

## **TO MAKE THE MOST OF YOUR FIRST VISIT**

It is important that we have all fertility related medical records for you and your partner on file at our office before your visit. This allows the doctor adequate time to review these records before meeting with you. It also helps us to avoid duplicating tests that you have already had done.

These records include any recent care provided by:

- Your gynecologist (including your most recent pap smear and mammogram results)
- Your urologist
- Another reproductive endocrinologist (fertility doctor)

Please contact all of the above offices to have the requested information sent to us. Our fax number is (248) 619-9031.

## **WHAT TO EXPECT AT YOUR INITIAL APPOINTMENT**

Part 1: Please plan on your consultation lasting 1 – 1 ½ hours. Your evaluation starts with a consultation with either Dr. Brad Miller or Dr. Lynda Wolf (both of whom are board certified reproductive endocrinologists). The doctor you meet during your initial consultation will direct your care. However, since the nature of our practice requires that monitoring & treatment be provided 365 days a year, some of your monitoring ultrasounds and/or your procedures may be performed by the other physician.

During this initial consultation, a comprehensive history will be taken. A physical exam may be performed. The doctor will discuss possible causes of your infertility and make recommendations about testing that may be helpful in determining a treatment plan. Some of this testing (including blood work and ultrasounds) may be done during this visit; some testing must be delayed until an appropriate time in your menstrual cycle.

Please Note: Exams, blood work and ultrasounds are not part of the \$280 consultation fee and incur an additional cost that may or may not be covered by insurance. If your blood work needs to be sent to a specific lab due to insurance coverage please notify the lab tech who draws your blood of this fact.

Part 2: You will be introduced to your primary nurse. This nurse has special training in infertility care. She follows you through your treatment cycle and is your primary point of contact for any questions or concerns. She will schedule all diagnostic testing and order medications for you.

Part 3: You will have the opportunity to meet with a financial coordinator to discuss insurance coverage, available financial resources, multi-cycle plans, refund programs and the typical costs associated with your recommended treatment plan.



# PATIENT REGISTRATION

**PLEASE PRINT. ALL INFORMATION WILL REMAIN CONFIDENTIAL. THANK YOU!**

SCHEDULED APPOINTMENT DATE: \_\_\_\_\_ HAVE YOU OR YOUR PARTNER EVER BEEN HERE BEFORE?  YES  NO

PATIENT NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY PHONE \_\_\_\_\_  HOME  CELL  WORK DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

SECONDARY PHONE \_\_\_\_\_  HOME  CELL  WORK AGE \_\_\_\_\_

SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  SAME SEX COUPLE  
(THE LAST 6 DIGITS ARE REQUIRED)

MAY WE CONTACT YOU VIA EMAIL?  YES  NO IF YES, EMAIL ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

ARE YOU EMPLOYED?  YES  NO IF YES, YOUR EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ MAY WE CONTACT YOU THERE?  YES  NO

PARTNER NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**PATIENT INSURANCE COVERAGE**  
NAME OF INSURANCE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE \_\_\_\_\_  
POLICY # \_\_\_\_\_  
GROUP # \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_

**SPOUSE/PARTNER INSURANCE COVERAGE**  
NAME OF INSURANCE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE \_\_\_\_\_  
POLICY # \_\_\_\_\_  
GROUP # \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_

**PARTNER COVERED UNDER THIS POLICY?**  YES  NO

**PARTNER COVERED UNDER THIS POLICY?**  YES  NO

**\*\*\* PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD AND VALID GOVERNMENT ISSUED PHOTO ID TO THE RECEPTIONIST \*\*\***

**REFERRED BY (MARK ALL THAT APPLY)**

- DOCTOR (PLEASE LIST NAME) \_\_\_\_\_  MD  DO
- FRIEND / WORD OF MOUTH (PLEASE LIST NAME) \_\_\_\_\_  
 MAY WE CONTACT THIS PERSON FOR REFERRING YOU?  YES  NO, I PREFER TO BE DISCRETE
- INSURANCE CO. \_\_\_\_\_
- RMA OF MI EMPLOYEE \_\_\_\_\_
- RMA OF MI WEBSITE \_\_\_\_\_
- RMA OF MI SEMINAR \_\_\_\_\_
- RADIO \_\_\_\_\_
- INTERNET \_\_\_\_\_

I authorize payment of Medical Benefits to this facility/doctor. I authorize release of any medical information needed to process the claim. I hereby agree to pay for all services rendered to the above mentioned patient as incurred. I understand there is no guarantee any or all services will be covered by my insurance company. In the event of account default, I promise to pay collection costs and reasonable attorney fees as required effecting collection on the debt. I understand that should my account become delinquent or should I fail to pay as promise; RMA of Michigan reserves the right to deny further care to me either temporarily or permanently.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**SHARED PROTECTED HEALTH INFORMATION**

Name	Results / Medical Info	Bills / Account
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\_\_\_\_\_  
Please Print Patient / Guardian Name

\_\_\_\_\_  
If Guardian, Relationship to Patient

\_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_  
Date



# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE FOR WOMEN

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Partner Name: \_\_\_\_\_

What are your expectations for this visit and what questions would you like answered?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## GYNECOLOGICAL HISTORY

Current Gynecologist or Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

May we keep this doctor informed of your care: (Please check one)  Yes  No

Age at first period: \_\_\_\_\_ Date of first day of last period: \_\_\_\_\_

Are your periods:  Regular  Irregular Amount of flow:  Light  Moderate  Heavy

What are the usual # days from cycle day 1 to your next day 1? Minimum \_\_\_\_\_ Maximum \_\_\_\_\_

What is the usual duration of your periods (full flow): Minimum \_\_\_\_\_ Maximum \_\_\_\_\_

Do you have PMS:  Yes  No

If yes:  Mild  Moderate  Severe

Do you have painful periods?  Yes  No

If yes:  Mild  Moderate  Severe

Do you take pain medication for cramps:  Yes  No

If yes, please specify medication: \_\_\_\_\_

Do you bleed or spot in between periods:  Yes  No

Have you ever taken oral contraceptives:  Yes  No

If yes, please list date(s): \_\_\_\_\_

Were your cycles regular after discontinuing the oral contraceptives:  Yes  No

Have you used other forms of contraception:  Yes  No

If yes, what: \_\_\_\_\_

When was your last PAP smear performed: \_\_\_\_\_ Was it Normal?  Yes  No

Have you ever had an abnormal PAP?  Yes  No

If yes, please indicate date(s): \_\_\_\_\_

Treatment:  None or repeated  Colposcopy/biopsy  Laser

Conization  LEEP  Unknown

Is intercourse painful:  Yes  No

If Yes:  Mild  Moderate  Severe

Do you use lubricants:  Yes  No  
 If yes, which brand? \_\_\_\_\_

Do you douche before or after intercourse:  Yes  No

How many times per week do you and your partner have intercourse: \_\_\_\_\_

Have you ever used an intrauterine device (IUD):  Yes  No  
 If yes, when? / which brand? \_\_\_\_\_

Have you ever had pelvic inflammatory disease (PID):  Yes  No  
 If yes, when? \_\_\_\_\_

How many months have you had unprotected intercourse: \_\_\_\_\_ months

How many months have you been actively trying to achieve pregnancy: \_\_\_\_\_ months

Have you used Basal Body Temperature Charts (BBT):  Yes  No  
 If yes, what cycle day did you ovulate: \_\_\_\_\_

Have you used an ovulation predictor kit (OPK):  Yes  No  
 If yes, what cycle day did you ovulate: \_\_\_\_\_

Have you been exposed to any toxins or radiation:  Yes  No  
 If yes, describe: \_\_\_\_\_

Do you perform self breast exams on a regular basis:  Yes  No

Have you had a mammogram performed:  Yes  No  
 If yes, date of last one: \_\_\_\_\_  
 If yes, was it normal?  Yes  No  
 If no, treatment: \_\_\_\_\_

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### OBSTETRICAL HISTORY

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How many times have you been pregnant? \_\_\_\_\_

Number of abortions: \_\_\_\_\_      Number of miscarriages (<20 weeks): \_\_\_\_\_

Number of ectopic pregnancies: \_\_\_\_\_      Number of pre-term (<37 weeks) births: \_\_\_\_\_

Number of full term (>37 weeks) births: \_\_\_\_\_      How many children are alive and well: \_\_\_\_\_

Do any of your children have birth defects?  Yes  No  NA  
 If yes, please explain: \_\_\_\_\_

Please list all pregnancies:

Pregnancy #	Year Delivered	How many weeks?	Pregnancy Outcome: Live Birth? Miscarriage? Abortion? Ectopic? Complications?	Infertility therapy required to conceive?	How long in months did it take to conceive?	Is current partner the father?
1 <sup>st</sup> Pregnancy						
2 <sup>nd</sup> Pregnancy						
3 <sup>rd</sup> Pregnancy						
4 <sup>th</sup> Pregnancy						
5 <sup>th</sup> Pregnancy						

## MEDICAL HISTORY

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type (if known) \_\_\_\_\_

Do you have anything in your health history that your partner is not aware of that you wish to keep confidential?  Yes  No

If yes, please specify: \_\_\_\_\_

Have you lost or gained greater than 20 lbs. of weight in the last year:  Yes  No

Do you follow a particular food diet or have any special dietary habits:  Yes  No

If yes, please specify: \_\_\_\_\_

Have you ever had an eating disorder (anorexia or bulimia):  Yes  No

If yes, please specify: \_\_\_\_\_

Do you have any allergies (check all that apply):  Yes  No

If yes, please specify:  Medication \_\_\_\_\_

Food \_\_\_\_\_

Latex

Do you exercise:  Yes  No

If yes, please specify the form and frequency of regular vigorous exercise (swimming, cycling, etc.):

Exercise \_\_\_\_\_ Hours/Week \_\_\_\_\_

Within the last year, have you taken any prescription medications? If taking prenatal vitamins please include.

Medication	Diagnosis	Dosage / Frequency	Duration

Have you taken any of the following medications?  Thyroid (e.g. Synthroid)  Bromocriptine (Parlodel)

Are you taking any over the counter medications / supplements on a regular basis? Please note below.

Medication	Diagnosis	Dosage / Frequency	Duration

Please provide us with the phone number to your local pharmacy \_\_\_\_\_

### Vaccinations:

Chickenpox (Varicella)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
MMR	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
BCG (Tuberculosis)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Polio	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Hepatitis A	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Hepatitis B	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Tetanus	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know
Influenza	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date(s) _____	<input type="checkbox"/> Don't Know

Do you or have you ever had (please check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Scarlet fever                                | <input type="checkbox"/> Kidney Infection               | <input type="checkbox"/> Breast Tenderness   |
| <input type="checkbox"/> Rheumatic fever                              | <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Breast Soreness     |
| <input type="checkbox"/> Tuberculosis                                 | <input type="checkbox"/> Hirsutism (Excess Hair Growth) | <input type="checkbox"/> Breast Discharge    |
| <input type="checkbox"/> Hepatitis                                    | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Breast Cancer       |
| <input type="checkbox"/> Syphilis                                     | <input type="checkbox"/> Gallbladder Problems           | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Gonorrhea                                    | <input type="checkbox"/> Liver Problems                 | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Pelvic Infection                             | <input type="checkbox"/> Ulcers                         | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Chlamydia                                    | <input type="checkbox"/> Appendicitis                   | <input type="checkbox"/> Poor Sense of Smell |
| <br>  |   |  |
| <input type="checkbox"/> Herpes (HSV)                                 | <input type="checkbox"/> Colitis                        | <input type="checkbox"/> Dizziness           |
| <input type="checkbox"/> Chronic Bronchitis                           | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Loss of Balance     |
| <input type="checkbox"/> Measles: Regular                             | <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Chronic Headaches   |
| <input type="checkbox"/> Measles: German (Rubella)                    | <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Blood Transfusions  |
| <input type="checkbox"/> Chickenpox (Varicella)                       | <input type="checkbox"/> Thyroid Problems               | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Nongonococcal Urethritis                     | <input type="checkbox"/> Ovarian Cysts                  | <input type="checkbox"/> Endometriosis       |
| <input type="checkbox"/> Pneumonia                                    | <input type="checkbox"/> Cervical Dysplasia/Cancer      | <input type="checkbox"/> Ovarian cancer      |
| <input type="checkbox"/> Neurological Problems                        | <input type="checkbox"/> HPV or genital warts           |  |
| <input type="checkbox"/> Vaginitis: Trichomoniasis or yeast infection |   |  |
| <input type="checkbox"/> Other: _____                                 |   |  |

**Physical Symptoms:**

**General:**

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other \_\_\_\_\_
- None

**Head, Eyes, Ears, Nose and Throat:**

- Dizziness
- Loss of sense of smell
- Headaches
- Chronic nasal congestion
- Blurred vision
- Ringing ears
- Hearing loss/deafness
- Other \_\_\_\_\_
- None

**Respiratory:**

- Shortness of breath
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Bloody cough
- Other \_\_\_\_\_
- None

**Endocrine/Hormonal:**

- Diabetes
- Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance- hot flashes or feeling cold
- Other \_\_\_\_\_
- None

**Breasts:**

- Discharge (clear? \_\_\_ bloody? \_\_\_ milky? \_\_\_)
- Lumps
- Pain
- Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants (saline? \_\_\_ silicone? \_\_\_)
- Other \_\_\_\_\_
- None

**Neurological Problems:**

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other \_\_\_\_\_
- None

**Gastrointestinal:**

- Nausea/Vomiting
- Ulcers
- Hepatitis
- Diarrhea
- Blood in your stools
- Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other \_\_\_\_\_
- None

**Genito-Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Leaking urine
- Blood in urine
- Herpes
- Other \_\_\_\_\_
- None

**Skin/Extremities:**

- Unexplained rash
- Acne
- Skin cancer
- Burn injury
- Moles changing appearance
- Excess hair growth
- Other \_\_\_\_\_
- None

**Musculoskeletal:**

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_
- None

**Hematologic:**

- Blood clotting disorder/Blood clot
- Sickle cell Anemia
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons)
- Thrombophlebitis
- Other \_\_\_\_\_
- None

**Cardiovascular:**

- Palpitations/Skipped beats
- Chest pain
- Stroke
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse
- (Abx before dental procedures? Yes / No)
- Heart attack
- Murmurs
- Other \_\_\_\_\_
- None

**Mental Health Problems:**

- Depression
- Anxiety disorder
- Schizophrenia
- Other \_\_\_\_\_
- Do you see a counselor? \_\_\_\_\_ How long? \_\_\_\_\_
- None

## SURGICAL HISTORY

Have you ever been surgically sterilized:  Yes  No  
 If yes, date reversal performed: \_\_\_\_\_

Any complications from anesthesia:  Yes  No  
 If yes, explain: \_\_\_\_\_

Please list all surgeries:

Date	Hospital	Procedure	Findings	Surgeon

## PREVIOUS FERTILITY TESTING

	Yes	No	Date	Results (If Known)
Hysterosalpingogram (HSG)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Saline Sonogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endometrial Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Day 3 FSH, Estradiol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Postcoital Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mycoplasma / Chlamydia Cultures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

## INFERTILITY TREATMENT

Have you been treated for infertility before:  Yes  No  
 If yes, Diagnosis: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

### Clomid or Letrozole Cycles

Cycle #	Dates	Starting Dose	Number of Follicles	Insemination? Yes or No	Pregnancy Outcome
1					
2					
3					
4					
5					



**Follistim, Gonal-F, Menopur, Bravelle, etc. Cycles**

Cycle #	Dates	Starting Dose	Maximum Estradiol level	Number of Follicles	Insemination? Yes or No	Pregnancy Outcome
1						
2						
3						
4						
5						

**IVF History**

	Cycle # 1	Cycle # 2	Cycle # 3	Cycle # 4	Cycle # 5	Cycle # 6
Date						
IVF Center						
Frozen Cycle?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Max Start Dose						
Max Estradiol						
# Eggs Retrieved						
# Eggs Fertilized						
ICSI?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
# Embryos Transferred						
Embryo Age at Transfer Date (day 2, 3, 5 or 6)						
Pregnancy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Delivered?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**SOCIAL HISTORY**

Do you read and write English?  Yes  No

If no, what is your primary language? \_\_\_\_\_ Who will be your interpreter? \_\_\_\_\_

Do you or have you ever used:

Alcohol  Yes  No If yes, how many glasses per week? Wine \_\_\_\_\_ Beer \_\_\_\_\_ Cocktails \_\_\_\_\_

Caffeinated beverages  Yes  No If yes, how many do you consume per day? \_\_\_\_\_

Recreational drug use, past or current:  Yes  No If Yes, what \_\_\_\_\_ and when \_\_\_\_\_

Do you currently smoke cigarettes?  Yes  No

If yes, when did you quit? \_\_\_\_\_

Have you ever smoked?  Yes  No

## FAMILY HISTORY

Did your mother have any difficulty with conception or pregnancy:  Yes  No

Did your mother take diethylstilbestrol (DES) when she was pregnant with you:  Yes  No

At what age did your mother begin menopause: \_\_\_\_\_

Is there a family history of infertility:  Yes  No

If yes, who / relationship: \_\_\_\_\_

Is there a history of hormonal disorders in your family:  Yes  No

If yes, who / relationship: \_\_\_\_\_

Is there a family history of birth defects:  Yes  No

If yes, who / relationship: \_\_\_\_\_

Is there a family history of habitual pregnancy loss:  Yes  No

If yes, who / relationship: \_\_\_\_\_

Please list information below:

	<u>Living</u>		<u>Cause of Death/age at Death</u>
Mother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Father	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Brother(s)	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Sister(s)	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Maternal Grandmother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Maternal Grandfather	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Paternal Grandmother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Paternal Grandfather	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____

### Disorders in Your Family:

	<u>Relationship to You</u>		
Breast Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Ovarian Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Colon Cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Other Cancer _____	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Diabetes	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Thyroid problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Heart disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Blood clots	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Obesity	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Psychiatric problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Tuberculosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Endometriosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Infertility	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Menopause before age 40	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Birth defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Cystic Fibrosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know

### What is your Ancestry?

- African American
- American Indian  
or Alaskan Native
- Ashkenazi Jewish
- Asian
- Native Hawaiian or  
other Pacific Islander
- White
- Hispanic or Latino

- |                           |                                    |                                   |   |
|---------------------------|------------------------------------|-----------------------------------|---|
| Tay-Sachs disease         | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Canavan disease           | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Bloom syndrome            | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Gaucher disease           | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Niemann-Pick disease      | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Fanconi Anemia            | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Familial Dysautonia       | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Muscular Dystrophy        | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Neurologic (brain/spine)  | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Neural Tube Defects       | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Bone/skeletal Defects     | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Dwarfism                  | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Developmental delay       | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Learning problems         | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Polycystic kidney disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Heart defect from birth   | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Down syndrome             | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Other chromosome defects  | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Marfan Syndrome           | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Hemophilia                | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Sickle Cell Anemia        | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Thalasemia                | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Galactosemia              | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Deafness/Blindness        | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Color Blindness           | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Hemochromatosis           | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| Other _____               | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |

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**MALE PARTNER (IF APPLICABLE)**

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Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Have you ever conceived a pregnancy with a different partner?  Yes  No

Please give approximate dates and outcomes of any pregnancies conceived with a different partner:

Date of Pregnancy	Delivered	Aborted	Miscarried
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Have you ever seen an Urologist:  Yes  No If yes, why: \_\_\_\_\_

Have you ever had antisperm antibody testing?  Yes  No If yes, result: \_\_\_\_\_

Have you ever had a semen analysis (sperm count):  Yes  No If yes, please list below:

Date	Location	Count (Million/ml)	Motility	Grade	Morphology

Do you have any medical problems unrelated to your fertility? For example: Diabetes, Multiple Sclerosis, Hypertension, Prostate Disease, Uinary Tract or Kidney Infections.

Nature of Problem (Diagnosis)	Treatment	Physician

Have you had any surgeries?

Date	Type of Surgery	Physician

Do you take any medications? Indicate medication, dosage, frequency and duration:

Medication	Diagnosis	Dosage / Frequency	Duration

Do you or have you ever used:

Alcohol  Yes  No If yes, how many glasses per week? Wine \_\_\_\_\_ Beer \_\_\_\_\_ Cocktails \_\_\_\_\_

Caffeinated beverages  Yes  No If yes, how many do you consume per day? \_\_\_\_\_

Recreational drug use, past or current:  Yes  No If Yes, what \_\_\_\_\_ and when \_\_\_\_\_

Do you currently smoke cigarettes?  Yes  No Have you ever smoked?  Yes  No  
If yes, when did you quit? \_\_\_\_\_

Do you or have you ever had any difficulties with (check all that apply):

Erection:  Yes  No

If yes, please explain: \_\_\_\_\_

Ejaculation:  Yes  No

If yes, please explain: \_\_\_\_\_

Have you been exposed in last 3 months to excessive heat, hot tubs, saunas or fevers?  Yes  No

Have you had any serious injuries to your genitals?  Yes  No

Do you use your laptop on your lap?  Yes  No

- Have you had scrotal or testicular pain?  Left  Right  Both  Yes  No
- Have you had undescended testes?  Left  Right  Both  Yes  No
- Have you had a hernia repair, bladder or penis surgery as a child?  Yes  No
- Have you had a varicocele?  Left  Right  Both Date of Repair \_\_\_\_\_  Yes  No
- Have you had a vasectomy? Date \_\_\_\_\_ Reversed? Date \_\_\_\_\_  Yes  No
- Have you ever been exposed to radiation, chemotherapy or other toxins?  Yes  No
- Have you had any infections of your penis, testicles or prostate gland?  Yes  No
- Have you ever had any sexually transmitted diseases? Check all that apply below:  Yes  No
- HIV/AIDS  Herpes  Chlamydia  Gonorrhea  HPV/warts  Hepatitis A, B or C
- Syphilis  Mumps

- Is there any history of birth defects in your family?  Yes  No  Don't Know
- Is there any history of recurrent miscarriage or infertility in your family?  Yes  No  Don't Know
- Do you have any allergies?**  Yes  No

If yes, check all that apply:  Medication  Food  Latex

If yes, please specify: \_\_\_\_\_

**Do you have/use heated car seats?**  Yes  No

**Do you use heated driver's seat at the highest setting?**  Yes  No

Please list information below:

	<u>Living</u>		<u>Cause of Death/age at Death</u>
Mother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Father	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Brother(s)	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Sister(s)	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Maternal Grandmother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Maternal Grandfather	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Paternal Grandmother	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____
Paternal Grandfather	<input type="checkbox"/> Yes-age _____	<input type="checkbox"/> No	_____

**Disorders in Your Family:**

- |                      | <u>Relationship to You</u>         |                             |                                     |
|----------------------|------------------------------------|-----------------------------|-------------------------------------|
| Breast Cancer        | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Ovarian Cancer       | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Colon Cancer         | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Other Cancer _____   | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Diabetes             | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Thyroid problems     | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Heart disease        | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Blood clots          | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Obesity              | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Psychiatric problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Tuberculosis         | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Endometriosis        | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |

**What is your Ancestry?**

- African American
- American Indian or Alaskan Native
- Ashkenazi Jewish
- Asian
- Native Hawaiian or other Pacific Islander
- White
- Hispanic or Latino

Infertility	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Menopause before age 40	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Birth defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Cystic Fibrosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Tay-Sachs disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Canavan disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Bloom syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Gaucher disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Niemann-Pick disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Fanconi Anemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Familial Dysautonia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Muscular Dystrophy	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Neurologic (brain/spine)	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Neural Tube Defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Bone/skeletal Defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Dwarfism	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Developmental delay	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Learning problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Polycystic kidney disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Heart defect from birth	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Down syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Other chromosome defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Marfan Syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Hemophilia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Sickle Cell Anemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Thalasemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Galactosemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Deafness/Blindness	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Color Blindness	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Hemochromatosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____
Other _____	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No _____	<input type="checkbox"/> Don't Know _____

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**PATIENT COMMENTS**

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Do you or your partner (if applicable) have personal / religious objections to intrauterine insemination (IUI), invitro fertilization (IVF), Donor Sperm, Donor Egg, and Genetic Testing (PGD)? If yes, please list:

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Please use this space to add any additional comments or information you feel our physician should know.

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Brad T. Miller, M.D.  
Lynda J. Wolf, M.D.

## Patient Financial Agreement

### General Financial Provisions:

The patient, or their legal guardian, is ultimately responsible for all services incurred at RMA of Michigan. Spouses cannot sign this Agreement on behalf of the patient. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. RMA will do its best to verify your insurance benefits. However, RMA is not responsible if your insurance company provides incorrect or false information which results in unexpected out-of-pocket expenses. We strongly suggest you attempt to verify your own insurance benefits and ensure all necessary pre-authorizations are in place prior to the date of service.

### Financing Options:

RMA of Michigan has established relationships with several financing companies for those interested in obtaining a low-interest/no interest financing. **RMA does not carry balances or offer payment plans.** Our Financial Counselor is available to discuss these program details.

### If We Participate With Your Insurance Company:

RMA of Michigan participates and submits claims to the following insurance carriers provided we have all required information and you have granted Assignment of Benefits so that payment is made to us:

- Aetna
- Blue Cross Blue Shield of Michigan (excluding Blue Choice)
- William Beaumont Employee Health Plan
- Cofinity
- United HealthCare
- HAP
- HealthPlus PPO

Patient must pay the difference between the charges and the anticipated insurance payment at the time the services are incurred. This includes all non-covered services, unpaid deductibles and co-pays. If your insurance company pays less than anticipated; we will bill you for the balance. You agree to clear that balance within 30 days. We are not able to offer payment plans.

RMA will make every attempt to resolve insurance claim issues with your insurance company.

Please inform us upon receipt of a new insurance card or any changes in coverage. This prevents delays in processing claims.

### If We Do Not Participate With Your Insurance Company Or You Are Uninsured:

All services must be paid on the date services are rendered. We do not carry balances or offer payment plans. RMA of Michigan does not verify benefits or submit claims for insurance companies not listed above.

### Payment Methods

The following payment methods are accepted: Money order, cashier check, Debit Card, Visa, MasterCard, and Discover, cash and personal check for payments not to exceed \$700.00. IVF deposits may be paid by certified check or credit card and must be paid at least one week in advance of your cycle start.

### **NSF Check Policy**

Returned checks will incur a \$25.00 fee for each returned check. Once we receive a returned check, future payments must be made by credit card, money order, and cashier check. Cash can be used when payment does not exceed \$700.00.

### **Cryopreservation and Storage Fees**

If you have consented to freeze your embryos, oocyte, and/or sperm, a storage fee will occur. If storage fees are not paid within 30 days, the fee will be considered delinquent. Cryopreservation is not included in your cost estimate and is due within 5 days of the service being performed. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees. Additionally, RMA of Michigan reserves the right to consider unpaid cryopreserved items as unwanted or abandoned and has the right to discard after all internal attempts to obtain payment have been exhausted.

### **Cancellation of Cycle**

If your cycle is cancelled for any reason, you will be charged for all services up to that point. Any cycle deposit money remaining after those services are paid can be refunded to you. Please notify the financial department when the cycle is cancelled so that your refund request can be processed timely. Refunds take approximately 2 weeks from the date of request.

If you are undergoing an IVF cycle and convert to an insemination cycle, you will only be charged for the actual procedures performed during both cycles. An excess amount paid in your cycle deposit will be refunded to the patient/guarantor once the patient has been released from care and all insurance dispositions received.

### **Medications**

Your physician will provide you with the necessary prescriptions for your treatment cycle. You may have the prescriptions filled at your local pharmacy or we can recommend a specialty pharmacy that may offer a cost advantage if your fertility medications are not covered by insurance. Some insurance companies require prior authorization before they will cover the cost of the fertility medications. We will complete the paperwork necessary to obtain this authorization when necessary.

### **Anesthesia**

Anesthesia Staffing Consultants, Inc. (a separate entity) provides our patients with anesthesia services. The anesthesia fee for egg retrieval is **\$400.00** and will be **billed to you directly by Anesthesia Staffing Consultants, Inc. (ASC)**. Anesthesia payment is due at the same time your IVF payment is due. ASC accepts checks, Visa, MasterCard, Discover and American Express as method of payment. Any questions regarding your anesthesia charges and to make payment please contact them directly at **(248) 258-5058**.

### **Subsequent Cycles and Treatment**

Your account must be reconciled prior to any new cycle start. This means that you must have a \$0.00 balance on both your patient account and insurance account. If it is not, you will not be able to proceed with the start of further treatment until it is reconciled.

### **Requests for Medical Records**

We will gladly provide you with copies of your medical records. For each request we must have a signed medical records release form which contains the name, address and fax number of the healthcare provider where you wish the records to be sent. This form is available on our website at [www.rmami.com](http://www.rmami.com). Spouses cannot authorize record release for one another. Copying fees, based upon the Michigan Medical Records Access Act, Act 47 of 2004, are \$23.00 per request for 2012 and can change on an annual basis. This fee may be waived when your medical records are for the purpose of sharing with your primary care doctor or your ob-gyn. We cannot copy your medical records that were provided to us from your other healthcare providers. You will need to contact those healthcare providers directly. Please allow five (5) days for us to respond to your copying request.



**Refunds**

Overpayments and credit balances will be refunded to the appropriate party after review of the account. Patient refunds will not be processed until all insurance dispositions are received, if applicable. Once a refund is requested, it may take up to 2 weeks to be processed.

**Delinquent Accounts**

All accounts that cannot be collected by RMA of Michigan will be referred to a collection agency or attorney for further collection action in accordance with established guidelines as deemed appropriate. Any fees assessed will be the responsibility of the debtor. Additionally, RMA will no longer be able to offer care to those whose accounts needed third-party assistance to collect on the debt.

**Patient Acknowledgement and Guarantee**

I have read, understand, and agree to the Patient Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility and I guarantee that my account with RMA will be paid per the terms of the Agreement.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date