preventative measures that are aimed to prevent the spread of COVID-19, an inherent risk of becoming infected with COVID-19 by virtue of proceeding with fertility treatment still exists.

By seeking treatment at Women & Infants Fertility Center I _____
(Patient's Name)

(or _____ for _____)
(Legal Guardian) (Patient's Name)

and _____ (if applicable) acknowledge and understand:
Partner's Name

1. Despite all precautions offered to me/us or taken by my/our providers, there is no guarantee that I/we will not be exposed to and/or infected with COVID-19.
2. Use of personal protective equipment (PPE) can minimize risk but does not eliminate the risk of transmission of COVID-19.
3. Possible exposure to COVID-19 may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and/or the risk of death.
4. The impact of COVID-19 on pregnancy for both the mother and baby is not fully known. I/we acknowledge that any febrile illness in early pregnancy may increase the risk of miscarriages and birth defects and that pregnant women appear to be at greater risk of severe complications from other respiratory viral infections such as influenza.
5. Even if I/we have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus, there is a chance I/we may have contracted COVID-19 after the test and I/we acknowledge that I/we may still transmit the undetected virus to another person.
6. My/Ourtreatment/procedure may be delayed or canceled should I/we develop symptoms, be tested positive for COVID-19 or for a variety of others reasons including changing regulations and restrictions surrounding COVID-19, availability of staff, the availability of adequate PPE or other reasons. If treatment is modified or canceled this can interfere with the ability to become pregnant through treatment as well as have financial consequences including not being reimbursed for expenses already incurred.
7. I/we are expected to follow reasonable precautions set forth by the WIFC such as wearing a facemask at all times in the clinic and to observe social distancing and proper handwashing both inside and outside of the clinic during the course of treatment.
8. These precautions may also include the request to self-quarantine and to pursue any testing for patient, or partner if applicable, related to COVID-19 before treatment. I/we understand that it may be necessary to obtain this testing at an outside lab and there may be extra costs associated with this testing.
9. Failure to comply with these requests, follow recommended precautions, as well as exposure to, developing symptoms of, or testing positive for COVID 19 may result in the delay or cancelation of treatment.
10. If treatment is delayed or canceled, this can have financial consequences including not being reimbursed for expenses already incurred.

11. The staff at WIFC is providing fertility treatment and I/we are responsible for obtaining other healthcare needs through other providers including routine gynecologic and primary care, any ongoing obstetric care, and any care related to COVID-19.
12. I/we have the option to postpone fertility treatment to minimize the risk of acquiring COVID-19.

I/we have been counseled about resources available to provide further information about COVID-19. I /we have had the opportunity to read this form, or have it read to me/us, and I/we understand it. I/we have had the opportunity to ask questions and they have been answered to my/our satisfaction. Understanding all of the above, I/we desire to proceed with fertility treatments.

Time: _____ AM / PM Date: _____ Signature: _____
(Patient or Legal Guardian)

Relationship: _____

Time: _____ AM / PM Date: _____ Signature: _____
Partner, if applicable

Provider's Acknowledgement:

I confirm that consent as described above, has been given by this patient (or Legal Guardian) and partner.

Time: _____ AM / PM Date: _____ Signature: _____
(Provider)

Print Name: _____
(Provider)

Interpreter's Acknowledgement (if applicable):

I confirm that consent as described above, has been given by this patient (or Legal Guardian) and partner.

Time: _____ AM / PM Date: _____ Signature: _____
(Interpreter)

Print Name: _____
(Interpreter)

For Partner's Signature if not signed at WIFC

STATE OF _____

COUNTY OF _____

Then personally appeared before me the above named _____, and being duly sworn under the penalty of perjury acknowledged the foregoing to be his/her free act and deed this _____ day of _____, 20____.

NOTARY PUBLIC: _____
MY COMMISSION EXPIRES: _____

Notice: This practice is a hospital-based outpatient practice

This practice has been designated as an outpatient department of Women & Infants. Patients receiving a service at this practice may receive two charges: one charge reflecting the physician fee and the other charge reflecting the hospital's facility fee (cost of access and use of hospital facility and/or services). Please contact your insurance company to understand your financial responsibility.

For more information regarding your charges, please call the number on your bill. For information on applying for financial assistance, please call the Women & Infants Patient Financial Services department at (401) 921-7200.

Aviso: Este es un consultorio ambulatorio de hospital

Esta práctica ha sido designado como departamento de atención ambulatoria de Women & Infants. Los pacientes atendidos en este consultorio podrían tener que pagar los honorarios del médico y cargos del hospital (por acceso, uso del hospital o servicios). Por favor comuníquese con su aseguradora para saber cuál es su obligación de pago.

Para obtener más información sobre los cargos, sírvase llamar al número telefónico que aparece en la factura. Si desea información para solicitar ayuda financiera, por favor llame al departamento de servicios financieros para pacientes de Women & Infants, al (401) 921-7200.

40549

WOMEN & INFANTS HOSPITAL
101 Dudley Street • Providence, RI 02905

PATIENT FINANCIAL AGREEMENT & GENERAL CONSENT

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

MR-804 (8-2018)

CONSENT TO TREATMENT:

I understand that my care will be provided according to my attending physician's orders. I understand that when I request care for my medical condition I am generally consenting to other medical treatments such as x-ray examinations, laboratory tests and minor procedures that my physician may order. For major procedures, such as a surgery, my physician will explain them to me and I will be asked to sign a separate consent form.

CAREGIVER DESIGNATION:

I understand that if I designate a Caregiver the hospital will release information to the Caregiver.

HEALTH CARE EDUCATION:

I understand that Women & Infants Hospital (hereinafter, "Hospital") is a teaching hospital where individuals in training, residents, fellows, medical students, nursing students and other health care students may be observers or participants in my care under the direct or indirect supervision of licensed practitioner(s).

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I understand that Hospital can release all necessary health information for purposes of treatment, payment and healthcare operations as permitted by applicable law. This includes disclosures and/or requests by telephone, fax, photo copy or electronic means which may include HIV/AIDS related information, substance use disorder treatment information and information about diagnosis or treatment of mental illness, as permitted by law. I understand that this information may be shared with other treating providers and third party payers, including, but not limited to, insurance companies (and their review organizations), managed care organizations, Medicare, Medicaid or other governmental payers that may provide coverage and reimbursement for services rendered to me by the Hospital, or other third parties, including information pertaining to my identity, prognosis, diagnosis, treatment or any other information necessary to establish my eligibility for insurance benefits.

I further release the Hospital and its employees from any liability arising from the release of this information to such persons/agencies, provided that the release of information is done substantially in accordance with applicable law.

WORKER'S COMPENSATION:

If my care is related to an accident at work, I understand that my employer's Workers' Compensation carrier will also have access to information contained in my medical record. Such information may include, but is not limited to, HIV test results and information relating to diagnosis and/or treatment of mental illness or substance use disorder.

ASSIGNMENT OF INSURANCE BENEFITS:

To the extent permitted by law, I irrevocably assign to Hospital and other providers furnishing services to the patient any and all benefits of any type arising out of any claim or policy of insurance insuring the patient or any willing party liable to the patient. I authorize and request that payment of insurance benefits be made on my behalf for any services furnished to me by or in the Hospital, including physician services.

FEDERAL MEDICARE BENEFITS:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or their intermediaries or other agents any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize such physician or organization to submit claims to Medicare for payment to me. I acknowledge and agree that, to the extent permitted by law, I am responsible for payment for any services provided not covered by Medicare.

FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT:

I acknowledge that I am legally responsible for all charges incurred in connection with medical care and treatment provided by Hospital and physicians providing professional services to me through the Hospital (hereinafter "Physicians"). I agree and consent to medical care that has been or will be provided to the patient whose name appears above. For services rendered by the Hospital and Physicians, I guarantee payment of the account and agree to pay such account at the time services are rendered if it will not be paid by my insurance carrier or other third-party payer ("Payer"). I understand that Payer may require authorization prior to my receiving treatment and that it is my responsibility to obtain that prior authorization and know the coverage of my plan. I understand that receiving prior authorization does not guarantee that my Payer will pay because the benefits permitted depend upon my individual healthcare plan. I further understand that I am responsible for payment if my Payer deems Hospital or Physicians to be out of network. I acknowledge that if my child/dependent is cared for by Hospital or Physicians I will be responsible for payment for services provided under these same terms and conditions. I acknowledge and understand I may receive calls to the cellular and residential telephone numbers and any electronic communications to include text or emails I provided in my demographic information, including communications using any type of artificial or prerecorded voice or auto-dialer technologies made by or on behalf of the Hospital, its providers, assignees, agents, servicers, debt collectors, or any owner of a receivable for unpaid services or treatment provided to me by the Hospital or any of its providers.

PERSONAL BELONGINGS: I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the Hospital. I hereby release the Hospital from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

SIGNATURE: I have read the information above or have had it read to me. I understand the information and have had my questions answered to my satisfaction. My signature below verifies that I have voluntarily consented to the above.

_____ _____
Signature of Patient (Date/Time)

_____ _____
Signature of Authorized Representative (Date/Time)

_____
Relationship to Patient

_____ _____
Signature of Witness (Date/Time)

Coordination of Benefits for Other Insurance Coverage

If you have other insurance in addition to your Primary coverage, we will need your other insurance information.
By coordinating benefits among all insurance carriers, members receive the maximum benefits available.

* indicates required fields, as applicable

PATIENT » *Name of Patient: _____ *Date of Birth: _____

INSURED » *Name of Insured: _____ *Phone #: _____

*Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

***Insurance Plan Name**: _____ ***Policy and Group** #: _____

***Does the Patient have other insurance or Medicare Coverage?**

☐ YES » Continue with form

☐ NO » Go to **Signature** section

OTHER INSURANCE CARRIER:

* Name of person who holds Other Insurance policy: _____
* Name of this person's Employer: _____
* Name of Other Insurance Carrier: _____
Insurance Carrier address: _____
Insurance Carrier phone number: _____
*Policy Number: _____ *Group Number: _____
*Beginning date of Coverage: _____ *End date of Coverage (if applicable): _____

Other insurance covers? ☐ Self ☐ Spouse ☐ Child ☐ Other _____

PHARMACY

Pharmacy name: _____ Pharmacy phone number: _____

If the Patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple Patients, please complete a separate form for each Patient.

Name of Dependent(s): _____

Relationship of other insurance member to child: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other_____

Child resides with: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other_____

Person(s) with legal custody: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other_____

Is there a court decree that has assigned primary responsibility for health care coverage? ☐ Yes ☐ No

Relationship of party with decreed responsibility: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other_____
Name of responsible party: _____
Address: _____

Name and date of birth of both parents	Mother's name: Date of Birth:	Father's name: Date of birth:

MEDICARE:

*Name of Individual Covered by Medicare: _____
*Medicare ID#: _____
Date of Birth: _____ Date of Retirement (if applicable): _____
*Medicare Part A effective date (if applicable): _____
*Medicare Part B effective date (if applicable): _____
*Medicare Part D Prescription Drug Coverage effective date (if applicable): _____

*Eligibility Reason: ☐ Age
☐ Disability — Date disability began: _____
☐ End Stage Renal Disease — First date of dialysis: _____
Kidney transplant date: _____

SIGNATURE:

*Insured or Patient Name (print): _____

*Signature of Insured or Patient: _____ *Date: _____

10170

Care New England

☐ Care New England Medical Group
☐ Kent Hospital
☐ Women & Infants Hospital

PATIENT LABEL

ACKNOWLEDGEMENT OF DELIVERY
Privacy Policy

(7-2019)

Patient Name	Medical Record #	Date of Service

I hereby acknowledge that I have received a copy of the Care New England Privacy Policy. I understand that this document describes how my medical information may be used and disclosed and how I can obtain access to this information.

Time _____ Date _____ Patient's Signature _____

Time _____ Date _____ Witness Signature _____

Patient unable to accept or understand the Care New England Privacy Policy at this time.

☐ Patient's Representative _____
Print Name

_____
Relationship to Patient

Patient Representative's Signature: _____

☐ No patient representative available.

☐ Patient refuses Privacy Policy

Time _____ Date _____ Witness Signature _____

10131 (4-2020)

Care New England

CONSENT FOR VIDEOCONFERENCE OR TELECONFERENCE TREATMENT DURING COVID-19 EMERGENCY

1. Due to the state of emergency related to COVID-19, I have been offered and agreed to a teleconference or videoconference with my healthcare provider rather than appearing in person.

2. I understand and agree to the following:

   - that this videoconference or teleconference may not be a secure method of transmitting my information and that there is a risk of inadvertent disclosure of my confidential healthcare information due to this method of communication;
   - that use of this videoconference or teleconference will be limited to treatment that can be provided without benefit of an in person examination;
   - that I may pursue any alternative avenues of treatment, including scheduling an appointment with my healthcare provider or reporting to a local hospital's emergency department;
   - that, if my symptoms worsen, or if I am concerned that my symptoms have changed, I should call back for further advice or schedule an appointment with my healthcare provider or report to my local hospital's emergency department; and
   - that I am responsible for paying for the services provided via videoconference or teleconference if they are not paid by insurance carrier or other third-party payers (including any co-payments and/or coinsurance).

I have read the foregoing consent to the patient, the patient has affirmed his or her agreement to each of the foregoing paragraphs, t patient has had the opportunity to ask questions, and the patient has given consent to proceed with the receiving treatment v videoconference or teleconference.

Date	Time	Healthcare Provider or Staff Member (Signature)

(Print Name)

Women & Infants Hospital
Division of Reproductive Endocrinology and Infertility
Gynecologic Patient Questionnaire

If you need help filling out this form, please contact us and we will have someone help you. You may be asked to come in ½ hour earlier than your scheduled appointment to answer your questions.

Identifying Information

Name_____ Today's Date:_____

Name by which you wish to be addressed:_____ Date of Appointment:_____

Birth Date _____ Age _____ Occupation _____

Address _____

Which number do you prefer we call you at and leave a voice message? ☐ Home ☐ Work ☐ Cell

Home Phone Number: ( )_____ Cell Number: ( )_____

Work Phone Number and Hours: (_____)_____ext:_____ hours _____

Can we have permission to leave a confidential message concerning your treatment?
Work: ❑ Yes ❑ No Home: ❑ Yes ❑ No Cell: ❑ Yes ❑ No

Partner's Name (if appropriate)_____ Birth Date_____

Age_____ Occupation_____

Pharmacy Name and Phone Number:_____

Referring Physician (name and address):_____

Gynecologist IF different from above (name and address):_____

Chief Complaint (reason for visit):_____*If* Infertility, Duration:___ yrs.

Would you like us to contact you in an earlier appointment becomes available? ❑ Yes ❑ No

I. General Information

Are you: ❑ Single ❑ Married ❑ Long-Term Relationship ❑ Separated ❑ Divorced ❑ Remarried
Years with present partner _____ Date of Marriage (if applicable) _____
Either partner previously married or had previous pregnancies? ❑ Yes ❑ No If yes, please explain: _____
_____

Why would you like to be evaluated at Women & Infants?

☐ Delayed or absent periods
☐ Endometriosis
☐ Excessive hair growth or loss
☐ Fibroids
☐ Infertility
☐ Irregular or abnormal periods
☐ Recurrent miscarriages
☐ Pelvic pain
☐ Premature menopause
☐ Other _____

If you are trying to get pregnant, how long have you been trying to conceive? _____

II. GYN History

Age of first period? ________________ Date of most recent period (1st day) ____________________________________

Are your periods regular? ❑ Yes ❑ No

Usual number of days between periods: __________ Usual duration of bleeding: _______ days

Amount of flow? ❑ Minimal ❑ Moderate ❑ Severe

Cramps? ❑ Minimal ❑ Moderate ❑ Severe

Is pain medication necessary? If so, what type: ____________________________________	❑ Yes	❑ No
Are you aware of ovulation?	❑ Yes	❑ No
Do you have Pelvic Discomfort	❑ Yes	❑ No
Do you feel that you have excess hair growth (hirsutism) or acne?	❑ Yes	❑ No
Previous methods of contraception (check all methods used): ☐ Pills ☐ Condoms ☐ Foams ☐ Diaphragm ☐ IUD ☐ Withdrawal ☐ Rhythm ☐ None		

Usual frequency of sexual intercourse per week ______________ or per month _______________

Lubricants used: ❑ Yes ❑ No If yes, please specify: ____

Does your partner ejaculate in the vagina during intercourse? ❑ Yes ❑ No

Do you douche ❑ before or ❑ after intercourse? ❑ Yes ❑ No

Is intercourse painful or difficult for you or your partner? ❑ Yes ❑ No

If yes, please check all that apply:

Pain is: ☐ Mild ☐ Moderate ☐ Severe ☐ Always painful ☐ Rarely painful
☐ With all sexual positions ☐ Just with some positions
☐ Getting worse with time ☐ No change in last few years

Do you have a history of DES (*diethylstilbestrol*) exposure? ❑ Yes ❑ No

Date of last pap smear __________________ Results ____

Do you have a history of an abnormal pap smear? ❑ Yes ❑ No

If so, have your recent pap smears been normal? ❑ Yes ❑ No

History of: ☐ Pelvic pain ☐ Endometriosis ☐ Pelvic Infection (PID) ☐ Chlamydia ☐ Herpes
☐ Syphilis ☐ HPV (genital warts) ☐ Gonorrhea ☐ Tuberculosis (TB)

How many sexual partners have you had in your lifetime?

❑ I have never had intercourse ❑ 1 ❑ Less than 5 ❑ 5 or more

III. Obstetrical History

Have you ever been pregnant? ❑ Yes ❑ No If yes, complete the following:

Month/Year Pregnancy Ended	*Pregnancy Outcome* see below*	*With Current Partner?*	*Infertility Therapy (if so, type)*	*How Long to Conceive?*	*Sex (M/F) and weight of baby (if delivered)*	*If Miscarriage, was a D&C done?*	*Were there any complications with the pregnancy?*
		❑ Y ❑ N				❑ Y ❑ N	❑ Y ❑ N
		❑ Y ❑ N				❑ Y ❑ N	❑ Y ❑ N
		❑ Y ❑ N				❑ Y ❑ N	❑ Y ❑ N
		❑ Y ❑ N				❑ Y ❑ N	❑ Y ❑ N
		❑ Y ❑ N				❑ Y ❑ N	❑ Y ❑ N
		❑ Y ❑ N				❑ Y ❑ N	❑ Y ❑ N
		❑ Y ❑ N				❑ Y ❑ N	❑ Y ❑ N

*V=Vaginal delivery, CS=C-Section, M=Miscarriage, TOP=Termination of Pregnancy, TA=Therapeutic Abortion, EP=Ectopic/Tubal Pregnancy

IV. Past Medical History and Review of Systems

Have you ever had any procedure on your cervix such as biopsy, cauterization, cryosurgery, D&C (if yes, please specify)? _____	❑ Yes	❑ No
Any procedure on uterus, vagina, tubes, ovaries, or operations for inflammatory or infectious pelvic diseases, operations for adhesions or endometriosis?	❑ Yes	❑ No
Have you ever had a ☐ Laparoscopy? ☐ Hysteroscopy? If YES, when? _____	❑ Yes	❑ No
Have you ever had stimulation of ovulation with oral or injectable agents such as (check all that apply): ☐ clomiphene (clomid, serophene) ☐ HCG ☐ gonadotropins ☐ FSH	❑ Yes	❑ No
Have you ever had any treatment of endometriosis with drugs?	❑ Yes	❑ No
Have you ever undergone artificial insemination? If YES, with ☐ Partner or ☐ Donor	❑ Yes	❑ No
Have you ever had an endometrial biopsy, and if yes, when? _____	❑ Yes	❑ No
Have you experienced depression or anxiety related to your condition?	❑ Yes	❑ No
If you experienced depression/anxiety related to your condition, have you receive psychological treatment for it?	❑ Yes	❑ No
Have you used alternative medicine for infertility (herbs, acupuncture, etc)?	❑ Yes	❑ No
Do you have a heart murmur or condition which routinely requires antibiotics with all surgical or routine dental procedures?	❑ Yes	❑ No

Do you have any other significant medical history? ❑ Yes ❑ No If yes, please write down on the back of this form.

Please list any present medications you are currently taking:

Name	Purpose

Are you taking vitamins containing Folic Acid or Folic Acid supplement? ❑ Yes ❑ No

Do you have allergies to Medications? ❑ Yes ❑ No **If so, please complete the following:**

Medication	Type of reaction	Date

Do you have any other significant allergies?

			Date	Reaction/Symptoms
Latex	❑ Yes	❑ No		
Food(s) such as eggs, peanuts, iodine, shellfish. List: _____	❑ Yes	❑ No		
Environment. List: _____	❑ Yes	❑ No		

Present weight: _____ lbs. Weight 2 yrs ago: _____ lbs. Exposure to significant chemicals or x-rays: ❑ Yes ❑ No

Smoking habits: ❑ Yes Number/day _____; ❑ No If stopped, when _____

Caffeine intake: Cups/day: Coffee _____ Tea _____ Cola _____ Alcohol: Describe your intake: _____

Exercise (type, duration, how often): _____

Use of marijuana, opium or other non-medical or recreational drugs: ❑ Yes ❑ No If yes, ❑ current or ❑ past

Have you ever been the victim of sexual or physical abuse? ❑ Yes ❑ No

If yes, have you received counseling for this? ❑ Yes ❑ No

Please list below any previous hospital admission (for any reason) Medical/Surgical

Where (hospital, city, state)	When	Reason	Treating physician

Please indicate if any of the following have been present to a significant degree, and if so, when (year):

	Yes	No	Date		Yes	No	Date
Anemia	☐	☐		Gallbladder disease	☐	☐	
Bleeding tendency	☐	☐		GI reflux; heartburn	☐	☐	
Asthma/Chronic bronchitis/ Pneumonia	☐	☐		Kidney/Bladder disease (other than infection)	☐	☐	
Blood transfusion	☐	☐		Hot flushes and night sweats	☐	☐	
Breast discharge	☐	☐		Irritable Bowel Syndrome	☐	☐	
Breast lump/cyst	☐	☐		High blood pressure	☐	☐	
Cancer, type _____	☐	☐		Liver disease/hepatitis	☐	☐	
Cardiovascular disease	☐	☐		Ovarian tumors	☐	☐	
Chronic bronchitis	☐	☐		Radiation treatment	☐	☐	
Significant visual disturbances	☐	☐		Significant neurological problems	☐	☐	
Chronic muscle aches/joint pain	☐	☐		Chronic headaches	☐	☐	
Depression	☐	☐		Seizures	☐	☐	
Diabetes	☐	☐		Thyroid problems	☐	☐	

Have you or anyone in your family (and if so, whom) suffered from the following?	**Who**	**When**
Thrombophlebitis (blood clot)		
Pulmonary embolism (blood clot in the lung)		
Blood clot during pregnancy		
Blood clot while on birth control pills		
Any blood clot requiring treatment		
Stroke or heart attack prior to their 50th birthday		
Ever been placed on blood thinners for treatment or suspicion of a blood clot		

V. Family History

Patient's Family	Age	Alive	Deceased	Breast/ Uterine Cancer	Diabetes	Tay Sachs	Downs Syndrome	Sickle Cell	Cystic Fibrosis	Chromosomal	Other Health Problems
Mother											
Father											
Sisters											
Sisters											
Sisters											
Brothers											
Brothers											
Brothers											

Please be aware that our practice does not provide primary care services (for example: pap smears and other routine health screens and issues) and we request that you obtain this care from your primary care physician and/or gynecologist. Please describe the services you hope to receive from our practice:

_____

_____

_____

Please note any other questions or issues which you would like to discuss with your doctor:

_____

_____

The above information is correct.

Signature _____ Date _____

From time to time, television or other media interviewers request to speak to one of our patients concerning advances in treatment or other issues. Although we NEVER give out our patients' names or allow an interview without their permission, please indicate below if you would be willing to be contacted by our office to consider an interview in the future.

❑ Please feel free to contact me concerning an interview. I understand that I will ALWAYS have the right to say no and that my name and/or picture will NEVER be used without my permission.

Women & Infants' Fertility Center
Patient Checklist

- ☐ Medical Records
  - In order for the physician to perform a complete evaluation at the time of my appointment it is necessary to have medical records from my referring doctor in addition to results of all prior testing at the time of the appointment. Please arrange to have any medical records pertaining to your reproductive health, including any operative notes mailed or faxed to our office at least 2 weeks prior to your appointment.
    - Records can be faxed to our confidential fax line by faxing 401-453-7598
    - Records can be mailed to our office Attn: Women & Infants Fertility Center, New Patient Records, 101 Dudley Street, Providence, RI 02905
    - Please contact our office at 401-453-7500 five days prior to your appointment to confirm that your records have been received.
    - Please be aware that due to HIPAA regulations, once we have received your medical records we will be unable to return a copy to you so please retain a copy for yourself

- ☐ Insurance Worksheet
  - I have reviewed the Insurance Worksheet and have contacted my insurance company to see which diagnostic procedures and treatments are covered and whether there are any limitations to treatment. I understanding that it is my responsibilities to know which services are covered by my insurance company, and that the financial counseling staff will assist me in interpreting the coverage if I have any questions.

- ☐ Insurance Referral
  - If my insurance requires a referral, I have obtained it from my primary care physician prior to my visit. They can fax the referral to 401-277-3672.

- ☐ Folic Acid Supplements/Prenatal Vitamins
  - I am aware that both a folic acid supplement and prenatal vitamin are recommended prior to conception. Both of these supplements are available over the counter; please check with your pharmacist if you have any questions.

- ☐ Pre-Conception Screening
  - I have read the enclosed pamphlet on pre-conception counseling and will discuss this with my physician if I choose to proceed. I am aware that my insurance company may not cover the cost of this elective test.

- ☐ Directions
  - I have directions to the office in Providence at 90 Plain Street 4th floor (I am aware that this location is not at the main Women & infants Hospital site) or in East Greenwich at 1050 Main Street.

Women & Infants Fertility Center
Insurance Information & Worksheet

We have found that one of the most common problems that patients face when seeking treatment with us is finding out what treatments their health insurance policy will cover and what their out of pocket expenses for treatment will be.

As it is your responsibility to know what services are covered by your insurance policy, the information provided below can be used as a tool to contact your insurance company directly in order to learn about your coverage prior to your initial consultation. Our financial counseling staff will gladly assist you in understanding and interpreting the coverage to our best ability so you can make informed decisions about your treatment.

If you choose to proceed with treatment at our facility our financial counseling staff will review your insurance coverage to determine if authorization is required and if so we will submit a request for authorization on your behalf. Please be aware that it can take up to 15 business days to obtain authorization so it is important that you speak with a financial counselor as soon as you know that you will begin a treatment cycle. Most insurance carriers require a new authorization with each cycle.

Please note that if you are having any bloodwork done at a facility outside of Women & Infants you must make sure that your care team is aware of this so that your bloodwork is not repeated here.

Please be aware that it is the policy of Women & Infants Hospital that all balances with the hospital must be paid in full prior to proceeding with elective treatment which includes any fertility treatment cycles.

Your services are billed through Care New England's Professional Billing Office (401-273-0641) for office visits and Patient Financial Services (401-921-7200) for bloodwork, ultrasounds, procedures and treatment cycles. If you have questions regarding open balances or if you have questions after receiving a statement for services provided you should contact the appropriate billing office directly for clarification; if you have additional questions after speaking with either of those offices you can call us directly and we will assist you in attempting to resolve any issues.

<u>Questions to ask your insurance company</u>

There are several factors that impact whether you are eligible for infertility treatment. When contacting your insurance carrier please be sure to specify the duration of your infertility, your marital status, and any prior sterilization of yourself and/or your partner (tubal ligation or vasectomy) if applicable.

- Is my physician in-network? (provide your doctor's name). If my physician is not in-network do I have out-of network coverage and if so is my patient financial responsibility higher for out-of network services?
- Is Women & Infants Hospital in-network as a facility?
- Do I have a deductible and/or Out of pocket maximum? Do these run on a calendar year or a plan year basis?
- Do I need a referral from my PCP (Primary Care Physician) in order to seek treatment for infertility from a reproductive endocrinologist? (If yes please contact your PCP and ask them to fax a referral to our office at 401-453-7664).
- Do I have coverage for evaluation and diagnostic testing for infertility including surgery if necessary? (Make sure to indicate that services are being performed in an outpatient facility setting)
- For infertility medications (ie: Clomid, Follistim, Gonal-F, HCG, Repronex, Bravelle)
    - Is prior authorization required?
    - What is my patient financial responsibility (co-insurance)?
    - Is there an annual and/or lifetime maximum for this benefit?
- For the following procedures Artificial Insemination (CPT Code 58322), In Vitro Fertilization (IVF) (S4015 or 58970), Frozen Embryo Transfer (S4016), Cryopreservation (CPT 89258) and ICSI (CPT 89280)
    - Is this a covered service?
    - Is prior authorization required?
    - What is my patient financial responsibility (co-insurance) for these services when performed in an outpatient setting?
    - Is there an annual and/or lifetime maximum for this benefit?
- What is my patient financial responsibility (co-insurance) for bloodwork and ultrasounds performed with an infertility diagnosis when performed in an outpatient setting?

I have received the above information and understand that it is my responsibility to contact my insurance company directly to verify my coverage for any treatment received at the Women & Infants Fertility Center.

_____

Patient Name Patient Signature Date

_____

Hospital Representative Signature Date

INSURANCE BENEFIT VERIFICATION WORKSHEET

Policy is on: ☐ PLAN YR ☐ CALENDAR YR

Deductible: _____ *OOP Max:* _____

Specialist office visit co-pay: _____ *Do I need a specialist referral?* _____

Co-insurance for fertility services performed in an Outpatient Facility: _____

Co-insurance for labs (bloodwork) performed in an Outpatient Facility: _____

Co-insurance for diagnostic imaging (ultrasounds) performed in an Outpatient Facility: _____

Is authorization required for:

- ☐ Intrauterine Insemination (CPT 58322)
- ☐ In-Vitro Fertilization (CPT 4015)
- ☐ Sperm Injection (CPT 89280)
- ☐ Frozen Embryo Transfer (CPT S4016)
- ☐ Cryopreservation (CPT 89258)

Are there any exclusions on my policy? _____

Are there any cycle maximums: _____

*Reference # for call to insurance carrier:*_____

NOTES

_____

_____

Women & Infants' Fertility Center
Patient Demographic Worksheet

In order to ensure that you are registered completely and accurately please complete the following worksheet, including information for both yourself and your partner if your partner will be doing any testing with us here at our facility.

Patient Information

Name:	**DOB:**	**SS#**	
Address: If same as patient circle SAME			
Home Phone:	**Cell Phone:**	**Work Phone:**	**Email address**
Hispanic Latino (circle one) ☐ Yes ☐ No	**Marital Status** (circle one) ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Separated ☐ Widowed	**Race** (circle one) ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Cambodian ☐ Chinese ☐ Native Hawaiian/Pacific Islander ☐ Vietnamese ☐ White	
Preferred Language:		Multiracial _____ Other _____	
Employer and Address		**Work Status** (circle one) ☐ Full Time ☐ Part Time	
Insurance 1 (Carrier and ID)	**Subscriber**	**Subscriber DOB**	**Subscriber's Employer**
Insurance 2 (Carrier and ID)	**Subscriber**	**Subscriber DOB**	**Subscriber's Employer**

Partner Information

Name:	**DOB:**	**SS#**	
Address: If same as patient circle SAME			
Home Phone:	**Cell Phone:**	**Work Phone:**	**Email address**
Hispanic Latino (circle one) ☐ Yes ☐ No	**Marital Status** (circle one) ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Separated ☐ Widowed	**Race** (circle one) ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Cambodian ☐ Chinese ☐ Native Hawaiian/Pacific Islander ☐ Vietnamese ☐ White	
Preferred Language:		Multiracial _____ Other _____	
Employer and Address		**Work Status** (circle one) ☐ Full Time ☐ Part Time	
Insurance 1 (Carrier and ID) If same as patient circle SAME	**Subscriber**	**Subscriber DOB**	**Subscriber's Employer**
Insurance 2 (Carrier and ID) If same as patient circle SAME	**Subscriber**	**Subscriber DOB**	**Subscriber's Employer**

Women & Infants
A MEMBER OF CARE NEW ENGLAND

Women & Infants' Reproductive Medicine
90 Plain Street Providence, RI 02903
(401) 453-7500 Fax: (401) 453-7956

Authorization For Release of Confidential Information FOR YOUR PARTNER

Periodically, to provide optimal care and review your previous history and treatment, it is important to obtain your medical records from other physicians or hospitals. In a similar fashion, we attempt to keep your physician(s) informed of tests and results that they would like to obtain. By signing this form now, you are giving us permission to send these results to your physician(s) to allow for the best communication between our offices. To help us in this, we would appreciate it if you would sign this release form. We are also requesting your permission to talk to your partner about your results.

PARTNER'S Name:_____ DOB: _____

Address:_____

Treatment Date (s) to be disclosed: _____

1. I hereby authorize Center for Reproduction and Infertility, Women & Infants Hospital:
____Obtain From (Please include your current and any prior Gynecologist or other appropriate doctors along with their address: _____
_____

___Release To My Current Health Care Providers (e.g. Gynecologist or other appropriate doctors along with their address):_____
_____

2. All the following from my record **EXCEPT** (be specific :)

☐ Lab Results	☐ Psychiatric Evaluation	☐ Medication	☐ Assessment
☐ Treatment plan	☐ Discharge Summary	☐ Progress Reports	☐ Physical Examination
☐ Urine Drug	☐ Radiology Procedures/Films	☐ Other: _____	

3. I understand that this information is needed for the purpose of my assessment and co-ordination of current and ongoing care.

_____

4. I understand that my records are protected under applicable State and Federal confidentiality regulations, including but not limited to, HIPAA, 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment, RI Mental Health Law and RI General Laws ch. 5-37.3 and cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand this consent to disclose may be revoked by me at anytime in writing, except to the extent that action has already been taken. This consent, unless revoked earlier in writing, will expire **1 (one) year** from date of signature.

5. I give permission to the Center for Reproduction and Infertility to discuss my confidential healthcare information, including test results, with my partner, _____
My limitations are: _____

_____
Signature of PARTNER Date

_____
Signature of Witness Date: