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: _____

BROWN
Alpert Medical School

Division of Reproductive Endocrinology and Infertility
Women & Infants Hospital

Professor of Obstetrics and Gynecology
Warren Alpert Medical School of Brown University

Re: Research Study at Women & Infants' Fertility Center to Help with Stress

Dear Patient:

We are writing to see if you would like to participate in a new research study being conducted by the physicians at Women & Infants' Fertility Center. Although all of the physicians have agreed that their patients may participate, Drs. Ozcan and Frishman are running the study. Research plays an important role in advancing our understanding of clinical care and helps lead to improvements in the healthcare that we are able to provide.

Although more detailed information is provided below, essentially we are looking at a resource to help with the emotional stress and well-being associated with infertility. This study will be a randomized controlled trial. This means that approximately half of the participants will be randomized (chosen by chance) to receive this resource and the other half will be randomized to our current routine care with access to all of our traditional resources. Importantly, although the resource being studied was designed for couples in a heterosexual relationship and our study design reflects that, based on our strong belief and privilege in treating all patients, all patients and their partners (if applicable) are welcome and encouraged to participate.

If you are interested in learning more about this study, please go to the link listed below to find a time and date that works for you to talk to one of the physician investigators. It is important that your partner (if applicable) be available to participate in that conversation as we are requesting their participation as well so please choose your time accordingly. Of note, this scheduling software program is HIPAA-compliant, meaning that your personal information will not be available to anyone outside of the investigators. By scheduling this appointment, you are giving us permission to call you on the phone number that you provide us as well as to access your electronic medical record. As noted elsewhere, your decision to participate or not participate in the study will not in any way impact the care by your providers. Furthermore, your primary physician in our office will not be aware of whether you choose to participate unless you choose to share this with them.

To schedule a time/date: https://fertilityqol.clientsecure.me

Study Purpose:
Infertility can be stressful and impact one's emotional wellbeing. Although our practice offers resources to help address this, there is no one accepted resource that can be utilized independently at one's convenience outside of support groups and healthcare-related providers such as psychologists and social workers. We are studying the benefit of a web-based resource with accompanying written material on the emotional well-being of patients with infertility care. In this randomized controlled trial, approximately half of participants will receive the material, alongside our routine care, and the other half will receive routine care with all of the traditional

Address reply to: Women & Infants Hospital of Rhode Island, 101 Dudley Street, Providence, RI 02905-2499
Telephone: (401) 430-8467 • Fax: (401) 276-7845 • E-mail:Gary_Frishman@brown.edu

resources. Your treating physicians will not know whether or not you are participating in the study, much less which arm, and your participation or decision to not participate will not impact your care in any way.

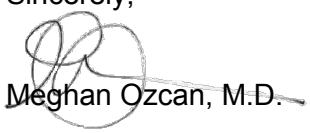
Participation Requirements:
Women age 18 to 45 are eligible to participate along with their partners (if applicable). Since this resource is currently available only in English, fluency in English is required. All of your participation will be outside of the office via the internet and, regardless of which group you are assigned, will consist of answering questions online upon entry into the study and at 3, 6, and 12 months. It is not anticipated that there will be any risk or side effects associated with participation in this study, but resources will be available for participants desiring additional help with their emotional health.

Compensation:
It is anticipated that you will not incur any costs for participation, and participants will not be given any compensation for enrolling. If you are randomized (chosen by chance) to use this emotional support resource, there will be no charge for this throughout the 12-month planned enrollment. Women choosing to utilize the resource after the year may do so through the third-party vendor. Of note, the researchers involved in this study have no financial interest in this resource and are not receiving any financial or other compensation for this investigation

Contact Information:
Please remember that participation is completely voluntary and you can choose to be in the study or not. If you are interested in participating in this study or learning more about it, please use the following link to schedule a convenient time for us to call you. It is important that your partner (if applicable) be available as well. It is anticipated that this call will take approximately 45 minutes.

https://fertilityqol.clientsecure.me

Sincerely,



Meghan Ozcan, M.D. and Gary Frishman, M.D.

Women & Infants' Fertility Center
Division of Reproductive Endocrinology and Infertility
The Warren Alpert Medical School of Brown University

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.

40594

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

CENTER FOR REPRODUCTION AND INFERTILITY
INFERTILITY QUESTIONNAIRE

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-769 (8-2014)

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: _____

Birth Date: _____ Age: _____

Home phone number: _____ Cell number: _____

Work phone number and hours: _____ ext._____ Hours: _____

Pharmacy name and phone number: _____

Chief Complaint (reason for visit): _____

If Infertility, duration (years): _____

BASIC INFORMATION

Who referred you?_____

Who is your gynecologist if different from above? _____

What is your occupation? _____

Are you ☐ married date_____ ☐ single ☐ long-term relationship ☐ other:_____

What is your partner's name? _____

What is your partner's birth date? _____

How many years have you been with your present partner? _____

What is your partner's occupation? _____

HEALTH STATUS

Do you have any allergies to any medicines? _____

If so, what are the allergic reactions? _____

Do you take any current medications (including vitamins & folic acid)? _____

MENSTRUAL HISTORY

What was your last menstrual period? _____

How old were you when you started your periods?_____

How many days between the first day of one period and the first day of the next period? _____

Would you describe your periods as: ☐ heavy ☐ moderate ☐ light

Are your periods: ☐ regular ☐ irregular

Are your periods painful? ☐ yes ☐ no

Would you describe that pain as: ☐ moderate ☐ severe ☐ mild

GYNECOLOGIC HISTORY

Do you have hair on your face that is concerning? ☐ yes ☐ no

Do you have acne? ☐ yes ☐ no

Do you use lubricants for sex? ☐ yes ☐ no

What type: _____

Do you douche? ☐ yes ☐ no

Do you have pain with intercourse? ☐ yes ☐ no

Have you ever had an abnormal pap smear? ☐ yes ☐ no
Have you had a pelvic infection? ☐ yes ☐ no
Have you had any sexually transmitted diseases? ☐ yes ☐ no
Have you ever used any contraception? ☐ yes ☐ no
If yes, please check: ☐ oral contraceptives ☐ IUD ☐ condoms ☐ other: ______________________

How often do you have sex? ____________________

SOCIAL HISTORY

Do you smoke? ☐ yes ☐ no
If yes, how many cigarettes per day? __________
Do you drink caffeine? ☐ yes ☐ no
If yes, how many cups per day? __________
Do you drink alcohol? ☐ yes ☐ no
If yes, how many drinks per week? __________
Do you take recreational drugs? ☐ yes ☐ no
Do you exercise? ☐ yes ☐ no
If yes, how many hours per week? __________

OBSTETRICAL HISTORY

How many times have you been pregnant? __________
For each pregnancy, please fill in the following chart:

	#1	#2	#3	#4
Month/year pregnancy ended				
Pregnancy outcome	☐ Vaginal delivery ☐ C-section ☐ Miscarriage w/ D&C ☐ Miscarriage w/o D&C (# of weeks: _____) ☐ Termination ☐ Ectopic/Tubal	☐ Vaginal delivery ☐ C-section ☐ Miscarriage w/ D&C ☐ Miscarriage w/o D&C (# of weeks: _____) ☐ Termination ☐ Ectopic/Tubal	☐ Vaginal delivery ☐ C-section ☐ Miscarriage w/ D&C ☐ Miscarriage w/o D&C (# of weeks: _____) ☐ Termination ☐ Ectopic/Tubal	☐ Vaginal delivery ☐ C-section ☐ Miscarriage w/ D&C ☐ Miscarriage w/o D&C (# of weeks: _____) ☐ Termination ☐ Ectopic/Tubal
With current partner?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Time it took to get pregnant?				
Infertility Therapy				
Sex of Baby	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female
Weight of Baby				
Pregnancy complications	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

PRIOR FERTILITY TESTING AND MEDICATION

Have you used any of the following, please check:
- ☐ Basal body temp monitoring
- ☐ Ovulation predictor kit
- ☐ Artificial insemination ☐ partner ☐ donor
- ☐ Clomiphene
- ☐ Femara/Letrozole
- ☐ Gonadotropins (fertility shots)
- ☐ In Vitro Fertilization

Have you ever had an x-ray (HSG) of your uterus and tubes? ☐ yes ☐ no

If yes, where was it done? ☐ WIH or ☐ elsewhere _____ Please bring disk/images with you.

What were the results? _____

Have you ever had a sonohysterogram (ultrasound with saline) of your uterus and tubes? ☐ yes ☐ no

If yes, where was it done? ☐ WIH or ☐ elsewhere _____ Please bring disk/images with you.

What were the results? _____

Has your partner had a semen analysis? ☐ yes ☐ no ☐ N/A

If yes, where was it done? ☐ WIH or ☐ elsewhere _____

If yes, what were the results? _____

PAST MEDICAL HISTORY

Do you have antibiotic therapy before dental work or a surgical procedure to protect your heart? ☐ yes ☐ no

Do you have a history of clots in your legs or lungs? ☐ yes ☐ no

Have you had a stroke or heart attack? ☐ yes ☐ no

Have you ever been told you had any of the following?

Anemia	☐ yes ☐ no
Bleeding tendency	☐ yes ☐ no
Prior blood transfusion	☐ yes ☐ no
Lung disease	☐ yes ☐ no
Heart disease	☐ yes ☐ no
High blood pressure	☐ yes ☐ no
Cancer	☐ yes ☐ no

If yes, type and treatment _____

Chronic headaches	☐ yes ☐ no
Seizures	☐ yes ☐ no
Depression	☐ yes ☐ no
Diabetes	☐ yes ☐ no
Thyroid disease	☐ yes ☐ no
Gall bladder disease	☐ yes ☐ no
Stomach reflux (GERD)	☐ yes ☐ no
Irritable bowel syndrome	☐ yes ☐ no
Liver disease/Hepatitis	☐ yes ☐ no
Infection in your kidneys/bladder	☐ yes ☐ no

PREVIOUS HOSPITALIZATIONS OR INPATIENT/OUTPATIENT SURGERIES

Please list any time you were in the hospital, the reason, and the year; list all your surgeries as well.

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

GYNECOLOGIC SURGERY

If you have had any of the following, please list the dates:			Date
Tubes and ovaries removed	☐ yes	☐ no	_____
D&C; cone	☐ yes	☐ no	_____
D&C, Leep	☐ yes	☐ no	_____
Treatment of endometriosis, medical or surgical	☐ yes	☐ no	_____
Hysteroscopy (view inside of uterus)	☐ yes	☐ no	_____
Laparoscopy (view inside abdominal cavity and pelvis)	☐ yes	☐ no	_____
Lysis of adhesions (scar tissue removal)	☐ yes	☐ no	_____
Fibroid removal	☐ yes	☐ no	_____
Hysterectomy (uterus removal)	☐ yes	☐ no	_____
Cutting of a uterine septum	☐ yes	☐ no	_____
Tubal ligation	☐ yes	☐ no	_____
Tubal ligation reversal	☐ yes	☐ no	_____

FAMILY HISTORY

	Age	Living	# of miscarriages	Cancer	Chromosomal	Diabetes	High blood pressure
Mother		☐ yes ☐ no		☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Father		☐ yes ☐ no		☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Sister		☐ yes ☐ no		☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Sister		☐ yes ☐ no		☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Brother		☐ yes ☐ no		☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Brother		☐ yes ☐ no		☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

PARTNER'S HISTORY

Has your partner had any pregnancies with another partner? ☐ yes ☐ no

Does your partner use recreational drugs? ☐ yes ☐ no

Does your partner smoke or use tobacco? ☐ yes ☐ no

Does your partner drink alcohol? ☐ yes ☐ no

Drinks per week: _____

Drinks per month: _____

Has your partner ever had a sexually transmitted disease? ☐ yes ☐ no

Is your partner allergic to any medications? ☐ yes ☐ no

What medicines does your partner now take? _____

REVIEW OF SYSTEMS

Do you have any of the following:

Fever	☐yes ☐no	Cough	☐yes ☐no
Chills	☐yes ☐no	Coughing up phlegm	☐yes ☐no
Sweats	☐yes ☐no	Coughing up blood	☐yes ☐no
Loss of appetite	☐yes ☐no	Wheezing	☐yes ☐no
Tiredness	☐yes ☐no	Nausea	☐yes ☐no
Weight loss	☐yes ☐no	Vomiting	☐yes ☐no
Blurred vision	☐yes ☐no	Diarrhea	☐yes ☐no
Double vision	☐yes ☐no	Constipation	☐yes ☐no
Burning eyes	☐yes ☐no	Change in bowel habits	☐yes ☐no
Discharge from your eyes	☐yes ☐no	Abdominal pain	☐yes ☐no
Loss of vision	☐yes ☐no	Blood in your stools	☐yes ☐no
Eye pain	☐yes ☐no	Black stools	☐yes ☐no
Pain with bright lights	☐yes ☐no	Yellow skin	☐yes ☐no
Ear pain	☐yes ☐no	Yellow eyes	☐yes ☐no
Ear discharge	☐yes ☐no	Vaginal discharge	☐yes ☐no
Ringing in your ears	☐yes ☐no	Loss of urine	☐yes ☐no
Decreased hearing	☐yes ☐no	Painful urine	☐yes ☐no
Blockage of your nose	☐yes ☐no	Blood in your urine	☐yes ☐no
Nosebleeds	☐yes ☐no	Frequent urination	☐yes ☐no
Sore throat	☐yes ☐no	No menstrual periods	☐yes ☐no
Hoarseness	☐yes ☐no	Abnormal vaginal bleeding	☐yes ☐no
Difficulty swallowing	☐yes ☐no	Pelvic pain	☐yes ☐no
Chest pain	☐yes ☐no	Back pain	☐yes ☐no
Fast heartbeat	☐yes ☐no	Joint pain	☐yes ☐no
Fainting	☐yes ☐no	Joint swelling	☐yes ☐no
Difficulty breathing	☐yes ☐no	Muscle cramps	☐yes ☐no
Difficulty breathing while you're laying down	☐yes ☐no	Muscle weakness	☐yes ☐no
Swelling of your feet or hands	☐yes ☐no	Stiffness or pain in your joints	☐yes ☐no
Itching	☐yes ☐no	Paranoia	☐yes ☐no
Rash	☐yes ☐no	Cold intolerance	☐yes ☐no
Dryness	☐yes ☐no	Heat intolerance	☐yes ☐no
Suspicious lesions on skin	☐yes ☐no	Excessive drinking	☐yes ☐no
Unable to move arms or legs	☐yes ☐no	Excessive eating	☐yes ☐no
Weakness	☐yes ☐no	Excessive urination	☐yes ☐no
Tingling in fingers, toes, arms or legs	☐yes ☐no	Weight change	☐yes ☐no
Seizures	☐yes ☐no	Abnormal bruising	☐yes ☐no
Fainting	☐yes ☐no	Bleeding	☐yes ☐no
Shaking	☐yes ☐no	Enlarged lymph nodes	☐yes ☐no
Dizziness	☐yes ☐no	Hives	☐yes ☐no
Depression	☐yes ☐no	Hayfever	☐yes ☐no
Anxiety/nervous condition	☐yes ☐no	Persistent infections	☐yes ☐no
Memory loss	☐yes ☐no	HIV exposure	☐yes ☐no
Mental illness	☐yes ☐no		
Suicidal thoughts	☐yes ☐no		
Hallucinations	☐yes ☐no		

BACKGROUND INFORMATION

1. Have you ever had or been vaccinated for Chicken Pox? ☐yes ☐no
2. Have you ever had or been vaccinated for Hepatitis? ☐yes ☐no
3. Have you ever been vaccinated for Rubella (German Measles)? ☐yes ☐no
4. Do you or your partner or any family member have a birth defect? ☐yes ☐no
   If yes, who has the defect and what is it? _____
5. Have any of your previous pregnancies, if any, resulted in a birth defect? ☐yes ☐no
   If yes, what was the defect? _____
6. Do you or your partner or any family member have Cystic Fibrosis? ☐yes ☐no
   If yes, who has cystic fibrosis? _____
7. Do you or your partner or any family member have Down Syndrome? ☐yes ☐no
   If yes, who has Down Syndrome? _____
8. Do you or your partner or any family member have hemophilia? ☐yes ☐no
   If yes, who has hemophilia? _____
9. Do you or your partner or any family member have Muscular Dystrophy? ☐yes ☐no
   If yes, who has Muscular Dystrophy? _____
10. Do you or your partner or any family member have a neural tube defect? ☐yes ☐no
    If yes, who has the defect and what is it? _____
11. Do you or your partner or any family member have any other chromosomal abnormalities? ☐yes ☐no
    If yes, who has the abnormality and what is it? _____
12. Do you or your partner or any family member have mental retardation? ☐yes ☐no
    If yes, who has mental retardation? _____
13. Are you or your partner of Ashkenazi Jewish ancestry? ☐myself ☐partner ☐both ☐yes ☐no
    If yes, have you/partner been screened for Tay-Sachs disease? _____
    Cystic Fibrosis? _____
    If yes, indicate who and the results: _____
14. Are you or your partner black? ☐myself ☐partner ☐both ☐yes ☐no
    If yes, have you/partner been screened for sickle cell? _____
    If yes, indicate who and the results: _____
15. Are you or your partner of French-Canadian ancestry? ☐myself ☐partner ☐both ☐yes ☐no
    If yes, have you/partner been screened for Tay-Sachs disease? _____
    Cystic Fibrosis? _____
    If yes, indicate who and the results: _____
16. Are you or your partner of Italian, Greek, Portuguese or Mediterranean background? ☐yes ☐no
    ☐myself ☐partner ☐both
    If yes, have you/partner been tested for ß-thalaseemia? _____
    If yes, indicate who and the results: _____
17. Are you or your partner of Philippine, Southeast Asian, or Indian ancestry? ☐yes ☐no
    ☐myself ☐partner ☐both
    If yes, have you/partner been screened for α-thalaseemia? _____
    If yes, indicate who and the results: _____

Form completed by

Name: _____

Date: _____ Time: _____

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 Multiracial _____ Other _____	
Preferred Language:			
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 Multiracial _____ Other _____	
Preferred Language:			
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:

EXHIBIT A

REQUEST FOR COMMUNICATION VIA EMAIL
BETWEEN PATIENT AND HEALTH CARE PROVIDER

Patient's Name:_____ Patient's DOB:_____
(mm/dd/yyy)

Patient's Home Address: _____

_____

Patient's Primary Phone Number:_____

Patient's Email Address:_____

Care New England –Individual Provider/Practice Provider/Hospital Provider ("Provider")***:_____
Women & Infants Fertility Center, Women & Infants Hospital, 101 Dudley Street, Providence, RI 02905
Fax: 401-453-7598

Listing a Practice Name or Hospital will allow the clinicians in the named practice or hospital, or an appropriate designee of such clinician, to communicate with you by email

I, the patient (or representative of the patient) identified above, request the Provider identified above to communicate private medical information concerning me (or the patient) via email. I make this request with the understanding that communication by email is not considered secure, and that the use of email creates a risk that private information may be misdirected, disclosed to or intercepted by unauthorized or unintended recipients. **I hereby certify that I have read and understand the Risks of Communicating Private Information by Email, which appears on the reverse side of this document, and I further agree that**:

- **I will not use email for medical emergencies or other time-sensitive matters.**
- I have reviewed the email address indicated above, and I confirm that it is correct and accurate, and I confirm that it is my private email address and not that of a relative, friend, employer or other party. I will promptly inform the health care provider identified above of any change to my email address.
- I acknowledge that any email exchanged between me and the Care New England Health System or any of its health care providers may be included in my medical record.
- I understand that Care New England Health System and/or Providers may use and/or disclose my emails and their contents to the same extent such Providers may use and disclose protected health information in other forms.
- I will not use any social media (e.g., Facebook, Twitter, etc.) to communicate with the Provider.
- **I may request to receive unencrypted emails but such request must be in writing, via email or other documentation.**
- I may revoke this request, but my revocation will not be effective unless and until it is communicated in writing to the health care provider identified above.
- I acknowledge that I have read and understand this form, and I understand the risks associated with the communication between a Provider and me. I shall hold Care New England Health System and its hospitals and other affiliated organizations and health care providers, as well as the employees, agents, officers, medical staff members, directors and representatives of all such organizations, harmless from any and all claims and liabilities arising from or related to this request for communication via email.

RISKS RELATED TO COMMUNICATING PRIVATE INFORMATION BY EMAIL

Before requesting that any Provider use email to communicate with you about your protected health information, you must read the information that appears below. Please ask for an explanation if any part of this document is unclear.

- If you request, via email or otherwise, unencrypted emails, you should be aware that sending an unencrypted email is like sending a post card through the U.S. Mail without enclosing it in an envelope. The content of the email is visible to others while it travels from the sender to the recipient. Therefore, when using unencrypted emails you should exclude from your email communication any information that you would not want other parties to know.
- The Provider might not see an email you send to him or her or might not be able to read your mail for a long time until after you send it. Therefore, if you believe you might have an illness, injury or other condition that might require prompt attention, you should not rely on email to request service. Instead, you should seek medical attention through other means.
- You should not use email to communicate sensitive medical information, such as information concerning sexually transmitted diseases, AIDS/HIV, developmental disabilities, mental health or substance abuse.
- Email messages sent from or received on a computer, smart phone or other device may be visible to other users of that device. Therefore, you should avoid accessing or sending health information or other private information on a device that you do not own or control, such as a computer at your work place.
- Emails sent from or received at a non-private email address, such as an address on an employer's email system, are generally visible to others. Therefore, you should only use your own, private email address to send or receive private information.
- Email users sometimes make mistakes in typing the recipient's email address. Accordingly, the misdirection of an email message to an unintended recipient may easily occur.
- Once you send an email, you may not cancel the email or stop its transmission.

Patient's Signature: _____

(Print and Sign)

_____ _____

Signature of Patient/Representative Date

_____ _____

Representative's Name (printed) Relationship to Patient