CU Advanced Reproductive Medicine
Anschutz Medical Campus
Department of Obstetrics and Gynecology
Division of Reproductive Endocrinology

3055 Roslyn Street
Suite 230
Denver, CO 80238
303-724-8089 Phone
303-724-8149 Fax

In order to provide you with an efficient and effective experience, a thorough review of your medical records (including the enclosed history form) prior to your appointment is necessary. Please send a written request to the physician's office or hospital where you have been treated to have your medical records faxed (less than 20 pages) or mailed (more than 21 pages) to the address above. Additionally, if an x-ray such as a hysterosalpingograms (uterine tubal x-ray) has been performed, please request that the actual x-ray films be sent. If it were not possible to send your records prior to your appointment, it would be very helpful to bring them with you when you come in. Please include the enclosed medical history form with your records.

The office is open Monday-Friday 7:15 am-3:00 pm; and Tuesday and Wednesday evenings for New Patient visits 4:15-6:30 pm.

Financial consideration is an important and necessary concern of all patients. We at CU Advanced Reproductive Medicine, University Physicians, Inc., and University of Colorado Hospital have made every effort to set fees at reasonable rates. **Please be sure that you understand your insurance plan completely and that you refer to our financial information.** If you have health insurance through a managed care plan, it might be necessary for you to obtain an authorization or referral from your primary care physician or insurance company prior to your visit. **Unfortunately, if you fail to do so, your insurance company may refuse to accept changes and you will be responsible for paying for services that might have been covered if you had obtained authorization.**

Enclosed for your convenience is a checklist which will prepare you for your visit. It is our hope that this information is helpful to you and addresses some of your concerns. Should there be any questions prior to your appointment, please feel free to contact our office at 303-724-8089.

Enclosed are two medical record release forms. **(These are optional)** These forms are not to release information outside of the clinic. These forms allow us to share medical information between spouses/significant others (**otherwise not acceptable under HIPAA).** Please bring all enclosed forms with you at the time of your first appointment.

You will also be asked to sign the "Consent to Treat" and the HIPAA form. This is necessitated by the passage of the Health Insurance Portability and Accountability Act (HIPAA). This law has placed very specific constraints on what medical information can be communicated or shared.

We look forward to meeting you.

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Financial Information for Patients

Billing Process

When you called our clinic as a new patient, our schedulers gather all your demographic and insurance information.

It is the patient's responsibility to know your coverage/benefits and obtain the proper referrals to be seen by the physician. **If you are coming to us as a "self-pay" (no insurance, no referral required), you will be asked to pay $200. This amount applies for all new and return visits as a self-pay only.**

Self-pay patients are eligible for discount services, when paid at the time of service.
UPI provides a 40% discount
UCH provides a 50% discount (for any service obtained at University of Colorado Hospital
If you are unsure if your insurance will pay for any given appointment or service, you may elect to utilize this "self-pay" discount and submit the claim to your insurance company yourself. If they do cover the service, they will reimburse you directly at their discretion.

Labs – The clinic utilizes **LabCorp** for any labs that are drawn at the clinic. We have a contract with LabCorp that allows us to provide a discount for labs. This discount only applies if you are self-pay at the time of service. If you are utilizing your insurance, please check with your insurance to make sure that they are contracted with LabCorp. If your insurance is not and you would like to use your insurance, a physical order will be given to you to obtain the labs at an in-network lab service.

Co-Payments, as indicated by your insurance plan, **are required at the time of service.** If you are unable to pay your copay at the time of service, your appointment may be rescheduled.

For each outpatient visit you will receive one statement.

- **UPI (University Physicians, Inc.)** will bill you for services provided by your physician as well as any physicians in ancillary departments who participate in your care (i.e., pathologist, radiologist, etc.)
- **If any services are provided through UCH, you will receive a separate billing statement for the facility component.**

If you have any questions regarding a statement or invoices from either UPI or UCH, please contact the appropriate billing department which will be listed on any invoice you receive. For your convenience, the telephone numbers for Patient Accounts are:
UPI: 303-493-7000 or 1-800-621-9134 and
UCH: 720-848-8800 or 1-866-429-6045
Statements are sent from the billing office of location.
NO BILLING OR STATEMENTS ARE GENERATED OR SENT FROM THE CLINIC. PLEASE CONTACT THE ABOVE PATIENT ACCOUNTS FOR ASSISTANCE.

Insurance Information
Please keep in mind that your insurance policy represents a contract between you and your insurance company. **It is your responsibility to understand your benefits and to submit information needed to correctly and timely process your claims.** Please contact your insurance representative if you have any questions.

If you have a health insurance that requires referrals, it may be necessary for you to contact your Primary Care Provided (PCP) to obtain a referral. If you fail to do so, your insurance company may refuse to accept charges and you will be responsible for paying for services for which you may have coverage.

In the event that additional information is needed to process a referral, do not hesitate to let us know. These are standard requests and can be easily accommodated when given sufficient time prior to your scheduled appointment. **Most insurance providers require at least 48 hours notification for a referral request.**

Assisted Reproductive Medicine Procedures
It is the policy of the CU Advanced Reproductive Medicine Center to **collect all fees** for assisted reproductive medicine procedures **prior to the procedure (this includes IVF procedures).** You may be required to sign a financial waiver if we currently have insurance information in our billing system.

Surgeries
Any time surgery is recommended, you should check on your insurance coverage. It is important also to know your diagnosis and to verify your own benefits for a procedure. For example, an outpatient laparoscopy procedure may be covered, but when done for a diagnosis of infertility, no benefit is provided. Your insurance company may contain stipulations about "preferred" or "network" providers. If your surgery is performed by a physician or in a hospital that is not within the network, your benefits may be reduced.

Remember—even though your surgery may be covered, it may not be covered at 100%. Additionally, your insurance company may pay only what they consider "usual and customary" charges. You may be responsible for any difference in these charges.

Co-payments for surgery, as indicated by your insurance plan, must be paid at the time of admission. Once you have been scheduled for surgery with one of our physicians at UCH, our Surgery Scheduler will contact your insurance company. At this time benefits will be verified. **The pre-certification from your insurance company does not guarantee payment**. *If you are having an elective procedure not paid by insurance, you will be responsible for paying 80% of the estimated operating room costs prior to the date of surgery. The remaining 20% will be billed to you by UCH and UPI post-services.*

If your insurance requires referrals, it may be necessary for you to obtain a referral from your Primary Care Physician for the surgery.
The following are a list of questions for you to ask your HR department and insurance company in order to assist you in understanding your benefit.

Questions for your Employer/Benefits Administrator (HR Department)

- Is infertility covered on my current health plan?
    - If NO: Do we have a plan that does cover infertility?
        - Can I change plan? When?
        - What is the waiting period before I can start treatment for a pre-existing infertility condition?
        - If infertility is a benefit, does it include diagnosis AND treatment?
        - Are there restrictions to the infertility benefit?
        - Are infertility medications covered?

Questions for your Insurance Company

Be sure to get the name of the person with whom you are speaking, as well as his/her telephone number an extension if available.

- What is my infertility benefit?
- Am I restricted to using certain specialists or infertility clinics? If so, which ones?
- Does my benefit include treatment and diagnosis? What is excluded?
- Do I have a lifetime maximum benefit? If so, what is the limit?
- Do I have a calendar year maximum benefit? If so, what is the limit?
- Do I need a referral for diagnostic or treatment procedures?
- What is the maximum number of allowed attempts for fertilization procedures other than In-Vitro Fertilization (VF), such as ovulation induction and intrauterine insemination?
- What is the maximum number of allowed attempts for IVF?
- Is embryo cryopreservation and storage covered?
- Are donor sperm and/or egg options covered?

Hopefully this document has helped with any questions you have regarding the financial aspect of our clinic. If you have any further questions, please call our front desk at 303-724-8089 and we will be happy to help.

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New Patient Checklist

___ **Medical Records:** Obtain past medical records by contacting physicians and hospitals where you have been treated (including x-rays such as a hysterosalpingograms [HSG]). Many medical offices take at least a week to respond to these requests. *Please have these records and films sent to us 7 days prior to your appointment or bring them with you.*

Our Fax Number: (303) 724-8149 - **for documents of 20 pages or less – PLEASE DO NOT FAX MORE THAN 20 PAGES AND ONLY PERTINENT RECORDS RELATED TO INFERTILITY TREATMENT**

Our Mailing Address or address for Fed-Ex or other overnight delivery services:

CU Advanced Reproductive Medicine
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___ **New Patient History Form:** Please complete the enclosed form before your appointment. It will take 30-45 minutes. *Please bring the completed form with you to your appointment. OR you can mail or fax it back to us at least 7 days prior to your appointment at the above address or fax number.*

___ **Release of Medical Information:** Due to the passage of the Health Insurance Portability and Accountability Act (HIPAA), there have been some very specific constraints on how medical information can be communicated or shared. You will have an opportunity to read our notice of privacy practice during check-in on the day of your appointment. In the meantime, *please complete the **pink and blue forms**. One form is to release reproductive medical information to our identified patient from her partner; the other is for the partner to release his/her reproductive medical information to our patient.*

___ **Insurance:** Insurance plans vary widely on their benefits for treatment of infertility. It is imperative that you understand your particular benefits. Please read the yellow packet of financial information specific to our clinic. You may find the list of suggested questions to ask your provider helpful in understanding your plan.

___ **Parking:** You are able to park in the lot at our building.

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INFORMATION REGARDING PSYCHOLOGICAL SERVICES

Lynn Starker Blyth, Ph.D.
Joan Manheimer, Ph.D.

We would like to introduce ourselves as the clinical psychologists at the CU Advanced Reproductive Medicine Center. Our affiliation with the Center indicates the program's commitment to addressing the emotional as well as the physical issues that are associated with working to achieve pregnancy.

The process of medical treatment can be highly stressful due to the intense levels of hope, frustration, anxiety, excitement, and sadness that many people experience. There are often emotional side effects to medication and hormonal treatments. People going through infertility treatment often feel confused and isolated, and feel that few other people can relate to their life situation. We are available to help you discuss these feelings and to work out plans for coping with this difficult time.

Our office hours at the Center are Wednesdays or we can meet at alternate times at our offices located near Cherry Creek. You can reach either one of us by calling the Center at 303-724-8089 (scheduling) or Dr. Blyth at 303-744-2121 and Dr. Manheimer at 303-331-1818. We are available for individual or couple appointments for consultation, counseling, or referral to appropriate resources.

Please do not hesitate to contact us or to let any of the staff know if we can be of help. We look forward to meeting you.

PLEASE FILL IN AS COMPLETELY AS POSSIBLE:

CU Advanced Reproductive Medicine
Division of Reproductive Endocrinology
Hormonal Disorders/Menopause History Form **Date of visit:** _____

Name: _____ Age: _____ Birth date: _____

Address: _____
Street *City* *State* *Zip Code*

Home telephone: (_____) _____-_____ E-mail address_____

Your occupation: _____Your employer: _____

Work telephone: _____Cell phone: _____

Marital status: Married Single Separated Divorced Other

If applicable:

Your partner's name_____ Partner's occupation: _____

Partner's employer: _____Partner's work telephone: _____

Partner's cell phone_____ Partner's e-mail address_____

Physician who referred you: _____

Referring physician address: _____
Street *City* *State* *Zip Code*

Referring physician telephone: _____ Fax: _____

Reason for your clinic visit: _____

Allergies to medications:

_____

_____

Allergy to: Latex ____ Iodine_____ Shellfish_____ Contrast material_____

Describe as thoroughly as possible the background of your present problem(s). Include all symptoms you feel may be helpful, how long you have experienced them, and indicate whether they have become worse, lessened, or stayed the same in severity over time. Please try to organize your problems by priority. List your most pressing problem as #1, your next more pressing as #2 and so on.

_____

_____

_____

_____

_____

_____

Please feel free to use the following section for any additional information you feel may be helpful in your evaluation: _____

_____

_____

_____

_____

_____

_____

I. MENSTRUAL HISTORY: (If you have not had a period in more than a year due to menopause, please skip to Section II)

At what age did you begin to menstruate? _____

What were the dates of your last two menstrual periods? _____ and _____

Have you ever gone more than 3 months without having a period? YES NO

If yes, how long? _____ months _____ years

List approximate dates when this occurred: _____

Are your cycles: REGULAR IRREGULAR

If irregular, please describe: _____

What is the average length of your menstrual cycle? _____

(Interval from first day of bleeding until day before bleeding of the next cycle.)

Has this changed since puberty? YES NO

If yes, please explain: _____

How many days does your period last? _____ Is the flow: LIGHT MEDIUM HEAVY

Does this vary? YES NO

If yes, please explain: _____

Can you tell you are about to have a period before you start bleeding (breast tenderness, fullness, etc)? YES NO

Do you have a clear vaginal discharge around the time of ovulation? YES NO

Do you have pain **during** your periods? YES NO

If yes, please explain: _____

Do you have pain **between** periods? YES NO

If yes, please explain: _____

Do you bleed between periods? YES NO

If yes, please describe frequency and amount of blood loss: _____

_____

Frequency of intercourse: _____ times per week _____ times per month _____ N/A

Changes in libido (interest in sex)? YES NO N/A

Do you bleed during or after intercourse? YES NO N/A

Any pain during or after intercourse: YES NO N/A

Do you have any noticeable discharge? YES NO N/A

If yes, describe your discharge (noting color, consistency, presence of odor, itching, etc.: _____

_____

Have you had regular gynecologic exams? YES NO

Date of last exam: _____

Date and result of last Pap smear: _____

Have you had regular breast examinations? YES NO

Date of last exam: _____

Date and findings of last abnormal exam: _____

Date and findings of last mammogram: _____

Have you ever had a milky discharge from one or both breasts? YES NO

If yes, when: _____

Have you had a history of: *[If yes, please give date(s)]*

Chlamydia: _____

Gonorrhea: _____

Pelvic (tubal) infection: _____

List all **gynecologic** surgical procedures you have had, the approximate date, duration of your hospitalization, and the name of the hospital where you had your surgeries performed.

Surgery	***Date***	***Stay***	***Hospital***	***City, State***

OBSTETRICAL HISTORY: *(If not applicable, please continue onto the next section.)*

	Number	**Date(s)**	**Months to conceive**	**Sex/Weight**	**Vaginal/C-section**
Full term deliveries (36+ weeks)					
Premature deliveries (<36 weeks)					

	Number	Date(s)
Miscarriages		
Induced abortions		
Ectopic pregnancies		
Stillbirths		
Newborn deaths		

Were there any complications during or after your pregnancies (infection, excessive bleeding, need for a transfusion)? YES NO

If yes, state which delivery and describe the complication(s): _____

Were any of your children born with congenital defects? YES NO

If yes, state which delivery and describe the congenital defects: _____

Dates of pregnancies with your present partner: _____

Number of living children from this relationship: _____

Did you have any pregnancies/children from a previous partner? YES NO

If yes, list the dates of the pregnancies: _____

Living children? _____

If applicable, dates of pregnancies through artificial insemination (donor sperm only): _____

Living children? _____

CONTRACEPTION: *(If not applicable, please continue onto next section.)*

Please check any of the following methods of contraception you are currently using and/or have used in the past. Fill in the dates of usage.

	Method		**Dates of usage:**
_____	Birth Control Pills	Type: _____	
_____	IUD	Type: _____	
_____	Diaphragm		
_____	Condom		
_____	Jellies/Foam		
_____	Withdrawal		
_____	Sterilization	___ Male ___ Female	
_____	Other	_____	

GENERAL MEDICAL HISTORY:

List current medication(s), including prenatal vitamins or supplements. State the name of the medication, indication for its use, and how long you have taken it. Include prescription and over-the-counter medications, herbs, and vitamins.

Medication	Began	Used through	Dosage	Indication(s)

List all serious medical illnesses and **non-gynecologic** surgeries/procedures with date(s). If hospitalized, list where.

Describe your general health: _____ Excellent _____Good _____Fair _____Poor

Childhood illnesses: _____ Routine (chicken pox, measles, mumps, etc.) _____ Unusual
*If unusual, please describe:*_____

Have you ever been in a serious accident? YES NO
*If yes, please describe:*_____

Have you ever had a blood transfusion? YES NO
If yes, approximate date(s): _____

Do you drink alcohol? DAILY WEEKLY MONTHLY NEVER

Do you smoke cigarettes? YES NO
*If yes, how many cigarettes per day?*_____
If you smoked in the past and have since quit, please give the approximate dates of smoking: _____

Do you exercise regularly? YES NO

If you exercise regularly, describe the frequency:

Every day 5-6 days/week 2-4 days/week 1-2 days per week

If you exercise regularly, describe the type of exercise:

Cardio Weight training Yoga Team sports Other_____

If you exercise regularly, describe the length of time you exercise daily:

Up to 20 minutes 20-45 minutes 45-60 minutes More than 60 minutes

Do you drink caffeinated beverages (coffee, tea, soda, etc)? If so, how what and how much:

_____

_____

Drug usage in the past year:

Drug	**Extent of exposure**
Marijuana	_____
Cocaine	_____
Depressants	_____
Stimulants	_____
Other: _____	_____
_____	_____

Have you had any difficulty or recent change in your habits of sleep, diet, or exercise? YES NO

If yes, please describe: _____

_____

ETHNICITY (circle all that apply)

Caucasian

Caucasian Hispanic (Latina)

Black Non-Hispanic

Black Hispanic (Latina)

Mainland Asian

Asian Pacific Islander

FAMILY HISTORY:

Are you adopted YES NO

	Living	**Age and cause of death**
Mother	Y N	_____
Father	Y N	_____
Brother(s)	Y N	_____
	Y N	_____
Sister(s)	Y N	_____
	Y N	_____

DISORDERS IN FAMILY:
Have any members of your family (parents, children, brothers, sisters, grandparents, uncles, aunts, or cousins) had any of the following?

Disorder			**Relationship to you**
Cancer	YES	NO	
Diabetes	YES	NO	
Thyroid disorders	YES	NO	
Blood clotting disorder	YES	NO	
Seizures	YES	NO	
Obesity	YES	NO	
Psychiatric disorders	YES	NO	
Infertility	YES	NO	
Multiple miscarriages	YES	NO	
Baby born with birth defects	YES	NO	
Chromosome abnormalities	YES	NO	
Kidney disease	YES	NO	
Depression	YES	NO	
Brain or spine abnormalities *(hydrocephalus, spina bifida)*	YES	NO	
Hearing problems/deafness	YES	NO	
Cleft lip and/or cleft palate	YES	NO	
Down syndrome	YES	NO	
Muscular dystrophy	YES	NO	
Epilepsy *(convulsions/seizures)*	YES	NO	
Mental retardation	YES	NO	

Family Mental Health History: Please indicate if any of your immediate family has a history of:

( ) Depression, Bipolar Disorder or other Mood Disorder
( ) Anxiety Disorders (panic attacks, general anxiety, phobias, obsessive-compulsive disorder)
( ) Psychiatric Hospitalizations or suicide attempts
( ) Eating Disorders
( ) Alcohol or other substance abuse problems
( ) Learning disabilities/ADHD
( ) Medications for depression or anxiety (please specify): _____

REVIEW OF SYSTEMS:
Check any of the following disorders **you** currently have or have a history of:

Central Nervous System
( ) Seizures
( ) Migraine headaches
( ) Other: _____

EENT
( ) Eye disorders
( ) Double or blurry vision
( ) Problem with sense of smell

( ) Other: _____

Cardiovascular
( ) Chest pain
( ) Palpitations
( ) Diagnosed with rheumatic fever
( ) Heart valve disease
( ) High blood pressure
( ) Mitral valve prolapse
( ) Given prophylactic antibiotics
( ) Other: _____

Respiratory
( ) Shortness of breath
( ) Asthma *(date of last attack: _____)*
( ) Bronchitis
( ) Pneumonia
( ) Cough producing blood
( ) Tuberculosis
( ) Other: _____

Gastrointestinal
( ) Nausea/vomiting
( ) Blood in stool
( ) Ulcers
( ) Hepatitis
( ) Constipation
( ) Spastic colon
( ) Other: _____

Genito-urinary
( ) Bladder infections *(cystitis)*
( ) Kidney infection
( ) Vaginal infections
( ) Frequent urination
( ) Other: _____

Musculo-skeletal
( ) Unusual muscle weakness
( ) Decreased energy/stamina
( ) Rheumatoid arthritis
( ) Lupus erythematosus
( ) Other: _____

Hematologic
( ) Unusual muscle weakness
( ) Sickle cell anemia or trait
( ) Thrombophlebitis
( ) Other: _____

Endocrine

( ) Diabetes
( ) Thyroid disease
( ) Excessive growth or hair on various parts of the body
( ) Hair loss
( ) Unexplained rash
( ) Rapid weight gain
( ) Rapid weight loss
( ) Excessive hunger/thirst
( ) Other: _____

Skin/Extremities

( ) Unexplained rash
( ) Acne
( ) Skin cancer
( ) Injuries
( ) Dermatitis
( ) Other: _____

Mental Health

Mental Health History: Please indicate if you have a history of:

( ) Depression, Bipolar Disorder or other Mood Disorder
( ) Anxiety Disorders (panic attacks, general anxiety, phobias, obsessive-compulsive disorder)
( ) Psychiatric Hospitalizations or suicide attempts
( ) Eating Disorders
( ) Alcohol or other substance abuse problems
( ) Learning disabilities/ADHD
( ) Medications for depression or anxiety (please specify): _____

Thank you for taking the time to fill out this questionnaire. Your responses to these questions will be used to guide your physician interview.

Google

To see all the details that are visible on the screen, use the "Print" link next to the map