NEW PATIENT QUESTIONNAIRE

Date: _____Name: _____Age/DOB_____

Marital Status: Single_____ Married_____ Prior Marriage: Wife____Husband_____

Referred by: _____

I. OBSTETRICAL HISTORY

Pregnancy Year	Length of Time to Conceive	Miscarriage Or abortion?	Current partner the father?	Complications
1.				
2.				
3.				
4.				
5.				

II. FERTILITY HISTORY

How many years have you been attempting pregnancy? _____

If married, how many years have you been married? _____

Have you ever been evaluated for infertility? Yes No

Who was your physician(s)? _____

What cause(s) of infertility was diagnosed? _____

Previous Fertility Treatment

Which drugs have you taken or treatments done for infertility? _____ None

___ Clomiphene Citrate (Clomid, Serophene)
___ Letrozole (Femara)
___ Repronex, Menopur, or Bravelle
___ Gonal-F, Follistim, or Luveris
___ hCG (Ovidrel, Pregnyl, Novarel)
___ Follicle monitoring with sonograms
___ Artificial Insemination: # cycles ___
___ Progesterone supplements
___ Acupuncture
___ Prednisone or Dexamethasone
___ Bromocriptine (Parlodel) or Dostinex
___ Danazol (Danocrine)
___ Lupron, Antagon/Cetrotide
___ In Vitro Fertilization: # cycles ___

_____

_____

_____

_____

Ovulation Assessment

Age period started_____ Date of last normal period_____

How many days do your periods last? _____

How many periods do you have in a year? _____

Do you ever "skip" periods? Explain. _____ Yes No

Have you ever taken birth control pills? If yes, what ages? _____Yes No

When (Month/Year) did you last take birth control pills? _____

Do you have any history of anorexia, bulimia (eating disorders)? _____Yes No

Thyroid Disease

Do you have (or had) thyroid disease? Explain. _____ Yes No

Galactorrhea/Hyperprolactinemia

Do you have (or had) nipple discharge? Yes No

Milky or Watery (clear), spontaneous or manually expressed (only)

Explain _____

Hirsutism

Do you have any hair growth you consider abnormal? (please circle) face, upper lip, chin, chest, nipples, lower abdomen? Yes No

If yes, how long has this been present? _____ years

If yes, how often do you shave, use depilatory creams, pluck, or undergo electrolysis?

Explain _____

Ovulation Monitoring/Testing

Can you tell when you are ovulating based on your physical symptoms? Yes No

Have you conducted any of the following tests?

___ Progesterone level (blood test) Results _____

___ Endometrial biopsy _____

___ Basal body temperature chart? _____

Have you used any ovulation predictor kits? Yes No

If yes, which brands have you used? _____

_____

If yes, which cycle days do you usually surge? _____

Do you find that the kits are reliable? Yes No

Uterotubal Assessment

Have you had a hysterosalpingogram or HSG (x-ray day test of the uterus)? Yes No

When _____

Results _____

Have you had a sexually transmitted disease or an infection in your pelvis or fallopian tubes? Yes No

i. e, pelvic inflammatory disease, Chlamydia, Gonorrhea, Syphilis, or Herpes.

Explain _____

Have you been diagnosed as having endometriosis? Yes No

Explain _____

Have you been diagnosed as having uterine fibroids? Yes No

Explain _____

Pelvic Pain

Do you suffer from pelvic pain? Yes No

Do you have painful cramps with your periods? Yes No

Are your cramps mild? moderate? severe?

Do you take pain medication for cramps? Which one (s) _____ Yes No

Do you experience painful intercourse? Yes No

Explain _____

Cervical Assessment

Have you had a postcoital test? Results _____ Yes No

Have you had surgery on your cervix, i.e., biopsy or conization? Yes No

Explain _____

Do you use lubricants for intercourse? Yes No

How many times per week do you and your partner have intercourse? _____

Male Factor Assessment

Husband's Name: _____ Age & Date of Birth_____

Has your husband been responsible for previous pregnancies (including miscarriages)? Yes No

Explain _____

Does your husband take any medications on a chronic basis? Yes No

Which medications? _____

Has your husband's sperm been tested? Yes No

Results _____

_____

Has your husband had genital surgery, or infections? Yes No

Explain _____

Does your husband smoke? Yes No

Use alcohol? # drinks per week_____ Yes No

Use illicit drugs? Yes No

Does your husband have medical allergies? _____ Yes N

Current occupation:_____ Previous_____

III. CURRENT MEDICATIONS- Wife (include dosage, frequency, and any over-the-counter drugs)

_____

_____

IV. MEDICATION ALLERGIES- Wife only

_____

Other allergies: _____

V. YOUR PAST MEDICAL HISTORY

Check any conditions that you had or currently have:

	Yes	No		Yes	No		Yes	No
Mitral Valve Prolapse	( )	( )	Diabetes	( )	( )	Stroke	( )	( )
Mental Disorder	( )	( )	Thyroid Disease	( )	( )	Liver or Gallbladder Disease	( )	( )
Arthritis	( )	( )	Heart Disease	( )	( )	High Blood Pressure	( )	( )
Asthma	( )	( )	Rheumatic Fever	( )	( )	Chronic Bronchitis	( )	( )
Ulcers	( )	( )	Phlebitis or Blood Clots	( )	( )	Blood disorder	( )	( )
Crohn's Disease	( )	( )	Seizures	( )	( )	Broken Bones	( )	( )
Ulcerative Colitis	( )	( )	Kidney Disease	( )	( )	Migraine Headaches	( )	( )

Explain _____

_____

Please list other physicians currently involved with your care: _____

_____

_____

VI. SURGICAL HISTORY

Surgeries/Hospitalization (dates): _____

_____

_____

VII. GYNECOLOGIC HISTORY:

Date of last Pap smear _____ ☐ Normal ☐ Abnormal

Date of last mammogram_____ ☐ Normal ☐ Abnormal ☐ Never done

Do you have a history of:	Yes	No	Explain
Abnormal Pap smears	( )	( )	_____
Breast lump or mass	( )	( )	_____

VIII. SOCIAL HISTORY

Current Occupation: _____ Previous_____

Habits:

Tobacco: packs/day_____ Non-smoker_____ Previous smoker_____

Alcohol: (circle one) Drinks per: Day_____ Week_____ Month_____ Year_____ Non-drinker_____

Caffeine: Number of beverages per day _____ Illicit drugs: _____

IX. FAMILY HISTORY:

Check if any blood relative has had:

	Yes	No		Yes	No		
Down Syndrome	( )	( )	Heart Disease	( )	( )	English/Irish	( )
Sickle Cell	( )	( )	High Blood Pressure	( )	( )	Greek/Italian	( )
Thalassemia	( )	( )	Endometriosis	( )	( )	Ashkenazi/Jewish	( )
Tay Sachs	( )	( )	Kidney Disease	( )	( )	African Descent	( )
Hemophilia	( )	( )	Diabetes	( )	( )	French Canadian	( )
Cystic Fibrosis	( )	( )	Uterine Fibroids	( )	( )	Other:_____	
Muscular Dystrophy	( )	( )	Tuberculosis	( )	( )	_____	
Mental Retardation	( )	( )	Cancer	( )	( )		
Polycystic Kidney	( )	( )	Mental Disorder	( )	( )		
Hydrocephalus(water on the brain)	( )	( )	Seizures	( )	( )		
Spina bifida(defect of the spine)	( )	( )	Thyroid Disease	( )	( )		
Birth Defects	( )	( )					

	Age	Living	Deceased	Health or Cause of Death
Father				
Mother				
Siblings				

X. REVIEW OF SYSTEMS

Do you have (please circle):

Constitutional: fever, chills, sweats, loss of appetite, rapid with loss, fatigue, or NONE

Eyes: vision loss, change in vision, or NONE

Ears/Nose: poor sense of smell, decreased hearing, or NONE

Throat: difficulty swallowing, chronic sore throat, hoarseness, or NONE

Cardiovascular: chest pains, palpitations, fainting spells, or NONE

Respiratory: chronic cough, shortness of breath, produce blood with coughing, wheezing, or NONE

GI: nausea, vomiting, abdominal pain, changes in stool, diarrhea, constipation, or NONE

GU: recurrent (>2/year) bladder infections, blood in urine, incontinence, or NONE

Psychiatric: depression, anxiety, or NONE

XI. COMMENTS:

_____

_____

_____

_____

_____

Robert A. Kaufmann, M.D.
Fort Worth Fertility, PA
1800 Mistletoe Blvd.
Ft. Worth, TX 76104
Phone: 817-348-8145
Fax: 817-348-8264

AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Please sign, date, and fax in ALL of the consent forms with the rest of your paperwork. A FWF employee will complete the "Witness" signatures where applicable at the time of your appointment. Thank you.

Payment for professional services are due at the time services are provided.

We accept cash, personal checks and most major credit cards.

INSURANCE

It is your responsibility to know what you insurance covers and does not cover. You are ultimately responsible for all charges not covered by your insurance. Some insurance plans limit the number of procedures they will cover within a treatment cycle, so there may be times when not all procedures done will be covered by your insurance.

If we have received all of your insurance information 48 hours prior to the day of the appointment and we are able to confirm eligibility, we will be happy to file claims on your behalf for covered services. The accuracy of all the information we receive is essential for proper claim filing. We will assist you in estimating your portion of the fee for services; however we cannot guarantee what your insurance company will pay on a claim. Please understand that filing your claims is a courtesy our office provides to our patients, it does not guarantee payment to us. We are providing our professional services to you—not the insurance company. Consequently, you are ultimately responsible for payment of our fees.

For example, if your insurance states that they will cover diagnostic testing only, this means that they will not pay for the midcycle or follicular ultrasound of a treatment cycle. This particular type of ultrasound would be considered self-pay. A treatment cycle is considered a cycle with the intent of assisting a couple conceive. For example any cycle requiring an insemination or use of fertility medications such as clomid other than a clomid challenge test and gonadotropins (example Follistim/Gonal-F)

If your insurance company does not offer treatment benefits we offer treatment cycles at a discounted prepaid price (global fee). You may also pay a fee for service price for each of your visits. In this situation your insurance will not be billed for these services. If you chose to pay a global fee and your cycle is not completed for some reason you may be refunded the balance of that cycle. The balance is calculated on a fee for service charge based on the services provided. For example: if you pay a global fee for an insemination cycle and the cycle is cancelled for some reason after you had two ultrasounds performed, we would calculate the fee for service for the two ultrasounds and office visits and subtract this from your global and refund the difference.

Outstanding balances must be paid otherwise you will not be allowed to initiate a treatment cycle.

If your insurance company pays for only diagnostic testing and you ask them if they cover ultrasounds they may say they cover this service. They will, however not cover this service if it is for treatment of infertility. It is difficult for them to know if this treatment by just the diagnostic code. The charge is billed to your insurance for treatment and you do not have this coverage then this would be considered fraud and we would be liable for excessive fines or other formal actions.

It is this important that you understand your insurance your insurance benefits before starting treatment.

It will be an advantage for you to obtain a copy of your insurance policy and contact your insurance company to determine benefits for infertility and IVF. If you believe you have coverage for IVF treatments it will be your responsibility to obtain written confirmation of benefits covering the treatment (predetermination letter) before you undergo the procedure. If you do not have this letter before you start your cycle (i.e.: lupron start) you will need to pay a global fee or wait for a subsequent cycle start. We have available a form letter you can use for this purpose. We will need a copy of written verification of the predetermination letter before the start of your cycle.

BENEFITS ARE NOT DETERMINED BY OUR OFFICE

You may have noticed that sometimes your medical insurer reimburses you or the doctor at a lower rate than the doctor's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your doctor's fee has exceeded the usual, customary, or reasonable fee (UCR) used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most doctors in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR fee. Frequently, this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20-30% profit.

Unfortunately, insurance companies imply that your doctor is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Once the physician has determined your treatment protocol, FWF at your request, will provide you with a financial visit to discuss the upcoming treatment and identify charges for expected procedures. However, once treatment begins, unique patient situations sometimes require additional procedures. These additional procedures may not be announced to you as "additional" by our clinician, as they are providing you with care based solely upon your individual needs. (These procedures for example may relate to extra ultrasounds and blood tests to monitor effects of medication during ovarian stimulation.)

Unless you have a written agreement with FWF, all prices quoted to you are quoted under a fee-for-service arrangement. Under the fee for service arrangement, you will be charged for all of the services provided by FWF, and you will not be entitled to a refund in the event that, for any reason, the treatment is not successful. This arrangement may not be modified by a verbal agreement.

It is your responsibility to keep track of the services provided to you as you progress in your individual treatment cycles. You will be financially responsible for all services provided, even if such services were not anticipated when you began treatment and are not included in the financial visit. Charges that are the patient's responsibility and remain unpaid after 30 days may be subject to an administrative fee of $15.00 per billing cycle.

I agree to be responsible for all charges incurred by me and to pay my account. If my account is sent to an attorney or collection agency, I agree to pay reasonable attorney's fees and/or collection expenses (currently at 30%). The amount of the attorney's fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.

If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to FWF or to the provider group rendering the service, for application on my bill. However, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL (see attachment). In rendering treatment, FWF is relying on my agreement to pay the account.

A photocopy of this statement is to be considered valid as an original.

I have read and understood FWF payment terms and conditions

Signature:_____

Date: _____

Witness: _____

Consent to Treat

Medical Treatment: The patient consents to the treatment, services, and procedures which may be performed in the office, which may include but are not limited to, multiple visits, laboratory procedures, ultrasound evaluation, x-ray examination, medical and surgical treatment, or procedures, anesthesia, or hospital services rendered under the general or specific instructions of the responsible physician or other healthcare providers. The office may establish certain criteria which will automatically trigger the performance of specific tests which patient agrees may be performed without any further separate consent.

Legal Relationship Between Office and Healthcare Providers: The patient will be treated by his/her attending doctor and healthcare providers and be under his/her care and supervision.

I have read and understand this treatment agreement. I am the patient, the parent of a minor child, or the legal representative of the patient and authorized to act on the patient's behalf to sign this agreement.

Patient: _____ Date: _____

Witness: _____Date: _____

Cancellation Policy

It is our policy to call and confirm appointments prior to the scheduled appointment time. If we are unable to reach you and leave a voice message reminding you of the appointment, we expect a confirmation call back from you the same day the message was left. You can do this by either calling and speaking to one of our office staff or by leaving us a voice message if after hours. If we do not receive a confirmation from you, your appointment slot may be given to someone else.

We understand that sometimes it is impossible for you to keep your scheduled appointment. However, if you know in advance that you will not be able to make it in for your appointment, we do require that you inform us at least 24 hours in advance so that we may schedule another patient in your time slot. Please call us at 817-348-8145 to notify us. We have voice messaging available for weekends and evenings so that you may leave us a message if necessary.

If you do not call to cancel or do not show for your appointment after confirming with us, you will be charged the full amount of your scheduled appointment. This charge is not billable to your insurance company and therefore must be paid by you. This policy helps us serve all our patients more effectively. Thank you for your cooperation in this matter.

I have read, understand and agree to abide by FWF cancellation policy.

Patient:_____Date:_____

Patient Satisfaction Survey

1. Overall Rating:

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

2. Please rate the physician who provided care:

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

How were you treated by our front office: (Patty or Barbara)

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

If you were seen by a nurses: (Joni or Richelle)
___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

If you were seen by a medical assistant: (Courtney)
___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Comments: _____

_____

3. Please rate the following aspects of your visit:

Were you seen at your scheduled time? ___ within 15 min. ___ 16-20 min. ___ 21-25 min. ___ 26-30 min. ___ over 30 min.

How well were your questions answered? ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Your treatment options clearly explained? ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Front office staff was helpful & friendly? ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Appearance and cleanliness of office? ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Comments: _____

_____

4. Has all of the staff been courteous and helpful? ___ Yes ___ No (If no, please explain)

_____

_____

5. Are you phone calls to our nursing staff returned by the next business day? ___ Yes ___ No

6. Are you calls to our administrative staff returned by the next business day? ___ Yes ___ No

7. If no, who has not been returning your calls? _____

8. Have any staff members been exceptionally courteous or helpful? (please give names) ___

_____

9. Has any staff member <u>not</u> performed well in your opinion? (If yes, please explain who and why)

_____

10. In one or two sentences, what would you tell a friend or colleague about your experience with FWF if they asked you for a recommendation? _____

May we use your opinions in our literature? ___ Yes ___ No

11. Additional comments on what we could do differently or better?

12a. If asked, would you refer a friend or colleague to FWF so that we might offer our services to them? ___ Yes ___ No Comments:

12b. Can you think of anyone who might be interested in our services? _____ If yes, we would appreciate it very much if you would give them our brochures or one of our business cards.

13. (Optional) If you would like us to contact you to followup on any of your comments, pease provide us with your name and phone number where we may reach you and we'll be sure to contact you as soon as possible.

Name:

Phone number:

Thank you very much for taking the time to complete this survey.

We value your comments and suggestions.

Sincerely, Robert A.

Kaufmann, MD

Please complete and send or give to:
Fort Worth Fertility
1800 Mistletoe Blvd.
Fort Worth, TX 76104