REGISTRATION
(PLEASE PRINT)

Southwest Florida Fertility Center, P.A.
Jacob L. Glock, M.D.
15730 New Hampshire Court unit 101
Ft. Myers, Fl. 33908
239.561.3430 Fax 239.561.6980

Date_____ Home Phone _____

Patient_____
Last Name First Name Initial

Responsible Party (if a minor) _____

Street Address _____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By_____

Business Address _____

Occupation_____ Business Phone_____

Spouse (or responsible party) Name _____ Birthdate _____

Business Name and Address _____

Occupation_____ Business Phone_____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐ No ☐ Yes ▶ If yes,

Name of Primary Insurer_____

Contract #_____ Group #_____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract #_____ Group #_____ Subscriber # _____

☐ Medicare ☐ Medicaid Claim ID # _____

If Welfare, your number_____ County of_____

In case of emergency, who should be notified? _____ Phone_____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

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Financial Agreement

I am aware that I am responsible for understanding the rules and regulations of my insurance company. Therefore, it is my responsibility to obtain any and all required authorizations from my primary care physician if necessary. I agree to be responsible for any and all charges incurred as a result of not obtaining the appropriate referral prior to my office visit. Furthermore, if at anytime, the claims submitted to my insurance company are rejected for any reason, I agree to be responsible for all charges and payments. I understand that this includes being fully responsible for any balance, which may remain after insurance payments.

I understand that any supplies or medications obtained from the office of Jacob L. Glock, M.D. must be paid for at the time of service. The office will provide me with a receipt to submit to my insurance company claims office.

I agree to immediately inform the office of Jacob L. Glock, M.D. of any changes in my insurance status.

I agree to make the office of Jacob L. Glock M.D. aware of any rider exclusions to my insurance coverage, i.e. pre-existing conditions.

I further understand, that at after reasonable attempts, by the office of Jacob L. Glock, M.D., to collect on my account, should my account be turned over to an outside collection agency, I will not only be responsible for the unpaid balance but the cost of collections efforts as well.

I authorize the release of any medical information necessary to process all claims incurred in the office of Jacob L. Glock, M.D.

I authorize payment of medical benefits to the office of Jacob L. Glock, M.D. for all supplies and services rendered.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Witness

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Patient Name: _____

Account Number: _____

Semen Analysis

I have been advised that Southwest Florida Fertility Center, P.A. does not accept insurance payment for semen analysis nor will they bill insurance for semen analysis testing. I have been advised that if I have benefits for this service and I choose to utilize these benefits under my insurance, I will be given a lab order for this testing to be preformed at an outside lab with the results being sent to Southwest Florida Fertility Center, P.A. I further understand, should I elect to have this testing performed at an outside lab, Southwest Florida Fertility Center, P.A. can not guarantee the integrity of these results.

I have been advised that the fee for this service is $135.00 and is due in full prior to the analysis being performed at Southwest Florida Fertility Center, P.A. I further understand that should an outside office request this analysis, without first being established as a patient of Southwest Florida Fertility Center, P.A. my results will be sent to the requesting physician and I will be notified of the results by my personal physician.

Finally, I have been advised that this acknowledgment will stand for any and all subsequent semen analysis performed by Southwest Florida Fertility Center, P.A.

_____ _____

Patient Signature Date

_____ _____

Witness Date

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NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visitis made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- a basis for planning your care and treatment
- a means of communication among the many health professionals who contribute to your care
- a legal document describing the care you received
- a means by which you or a third-party payer can verify that services billed were actually provided
- a tool in education health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- an understanding of what is in your record and how your health information is used to help you to:
    - ensure its accuracy
    - better understand who, what, when, where, and why others may access your health information
    - make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of *Southwest Florida Fertility Center, P.A.; Jacob L.Glock, M.D.*, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the director of health information management at *(239) 561-3430.*

If you believe your privacy rights have been violated, you can file a complaint with the directorof health information management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of our staff will be recorded in your record and used to determine the course of treatment that should work best for you. Dr. Glock will document in your record his expectations of the members of our staff. The staff will then record the actions they have taken and their observations. In that way, Dr. Glock will know how you are responding to treatment.

We will also provide Dr. Glock or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from our office or hospital; if applicable.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Federal Government: Due to the Centers for Disease Control and Prevention (CDC) implementing *The Fertility Clinic Success Rate and Certification Act of 1992 (FCSRCA)*, members of the medical staff must submit information related to all in vitro fertilization cycles to the Society for Assisted Reproductive Technology (SART) who will then forward the information to the CDC.

Business Associates: There are some services provided in our organization through contacts with Business Associates. Examples include diagnostic services, certain laboratory test, and anesthesia. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Organ / Tissue procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
For example: Members of our staff are required to notify the different Sperm Banks of pregnancies resulting from donated sperm.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Effective Date: April 10, 2003

_____ _____
Patient Signature **Date**

_____ _____
Witness **Date**

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Change in Office Policy

Dear Patient,

As I am sure you are aware of the new privacy laws, which become effective April 14, 2003, it will be necessary for our office to change some of our current procedures. The changes (which are required by law) are for your benefit in order to make sure that you can be confident that your private health care information is secure.

- When calling the office and requesting information you will be asked for the last 4 numbers of your social security number. If we are unable to verify with whom we are talking we will not release information. If you are having your spouse or someone else contact the office on your behalf, this person (s) must be noted on this form along with the last 4 numbers of their social security number and the relationship to you. You may make changes at any time by updating this form.

- If you are picking up forms, prescriptions or other information you will be asked to verify your entire social security number before we can give you the information. Please understand that this is for your benefit. We are required by law to safe guard your private healthcare information. The staff will try to accommodate you as best they can, however, they are required to ask for this information.

- If you are requesting our staff to release private healthcare information, you must complete the *Request for Access to Patient's Health Information* form. We are no longer able to accept a written note requesting medical information.

- If Dr. Glock is referring you to another physician for consultation, obstetrical care, etc. you must complete the *Patient Authorization to Use or Disclose Protected Health Information Patient Referral to Specialist* form.

- *Effective immediately,* our office will not forward / copy any protected health information received from another office / physician. This information is solely intended to aid Dr. Glock in his medical assessment of your condition and does not reflect his care of your medical treatment. Therefore, should you require a copy of your previous protected health information, you will need to request it form the provider of services.

In closing, our staff appreciates your patience and understanding of these changes

The following person (s) may have access to my private health care information:

Name	Relationship	Last 4 numbers of SS#

Patient Signature

Date

Southwest Florida Fertility Center, P.A.
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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Southwest Florida Fertility Center, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Southwest Florida Fertility Center, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Southwest Florida Fertility Center, P.A. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Southwest Florida Fertility Center, P.A. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept** / **decline** the terms of this consent.

_____
Patient's Signature

_____
Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PLEASE PRINT CLEARLY

To: Physician: _____

Address: _____

City/State/Zip: _____

Phone: (_____)_____

Fax: (_____)_____

You are hereby authorized to release and disclose the information from my medical record. I agree to the release and / or faxing of all of my medical records including records pertaining to HIV, sexually transmitted diseases, drug / alcohol abuse and psychiatric records to Southwest Florida Fertility Center, P.A., Jacob L. Glock, M.D.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Medical Record Number: _____

Please Include: *(Patient must initial each request)*

_____ Physician / Nurse / Staff Notes and / or Dictation

_____ Pertinent X-Ray copies and / or Narratives

_____ Lab Values, including HIV and Hepatitis

_____ Pathology Reports

_____ Operative Reports

_____ Psychiatric Records

_____ Medical Records from other Physicians contained within my chart

_____ Other: _____

Forward Medical Records to:

Southwest Florida Fertility Center, P.A.
Jacob L. Glock, M.D.
15730 New Hampshire Court unit 101
Ft. Myers, Fl. 33908
239.561.3430 Fax 239.561.6980

_____ _____
Signature of Consenting Party Date

_____
Relationship if other than patient

_____ _____
Witness Date

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PLEASE PRINT CLEARLY

Identifying Data

Date: _____

Your name _____ Partners name _____

Your age _____ Birth date _____ Height _____ Weight _____

Your occupation _____

Years of formal education _____

Length of marriage (or relationship) _____

How long have you been trying unsuccessfully to get pregnant? _____

Have you previously tried to get pregnant? _____

Reason for your visit today _____

_____

Do you have a Gynecologist? If yes, who? _____

When was your last pap smear? Date: _____ Mammogram? Date: _____

Pregnancy History

Times pregnant _____ Term births _____ Premature births _____ Miscarriages _____

Elective abortions _____ Adopted children _____

Date	mis-carriage	Elective abortion	Ectopic	Months to conceive	Infertility treatment	Weight & sex	Complications or c-section	Is current partner father
1.								
2.								
3.								
4.								
5.								

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Contraceptive Use

Type	From when to when	Reason discontinued
1.		
2.		

Operations and Hospitalizations

Date	Diagnosis	Operation	Where Performed	Physician
1.				
2.				
3.				
4.				

Medication:
Please list all prescriptions and over- the-counter drugs used during the past year.

Drug	Dosage and Frequency	From when to when	Reason for taking
1.			
2.			
3.			
4.			
5.			

Allergies

To what drug or substance	When	Reaction
1.		
2.		
3.		

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Menstrual (hormonal) history

First day, actual flow not spotting, of your last menstrual period _____

Your age at your first period _____

Are your periods regular _____

How many days form onset to onset _____

How many days does your period last _____

Do you bleed between periods _____

Do you have premenstrual symptoms ☐ Almost always ☐ Rarely ☐ Never

Vigorous exercise: Type_____ Hours/week _____

If you have a hormonal disorder, please specify type and treatment _____

_____

Pelvic pain/cramps: ☐ none ☐ during your period ☐ before your period ☐ after your period
☐ at mid cycle ☐ during intercourse ☐ with urination ☐ with bowel movement
☐ cause you to miss usual activities ☐ cause you to miss work/school

Pelvic pain/ cramps are: ☐ mild ☐ moderate ☐ severe ☐ getting worse ☐ improving ☐ not changing
☐ on the right side ☐ on the left side ☐ in the middle

Do you have or have you had:

Hot flashes	☐ Yes	☐ No	Increased facial or body hair	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No	Increased acne	☐ Yes	☐ No
Vision problems	☐ Yes	☐ No	Weight gain greater than 10 pounds	☐ Yes	☐ No
Poor sense of smell	☐ Yes	☐ No	Weight loss greater than 10 pounds	☐ Yes	☐ No
Chronic headache	☐ Yes	☐ No	Special dietary habits	☐ Yes	☐ No
Head injury	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Autoimmune	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No	Psychiatric treatment	☐ Yes	☐ No
Excessive stress	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No

If you answered yes to any questions, please explain _____

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Physical Conditions/ Infections

Do you have or have you had

Pelvic infection	◻ Yes	◻ No	Abnormal uterus	◻ Yes	◻ No
Chlamydia	◻ Yes	◻ No	Colitis or enteritis	◻ Yes	◻ No
Antichlamydial antibodies	◻ Yes	◻ No	Endometriosis	◻ Yes	◻ No
Gonorrhea	◻ Yes	◻ No	Pelvic Adhesions	◻ Yes	◻ No
Syphilis	◻ Yes	◻ No	Ovarian cyst	◻ Yes	◻ No
Mycoplasma	◻ Yes	◻ No	Uterine fibroids	◻ Yes	◻ No
Ureaplasma	◻ Yes	◻ No	Toxoplasmosis	◻ Yes	◻ No
Tuberculosis	◻ Yes	◻ No	DES exposure		
Cytomegalovirus (CMV)	◻ Yes	◻ No	in womb	◻ Yes	◻ No
Cervicitis	◻ Yes	◻ No	Recurring vaginitis	◻ Yes	◻ No
Genital herpes	◻ Yes	◻ No	Abnormal pap smears	◻ Yes	◻ No
Genital warts/ condyloma	◻ Yes	◻ No	Cryo (freezing) or		
Trichomonas	◻ Yes	◻ No	surgery of the cervix	◻ Yes	◻ No

How many times per week do you have sexual intercourse? _____

How many times do you have intercourse around ovulation? _____

Do you use lubricants for intercourse? If yes, what? _____

Do you douche before or after intercourse? _____

Number of current sexual partners: _____

Number of total past sexual partners: _____

Have you ever tried conceiving with another partner? ◻ Yes ◻ No

Problems with conceiving in your previous relationship? ◻ Yes ◻ No

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Other Medical History

Cigarettes –packs smoked per day _____

Alcohol-type and number of drinks/week _____

Marijuana-amount _____

Other drugs-type and amount _____

Ever used intravenous drugs _____

Caffeine drinks per day _____

Radiation Exposure _____

Toxic exposure _____

Electric blanket use _____

List all serious or chronic illnesses or injuries not already described _____

_____

_____

_____

_____

Do you or your family members have: ☐ infertility ☐ hormonal disorder ☐ other inherited disorders

If yes, please explain _____

_____

_____

_____

_____

_____

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Partner's Medical History

Your partner's age _____ Occupation _____

List all serious or chronic illnesses or injuries _____

Medications _____

Cigarettes-packs smoked/day _____

Alcohol-type and number of drinks/week _____

Marijuana-amount _____

Other drugs-type and amount _____

Ever use intravenous drugs _____

Caffeine drinks per day _____

Radiation exposure _____

Toxic exposure _____

Electric blanket use _____

Hot tub or sauna use _____

Any problems with erection or ejaculation _____

Has a semen analysis ever been abnormal _____

Has your partner seen a doctor for infertility evaluation _____

Doctor _____

Diagnosis _____

Treatment _____

Has your partner ever initiated any pregnancies in the past? ☐ Yes ☐ No

Number of pregnancies? _____

Number with current partner? _____

When was the most recent pregnancy? _____

Number of current sexual partners: _____

Number of total past sexual partners: _____

How many times per week does your partner have sexual intercourse? _____

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Partner's Medical History Continued

Has your partner ever tried conceiving with another partner before? ☐ Yes ☐ No

Problems with conceiving in previous relationship? ☐ Yes ☐ No

Any inherited diseases in your partner's family _____

Dose your partner have or has he had:

Chlamydia	☐ Yes	☐ No	Vasectomy	☐ Yes	☐ No
Antichlamydial antibodies	☐ Yes	☐ No	Vasectomy reversal	☐ Yes	☐ No
Gonorrhea	☐ Yes	☐ No	Varicocele	☐ Yes	☐ No
Syphilis	☐ Yes	☐ No	Varicocele surgery	☐ Yes	☐ No
Mycoplasma	☐ Yes	☐ No	Biopsy of testicles	☐ Yes	☐ No
Ureaplasma	☐ Yes	☐ No	Hernia surgery	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Abdominal surgery	☐ Yes	☐ No
Cervicitis	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Genital herpes	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Genital warts/ condyloma	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Colitis	☐ Yes	☐ No
Urethritis/epididymitis	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Prostatitis	☐ Yes	☐ No	Psychiatric treatment	☐ Yes	☐ No
Penile discharge or pain	☐ Yes	☐ No	Excessive stress	☐ Yes	☐ No
Undescended testicle	☐ Yes	☐ No	Strenuous exercise	☐ Yes	☐ No
Injury to the testicle(s)	☐ Yes	☐ No	Tight underwear	☐ Yes	☐ No
Mumps with injury to testicles			Physical abnormality	☐ Yes	☐ No
injury to testicles	☐ Yes	☐ No	DES exposure in womb	☐ Yes	☐ No

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Previous Treatment

Treatment	Patient	Partner	How many months	Dosage (in known)	Approx. dates taken
Antibiotics					
Name of:					
Provera (to bring on menses)					
Clomiphehe (Clomid)					
hCG (Profasi)					
Progesterone in Oil					
Crione 8% gel					
Follistim					
Gonal-F					
Pergonal					
Repronex					
Lupron 2 week kit					
Lupron monthly dose					
Intrauterine Insemination					
Insemination with Donor sperm					
IVF					
ICSI					
GIFT					