New England Reproductive Medicine and Surgery LLC

Intake Form

Name: _____ **Date of birth:** _____
Address: _____
Preferred Pharmacy: _____ **Address:** _____
Primary Care Provider: _____ **Referring Provider:** _____

Medications/supplements: list name(s) and dosage below, attach additional sheet if necessary.

_____
_____
_____

Allergies: list name(s) and reactions below, attach additional sheet if necessary.

_____
_____
_____

Social History: (select one) ____ Married ____ Partner ____ Single ____ Divorced
Are you safe? ____ Yes ____ No
Who do you live with? _____
What do you do for exercise? _____
What do you do for work? _____
What tobacco/nicotine products do you use? _____
Did you use tobacco/nicotine products in the past? ____ Yes; When? _____ ____ No
Do you drink alcohol? ____ Yes; How often? _____ ____ No
What other drugs do you use? _____

Mental Health History:
Do you/did you experience anxiety?
____ Yes; What treatments? _____ ____ No
Do you/did you experience depression?
____ Yes; What treatments? _____ ____ No
Do you/did you experience mood issues?
____ Yes; What treatments? _____ ____ No
Were you hospitalized for anxiety, depression and/or mood issues? ____ Yes ____ No

Family History:
Mom Alive? ____ Yes ____ No; Age at death: _____
Mom's Medical history: _____

Dad Alive? ____ Yes ____ No; Age at death: _____
Dad's Medical history: _____

Mother's Mother Alive?____ Yes ____ No; Age at death: _____
Mother's Mother's Medical history: _____

New England Reproductive Medicine and Surgery LLC

Name: _____ **Date of birth:** _____

Mother's Father Alive? ____ Yes ____ No; Age at death: _____
Mother's Father's Medical history: _____

Father's Mother Alive? ____ Yes ____ No; Age at death: _____
Father's Mother's Medical history: _____

Father's Father Alive? ____ Yes ____ No; Age at death: _____
Father's Father's Medical history: _____

Sister(s) Alive? ____ Yes ____ No; Age at death: _____
Sister(s) Medical history: _____

Brother(s) Alive? ____ Yes ____ No; Age at death: _____
Brother(s) Medical history: _____

Daughter(s) Alive? ____ Yes ____ No; Age at death: _____
Daughter(s) Medical history: _____

Son(s) Alive? ____ Yes ____ No; Age at death: _____
Son(s) Medical history? _____

Surgical History: attach additional sheet if necessary.

_____
_____
_____

Medical Problems: attach additional sheet if necessary.

_____
_____
_____

Gynecological History:
First period occurred at _____ years old
Date of last period: _____
Cycles are: ____ regular ____ irregular
Cycle length is: ____ 28-30 days ____ >30 days ____ <28 days
Cycle flow is: ____ light ____ heavy
Pain with: ____ periods ____ sex ____ urination ____ BMs ____ other: _____
History of: ____ endometriosis ____ cysts ____ fibroids ____ pelvic inflammatory disease
____ sexually transmitted infections
Pregnancy, number of: pregnancies ____ living children ____ full term births ____ premature births ____
stillbirths ____ c-section(s) ____ spontaneous miscarriage(s) ____ therapeutic abortion(s) ____

Authorization to Treat

I voluntarily give my permission to the healthcare providers of ***New England Reproductive Medicine and Surgery, LLC*** and such assistants and other healthcare providers as they may deem necessary to provide medical services to me. I understand by signing this form I am authorizing them to treat me for as long as I seek care from ***New England Reproductive Medicine and Surgery, LLC*** providers or until I withdraw my authorization in writing.

HIPAA Privacy Policy

I acknowledge that I have read and understand the 'Notice of Privacy Practices' and that ***New England Reproductive Medicine and Surgery, LLC*** has offered access, via their website at www.nermas.com, to a copy of their 'Notice of Privacy Practices' in compliance with current HIPAA regulations.

Release of Information and Assignment of Benefits

I hereby authorize ***New England Reproductive Medicine and Surgery, LLC*** to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim. Additionally, I hereby authorize payment directly to ***New England Reproductive Medicine and Surgery, LLC*** of the medical and/or surgical benefits, if any, otherwise payable to me for the services as described.

Authorization for Disclosure of Information

Our providers and/or staff may need, from time to time, to contact you. We would likely be contacting you about appointments as well as communicating information with you concerning your healthcare and financial responsibilities. Please provide us with the following information so that we can best interact with you and get our message to you:

Method of contact (check all that you approve) _____cell _____home

Preferred Phone Number: _____

If there is someone other than yourself that you would like us to be able to share your healthcare information with, please provide us with their information:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

If there are healthcare providers that you would like us to be able to share your healthcare information with, please provide us with the following information. (Check all that you approve. If another provider, please provide their name):

____ **Referring** Provider on file ____ **Primary Care** Provider on file ____**Other** Provider:_____

Authorization of Secure Telemedicine Communication

We are delivering telemedicine services for certain appointments through **doxy.me™** to continue our dedication to providing exemplary care for our patients. This platform meets the HIPAA requirement of a HIPAA-secured platform and will require that you have access to both email and the internet.
By providing your preferred email address, you are accepting and authorizing this platform as a means of communication and access to **New England Reproductive Medicine and Surgery, LLC services**.

Preferred email address: _____

By signing below, I understand, agree with, and authorize the above five statements.

_____ _____
Printed Name of Patient Signer's Relationship to Patient, if other than Self

_____ _____
Signature of Patient / Guardian Date

Our general process to best assess your specific needs/issues/concerns is as follows:

1. Have an initial consultation with Dr. Clark
2. Have imaging done in our office
3. Have lab work done (if needed)
4. Follow up with a discussion about testing results and the options to move forward
5. A. Follow up with a surgical discussion if surgery is the chosen pathway
   B. Follow up with a fertility discussion if fertility treatment is the chosen pathway

Questions To Ask Your Insurance Company

Please be advised it is your responsibility to know your insurance coverage. The following are questions to ask your insurance company regarding what you will be having done to treat your needs/issues/concerns:

1. Do I need a **PCP referral or authorization** for visits with Dr. Clark?
2. Do I have coverage for?
   a. Sonohysterograms (SHG) and Pelvic Ultrasounds (GYN scan)
   b. Blood Draws and Labs
   c. Medications: such as Lupron, Letrozole, Myfembree, Oriahnn or Orilissa

   *If yes for any of the above:
   - **Do I need an authorization for these treatments/services beyond office visits?**
   - **Do I have copays on these services?**
   - **Do I have deductible that applies to these services?**
   - **Do I have a percentage of coinsurance that applies to these services?**

Financial Policy

We are dedicated to providing the best possible care and service to you. Therefore, we believe your understanding of your financial responsibilities, including understanding of your insurance plan, is essential. Outlined below is our financial policy:

- Notification of new insurance must be provided no less than **TWO business days** before a scheduled appointment; otherwise, full payment for the appointment will be collected at check-in.
- **Copays/deductibles/coinsurance are due at check-in/prior to any telemedicine or in office appointment**.
- Payment for all services, including office paperwork, that are not covered by your insurance plan is your financial responsibility.
- **Payment:** accepted by **card** or **cash**. A $10 assessment fee is charged for every declined card payment attempt.
- **Self-Pay: full payment** for service(s) rendered required prior to every appointment.
- **Account Balances:** payment is **due upon receipt** of your statement, made available on your patient portal and sent electronically via Square, unless you have opted out of e-mail communication (see e-mail communication consent) then yours will be mailed.

Appointment Policy

We make every effort to accommodate you and your needs. We greatly appreciate your cooperation in assisting us to make this a smooth process. The time we have set aside for your appointment is valuable, which is why a system-generated email is sent 24-48 hours prior to your appointment for confirmation. We require you to be on time to your appointment; if not, we will immediately reschedule your appointment.

If you need to cancel or reschedule your appointment, we request that you contact us immediately. *There is a $50 charge for the initial missed appointment and $100 for the second*. After two appointments for which you did not notify us in advance, you will be discharged from our practice. Additionally, we understand that there are circumstances that may cause you to be late for your scheduled appointment. If this happens, *please contact the office at (508) 917-6720.*

By signing below, I certify that I have read, fully understand, and agree to contact my insurance company to understand my coverage, the terms of the Financial Policy and the terms of the Appointment Policy.

_____ _____

Printed Name of Patient | Signer's Relationship to Patient, if other than Self

_____ _____

Signature of Patient / Guardian | Date

New England Reproductive Medicine and Surgery LLC

Illness/COVID-19 Protocol

We have created our ILLNESS/COVID-19 protocol based on CDC guidelines and the Massachusetts Department of Health in an effort to keep our patients, providers and staff safe. Please note that this protocol is subject to change.

1. Masks are appreciated, but not required.

2. If you have any symptoms of illness prior to an in-office visit, please contact us immediately as we will advise you on the next steps as they relate to your appointment. We may need to reschedule your upcoming visit.

    - If COVID positive, you are required, per CDC COVID guidelines, to quarantine until symptoms subside. ****PLEASE REFER TO CDC.GOV FOR A FULL LIST OF SYMPTOMS.****
    - If COVID negative, but known exposure, please wear a mask for the safety of all patients and/or staff.

3. If you test COVID positive prior to surgery and you are:

    - **SYPMTOMATIC:**
        i. Your surgery will be cancelled for now. Once you are no longer experiencing symptoms you will need to report that to the office and your surgery then could be rescheduled in 6 weeks from that point (depending on availability).
            1. If you have already signed consents, they will need to be resigned at an in-office visit. Please see #2.
    - **ASYMPTOMATIC:**
        i. Your surgery will be rescheduled for 6 weeks from your positive test (depending on availability).
            1. If you have already signed consents, they will need to be resigned at an in-office visit. Please see #2.

Note: If you must bring someone with you to your appointment, our protocol applies to that person as well

If at any point you have questions regarding this protocol, please contact the office:

- Phone: (508) 917 – 6720
  Email: talktous@nermas.com

By signing below, I understand the above, acknowledge receipt of this document, agree to adhere to the protocol as outlined above, and understand that this protocol is subject to change.

_____ _____
Printed Name of Patient Signer's Relationship to Patient, if other than Self

_____ _____
Signature of Patient / Guardian Date

Authorization for E-Mail as a Communication Means

We at New England Reproductive Medicine and Surgery, LLC (hereafter known as NERMAS) respect your right to confidential communications as well as your right to direct how communication occurs. We offer communication via e-mail as a convenience. Since e-mail is inherently not secure, we will only communicate with you via e-mail with your written authorization. This communication could contain information about appointments, financial responsibilities, and care coordination activities. This communication method also includes e-mails NERMAS generates to you via Square and Meditouch/Nextgen. We will limit information sent via e-mail to the minimum necessary.

Acknowledgements

E-Mail Risks: I understand that these e-mails will not be encrypted and the risk of exposure of my health information exists. These e-mails can be inadvertently misdirected by the sender or intentionally intercepted by third parties. NERMAS cannot and does not guarantee the security of these e-mails, nor is it responsible for e-mails that are lost due to technical failure during transmission and/or storage.

Privacy and Confidentiality: I understand that the content of an e-mail may be viewed by any person who has access to my computer/phone. The use of electronic communication means that my confidentiality cannot be guaranteed according to HIPAA regulations.

Ending E-Mail Communication: I understand that I may revoke at any time the authorization thereby ending e-mail communications with NERMAS. The revocation must be in writing via email or by letter notifying NERMAS. The notification to end e-mails will not impact any e-mails that have already been initiated at the time of my notification.

Change in E-Mail Address: I understand that it is my responsibility to notify NERMAS when my e-mail address changes.

Timeframe of E-Mails: I understand that this authorization is valid only while in a treatment relationship with NERMAS.

Purpose of E-Mails: NERMAS does not encourage e-mail for purposes other than routine communication. I understand that if e-mail is chosen to be used in the event of emergency or an urgent request, contact must also be made via phone to the office.

Check **ONLY ONE** option below:

I confirm I have read and understand the above Acknowledgements and I hereby:

____ ***Authorize*** NERMAS to communicate with me via e-mail to the authorized e-mail address provided:
_____

____ ***Decline*** e-mail messages as a communication means with NERMAS. I understand that by doing so I have also opted out of appointment reminders, paperless statements, and paperless visit summaries/flowsheets.

_____ _____
Printed Name of Patient Date of Birth

_____ _____
Signature of Patient / Guardian Date

Authorization To Treat a Minor

Patient Name: _____

Date of Birth: _____

I, _____, give permission and authorize ***New England Reproductive Medicine and Surgery, LLC*** to treat my legal child, who is a minor (under the age of 18) as listed above as the patient.

By signing below, I understand that this authorization is applicable until my legal child turns 18 or we have provided a signed document stating that we no longer give consent and authorize for further treatment here.

By signing below, my legal child understands that even though I have consented to and authorize my legal child being treated by ***New England Reproductive Medicine and Surgery, LLC*** I am not required to be present during treatment if they do not want, as a chaperone from the office will always be provided during any examination.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Parent/Legal Guardian Date Relation to Minor