REPRODUCTIVE SPECIALISTS OF NEW YORK

200 Old Country Road, Suite 350, Mineola, NY 11501 516.739.2100
2500 Nesconset Highway, Building 23B, Stony Brook, NY 11790 631.246.9100
1111 Montauk Highway, Suite 204, West Islip, NY 11795 631.482.9020
16 Court Street, 27th Floor, Brooklyn, NY 11241 718.935.9766

YOU HAVE AN APPOINTMENT WITH DR. _____

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT, YOU MUST CALL AND CANCEL WITHIN 24 HOURS PRIOR TO YOUR SCHEDULED TIME.

PLEASE BE AWARE THAT PAYMENT IS DUE AT THE TIME OF SERVICE.

HERE IS A LIST OF INSURANCE COMPANIES THAT OFTEN REQUIRE REFERRALS. IF YOU HAVE ONE OF THESE POLICIES, PLEASE CONTACT YOUR INSURANCE COMPANY TO OBTAIN A REFERRAL. FAILURE TO BRING A VALID REFERRAL WILL RESULT IN THE RESCHEDULING OF YOUR APPOINTMENT.

AETNA (All policies)……**Call to register with Aetna's Infertility Hotline 800.575.5999**

AETNA (HMO)……**Aetna referral from PCP only** (in addition to above registration)

BCBS (HMO)……... **BCBS referral from PCP only**

HIP ……**HIP authorized referral from PCP or Gyn**

OXFORD (All policies)……**Call to register with Optum (877) 512-9340**
Oxford's managed infertility program

OXFORD (HMO)……**Oxford referral from PCP or Gyn**
(in addition to above registration)

NYS EMPIRE PLAN……**Call to register 877.769.7447 (**Only when planning IVF)

all referrals require an authorization number; handwritten referrals are not insurance-acceptable

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Dear Patient,

All of us at Reproductive Specialists of New York would like to take this opportunity to welcome you to our practice.

As you may know, Insurance coverage for Infertility treatment varies greatly depending on carrier and plan.

Many insurance companies will require you to obtain a referral from your primary care physician or your OB/GYN prior to seeing one of our physicians. In most instances, the referral will specify the exact type of service (consultation) or number of visits authorized. It is very important for you to monitor this carefully and obtain subsequent referrals when necessary. You will be responsible for any services denied due to lack of referral and or authorization as well as any co-payments or deductibles that may apply.

It is also extremely important to have thorough knowledge of the extent of your coverage for infertility. For instance, although you may have coverage for diagnostic treatment relating to infertility, the treatment of infertility may not be a covered benefit. **It is important that you contact your insurance carrier or refer to your policy booklet in order to fully understand your specific infertility coverage prior to starting treatment.**

The attached forms must be completed and handed in at the time of your new patient appointment. If you have any questions, our support staff is always available to assist you in any way possible.

Thank you,
The Team at Reproductive Specialists of New York

Reproductive Specialists of New York

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

This Joint Notice of Privacy Practices is being provided to you on behalf of Reproductive Specialists of New York with respect to reproductive medicine services provided at Reproductive Specialists of New York's facilities (collectively referred to herein as "We" or "Our). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

Your Rights

Although your health record is the physical property of Reproductive Specialists of New York, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by applicable law.
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for by applicable law.
- request to amend your health record as provided by applicable law.
- obtain an accounting of disclosures of your health information as provided by applicable law.
- 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:

We are 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 requests 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 us.

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

Permitted Uses and Disclosures

*We will use your health information for **treatment**. For example:* Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

*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, procedures and supplies used.

*We will use your health information for regular **health operations**. For example:* Members of the clinical 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 healthcare and the reproductive medicine service we provide.

We will collect health information on you and your spouse/significant other. For example: Although health information in your medical record belongs to you, it will contain some information pertaining to your spouse/significant other. This is because the treatment of infertility may focus on the couple, rather than the individual. We will share information with either partner, unless you indicate otherwise.

Other Uses or Disclosures of Protected Health Information

***Business Associates**:* There are some services provided at Reproductive Specialists of New York through contacts with business associates. Examples include: certain laboratory tests, and the services of social workers or psychologists. [Note: Reproductive Specialists of New York must identify BAs who use or disclose PHI] When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do, and bill you or your third party payer for services rendered. So that your health information is protected, 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 Spouse/ Family*:** Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

***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. In most cases, we will de-identify your patient information so that others can use the de-identified information to study reproductive health care and health care delivery without learning who you are.

***Marketing*:** We may contact you to tell you about or recommend possible treatment alternatives or other reproductive medicine technology 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, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

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. Data from your assisted reproductive technology (ART) procedure will also be provided to the Centers for Disease Control and Prevention (CDC). The 1992 Fertility Clinics Success Rate and Certification Act requires that the CDC collect data on all ART cycles performed in the United States annually and report success rates using these data. Because sensitive information will be collected on you, the CDC applied for and received an "assurance of confidentiality" for this project under the provisions of the Public Health Service Act, Section 308(d). This means that any information that the CDC has that identifies you will not be disclosed to anyone else without your authorization.

***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 workforce 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.

Note: HIV-related information, genetic information, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

For More Information or to Report a Problem/Complaint

If you believe your privacy rights have been violated, you should immediately contact:

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

If you have any questions or would like further information about this notice, please contact:

Selvi Kircher
200 Old Country Rd Ste 330
Mineola NY 11501
(516) 739-2100

This notice is also available on our website at www.rsofny.com

This notice is effective as of April 14, 2013.

Fertility Treatment and My Insurance:

WHAT DO I NEED TO KNOW?

First, check your wallet to determine if the "carrier" or insurance company responsible for your medical benefits is ALSO responsible for your pharmacy or drug coverage. How many cards do you have? It is not uncommon for your employer to have "unbundled" your health benefit from your drug benefit. This is extremely important since you will be prescribed medication during your treatment.

Prior to treatment, you will need to be familiar with how your medical AND pharmacy benefits are administered. This means you will need the following:

1. Your medical and pharmacy benefit cards. These may be together on one card or separate, depending on your plan.
2. The patient/member services contact information for BOTH.

Next, **FIND OUT EVERYTHING YOU CAN ABOUT YOUR COVERAGE!**

There is a great deal of information provided by most commercial health carriers regarding their medical and pharmacy policies. Your insurance company's website is a vital part of your quest to understand your coverage and maximize any available benefit you may have. This a good place to start.

When visiting the website, search "**medical policies**" for "**infertility" (some plans may refer to it as "ART", Assisted Reproductive Technology or Family Planning).** Next, determine what **your specific plan benefits include.** Remember, **not all plans have the same benefits – your employer dictates what benefit package you have.** If you are unable to find the information online (or in your employee handbook) it is best to call member services.

Keep in mind, many member services employees are highly unfamiliar with infertility treatment. If you get the feeling that the person you are speaking with does not understand your questions, it's best to ask for a supervisor before you get too frustrated.

On the next page you will find specific questions to ask regarding your coverage. Have these questions handy when calling your carrier.

QUESTIONS TO ASK ABOUT TREATMENT :

1. Do I have coverage for the diagnosis AND treatment of infertility?
2. If yes, are IUI's (Artificial Inseminations) covered? If so, is there any limit to how many?
3. If yes, is IVF (in-vitro fertilization) covered? If so, is there any limit to how many? For example, 3 cycle per year of IVF or 3 cycles per lifetime?
4. Is there a maximum dollar amount to my infertility treatment coverage? For example, $50,000.00 lifetime maximum for treatment?
5. If there is a dollar maximum, does it include medications?
6. Is there any age restriction for treatment?
7. Is pre-authorization required for treatment?
8. What is my co-pay and deductible obligation for my treatment?
9. Is there a limit to my out of pocket expense?

QUESTIONS TO ASK ABOUT PHARMACY/DRUG COVERAGE:

Since drugs used to treat infertility are considered "specialty drugs, they are often considered a drug benefit specific to high cost injectable medications.

1. Are drugs indicated for the treatment of infertility covered under my plan?
2. Do I need to use a specific pharmacy to have access to infertility drugs?
3. If I have to use a mail-order pharmacy, is there a local back-up available?
4. Do medications need pre-authorization?
5. What is my co-pay and deductible for infertility medications?
6. Is there a dollar limit or annual/lifetime maximum for medications?

It is important you take an active role in understanding your coverage. Understanding your benefits will allow you to maximize the coverage available to you!!

DIRECTIONS TO REPRODUCTIVE SPECIALISTS OF NEW YORK
200 Old Country Road, Suites 325, 330 and 350
Mineola, New York 11501
Telephone (516) 739-2100
Fax (516) 873-8068

From New York City and Queens:

Take 495 (Long Island Expressway East) to Exit 37 South (Willis Avenue). You will travel a short distance on the service road and make a right onto Willis Avenue South. ***** Continue on Willis Avenue (Willis Avenue ends at Old Country Road) to Old Country Road and make a right. We are located on the corner of Old Country Road and Mineola Boulevard (White and Glass Building). Make a right onto Mineola Boulevard and make the first right behind the building onto Third Street. Parking is available in the parking garage behind our building with the entrance to your left. Proceed to Level 2 of the garage, you will see a Blue visitor sign, and park in any of the unmarked spaces. The crosswalk is on level 4.

From the Bronx and Northern New Jersey:

Take the George Washington Bridge to the Cross-Bronx Expressway and follow the signs to the Throgs Neck Bridge. Take Throgs Neck Bridge to the Clearview Expressway to 495 East (Long Island Expressway). Follow directions above. *

From Staten Island, Brooklyn and Southern New Jersey:

Take the Verrazano Bridge to the Belt Parkway East to the Southern State Parkway East. Continue on the Southern State to the Meadowbrook Parkway North and get off at Exit M1 West (Old Country Road). ****** Make a left onto Old Country Road and continue for approximately 1 mile. Make a right onto Mineola Boulevard and make the first right behind the building onto Third Street. Parking is available in the parking garage behind our building with the entrance to your left. Proceed to Level 2 of the garage, you will see a Blue visitor sign, and park in any of the unmarked spaces. The crosswalk is on level 4.

From Eastern Long Island:

Take the Long Island Expressway West to Exit 37 South (Willis Avenue). Make a left (South) onto Willis Avenue and follow directions from above. *****

OR

Take the Southern State Parkway to the Meadowbrook Parkway North and get off at Exit M1 West (Old Country Road). Follow directions from above. ******

*****WEEKENDS AND HOLIDAYS*** YOU CAN PARK ON ANY LEVEL BELOW THE SECURITY GATE INCLUDING THE GROUND LEVEL OF THE GARAGE. TAKE THE GARAGE ELEVATOR TO THE 4TH LEVEL. IF THE DOOR IS LOCKED, YOU MUST USE THE SECURITY PAD AT END OF BLUE BRIDGE. ENTER 330 OR 350, WE WILL ANSWER AND THEN BUZZ THE DOOR OPEN FOR YOU.**

DIRECTIONS TO REPRODUCTIVE SPECIALIST OF NEW YORK
16 Court Street, 27th Floor
Brooklyn, NY 11241
Telephone 718-935-9766
Fax 718-935-9765

FROM QUEENS, NASSAU & SUFFOLK:

Take 495 (Long Island Expressway) east to the Brooklyn Queens Expressway (exit 17w) toward Staten Island. On the BQE travel approximately 5 miles. Stay in one of the two right lanes (to avoid the ramp to the Williamsburg Bridge). Take exit 29 for Tillary Street toward Manhattan Bridge/Brooklyn Civic Center. Stay in the middle lane to Cadman Plaza/Court Street. Turn left onto Court Street. Go 2 blocks to Montague Street. The building is on the corner of Court and Montague Streets, entrance next to Duane Reade pharmacy. 16 Court Street. 27th Floor.

From Staten Island and Southern New Jersey:

From the Verrazano Bridge take the Brooklyn Queens Expressway to exit 27- (Atlantic Avenue) turn right onto Atlantic Avenue and move immediately to the left lane. Turn left onto Hicks Street. Go 2 traffic lights and turn right onto Remsen Street. Take Remsen Street 3 blocks to Court Street and turn left (or park if you see a spot). The building is on the corner of Court and Montague Streets, entrance next to Duane Reade pharmacy. 16 Court Street 27th Floor.

SUBWAY:

2,3,4,5 or R train to Court Street/Borough Hall stop.

Exit from subway at the corner of Court Street & Montague Street. Enter building at 16 Court Street. (You are now on this corner).

A and C or F to Jay Street-MetroTech

Walk 3 blocks west to Court Street; Turn right and go 2 blocks to 16 Court Street.

Long Island Rail Road:

Take the Long Island Rail Road to Atlantic Terminal. (You may need to change trains in Jamaica, but it usually is just across the platform). Switch to the Brooklyn train to Atlantic Terminal Stop. At Atlantic Avenue station take the **2 or 3 subway line and follow above directions to Borough Hall Stop.**

DIRECTIONS TO REPRODUCTIVE SPECIALISTS OF NEW YORK
Stony Brook Medical Park
2500 Nesconset Highway
Building 23B
Stony Brook, New York 11790
Phone: 631-246-9100
Fax: 631-246-9156

L.I. Expressway (Route 495) to Exit 62, North-Stony Brook. Take 97 North (Nicolls Road) for approximately 6 miles. Make a left on Route 347 West to the first traffic light (entrance to Stony Brook Medical Park). Make a right into the Medical Park and proceed to Building 23 (in the back on the right hand side).

Northern and Southern State Parkways via Nesconset Highway (Route 347). Proceed on Nesconset Highway East past the Smith Haven Mall. The traffic light after Stony Brook Road (Hess Gas Station) is the entrance to the Stony Brook Medical Park (next to Burger King). Make a left at the light and proceed to Building 23 (in the back on the right hand side).

Routes 25, 25A, and 27 can also be used. These are East-West routes which feed into Route 97 (Nicolls Road).

DIRECTIONS TO REPRODUCTIVE SPECIALISTS OF NEW YORK
1111 Montauk Highway, Suite 204
West Islip, New York 11795
Phone 631-482-9020
Fax 631-482-9027

From the North Shore :

Take the LIE or Northern State Parkway to the Sagtikos Parkway South. Merge right (West) onto the Southern State Parkway. Take the Robert Moses Causeway exit South. Exit at RM2W (West) – Montauk Highway. Make a right at the traffic light and proceed ½ mile to 1111 Montauk Highway. The building is across from Good Samaritan Hospital.

From the South Shore:

Take the Southern State Parkway to the Robert Moses Causeway exit South. Exit at RM2W (West) - Montauk Highway. Make a right at the traffic light and proceed ½ mile to 1111 Montauk Highway. The building is across from Good Samaritan Hospital.

Alternate South Shore Route:

Take Ocean Parkway to Robert Moses Causeway exit North. Exit onto Montauk Highway West and proceed ½ mile to 1111 Montauk Highway. The building is across from Good Samaritan Hospital.

REPRODUCTIVE SPECIALISTS OF NEW YORK

Please choose an option for each section and INITIAL in box:

Authorization to Leave Voicemail

INITIALS (Patient) (Partner) **INITIALS**

YES, I allow Reproductive Specialists of New York (RS of NY) to leave a detailed message at the phone number(s) below with the detailed protected health information to convey my results including but not limited to: the type of test performed, the result, as well as any instructions pertaining to my infertility treatment.

Patient Phone Numbers : (1) _____ **Partner**: (1) _____

Please list in order of preference: (2) _____ (2) _____

(3) _____ (3)_____

OR ***OR***

NO, I do **NOT** allow RS of NY to leave a voicemail message to convey my results.

Patient **Authorization to Leave Information with Spouse/Partner** **Partner**

YES, I allow RS of NY to discuss my results by telephone with my spouse/partner, as long as they identify themselves as such.

OR ***OR***

NO, I do **NOT** allow RS of NY to discuss my results with my spouse/partner.

Authorization to E-mail

Patient **Partner**

YES, I allow RS of NY to use the email address listed below to communicate detailed protected health information including but not limited to: the type of test performed, the result, as well as any instructions pertaining to my infertility treatment. I understand that standard email is not a secure means of communication and that there is risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. I understand that phone and fax are alternative methods of communication available to me.

Patient E-mail: _____

Partner E-mail: _____

OR ***OR***

NO, I do **NOT** allow RS of NY to contact me by email to convey my results.

Patient Name: _____ DOB: _____

Signature: _____ Today's Date: _____

Partner Name: _____ DOB: _____

Signature: _____ Today's Date: _____

REPRODUCTIVE SPECIALISTS OF NEW YORK

PATIENT REGISTRATION SHEET

Patient Name: First_____ MI:____ Last:_____ Date_____
Address:_____
_____

Phone: Home: (_____) _____
Work: (_____) _____
Cell: (_____) _____
Email address:_____
Ethnicity: _____
Date of Birth: _____/_____/_____
Employer:_____
Social Security #: _____

HOW DID YOU HEAR ABOUT US?_____

PCP/OBGYN: Name_____ Phone:_____

Partner Name: First_____ MI:____ Last:_____
Address (if different than above):_____
_____
Phone: Work: (_____) _____
Email address:_____
Ethnicity: _____
Date of Birth: _____/_____/_____
Employer:_____
Social Security #: _____

Please be sure to include all zeros and do not use abbreviations

Insurance Information: Primary (Patient)
Insurance Company: _____
Name of Insured: _____
SSN of Insured:_____ Date of Birth of Insured: ____/____/_____
Policy #/Subscriber ID: _____ Group # _____

Insurance Information: Secondary (Spouse)

Insurance Company: _____
Name of Insured: _____
SSN of Insured:_____ Date of Birth of Insured: ____/____/_____
Policy #/Subscriber ID: _____ Group # _____

IMPORTANT: PLEASE BRING YOUR PRIMARY & SECONDARY INSURANCE CARDS WITH YOU AND A PHOTO ID

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REFERRAL WAIVER

It is required that this waiver be completed for all patients who have services rendered in our medical practice, regardless of insurance requirements, in the event that your insurance policy requirements change during your treatment at RS of NY.

It is the responsibility of the patient to ensure that our office receives all ***insurance-authorized*** referrals prepared by your primary care physician or gynecologist, as required by your insurance carrier. Note that *hand-written* doctor referrals are **NOT** acceptable for insurance purposes.

I, _____, understand that by signing this waiver I am responsible for payment of all services rendered if I do not provide RS of NY with a valid ***insurance-authorized*** referral for the services provided to me, should my insurance require a referral. If I do not possess a valid referral, **I fully understand I will be responsible for services denied due to not obtaining an insurance-authorized referral.** I am aware that a valid referral must be received within 24 hours of the date of service in order to be reimbursed.

Patient Signature _____

Date _____

Note: Currently, BlueCross/BlueShield HMO policies and Aetna HMO policies allow for referrals from your primary care physician **only**. No other physician is authorized to complete the referral. If you have never seen a primary care physician under your current insurance policy, contact your insurance company to see whom they have listed as your primary care physician. This information is subject to change without notice. Please contact your insurance carrier for referral details of your policy.

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FINANCIAL RESPONSIBILITY STATEMENT

I understand that if I am uninsured, or if Reproductive Specialists of New York does not participate with my insurance company, or if services are not covered by my insurance company, payment in full is due at the time of my appointment.

I understand that Reproductive Specialists of New York will invoice my insurance carrier for all services rendered for which I am covered by my insurer. I acknowledge that I am responsible for all charges incurred for my appointments, and associated labs and radiology, that may not be covered or may be denied by my insurance company.

It is my responsibility to inform Reproductive Specialists of New York of any change(s) in my insurance prior to any appointment scheduled, for which the insurance is to be billed. If I do not provide said information, I understand that I may be responsible for any charges incurred up until such date that I do provide all of the insurance information required. I further understand that failure to provide changes in my insurance information to Reproductive Specialists of New York may result in the denial of authorization for certain services which would have otherwise been payable by my insurer, for which I will become financially responsible.

I understand that, should my insurer require, it is my responsibility to obtain the proper authorization and/or referral from my primary care physician or gynecologist for treatment.

I understand that, should my insurer require, it is my responsibility to contact my insurance company and register with their infertility department (if applicable) prior to being treated and, in some cases, prior to my initial appointment. Should I fail to do this, I understand that I may be responsible for charges incurred that may have otherwise been payable by my insurer had I contacted and/or registered with them in a timely manner.

I have read the above statements and understand my responsibility.

_____ _____

Patient Signature Date

_____

Patient Name (please print)

Please refer to your individual plan booklet, the subscriber's human resource department, or your insurer for your policy limitations and exclusions.

REPRODUCTIVE SPECIALISTS OF NEW YORK

ACKNOWLEDGEMENT FORM

JOINT NOTICE OF PRIVACY PRACTICES

This is to acknowledge that I have received a copy of Reproductive Specialists of New York's

Joint Notice of Privacy Practices

Name: _____

Patient ID Number (RS of NY to provide)**: _____**

Signature: _____ Date: _____

Disposition: File this Acknowledgement Form in the patient's medical record.

REPRODUCTIVE SPECIALISTS OF NEW YORK

RECORDS RELEASE AUTHORIZATION

Date _____

_____ , _____DO HEREBY AUTHORIZE
(Print Your Name Here) (Date of Birth)

_____
DOCTOR'S NAME TELEPHONE
(gynecologist or other doctor from
whom we are requesting records) _____
FAX NUMBER

PLEASE PROVIDE THE MOST RECENT COPIES OF THE FOLLOWING:
PAP
SEMEN ANALYSIS
HYSTEROSALPINGOGRAM REPORT
BLOODWORK RESULTS
MAMMOGRAM
CERVICAL CULTURES
ALL IUI/IVF CYCLE RECORDS (STIM SHEETS, EMBRYOLOGY PAPERWORK, ETC.)

TO THE FOLLOWING DOCTORS AT REPRODUCTIVE SPECIALISTS OF NEW YORK:

JAMES STELLING, M.D. MARIA SAKETOS, M.D. LINDA SUNG, M.D. MARY BRAY, M.D. BRAD TRIVAX, M.D. MICHAEL LYDIC, M.D.	200 OLD COUNTRY RD, STE 350 MINEOLA, N.Y. 11501 TEL: 516-739-2100 FAX: 516-873-8068	2500 NESCONSET HGWY, BLDG 23B STONY BROOK, N.Y. 11790 TEL: 631-246-9100 FAX: 631-246-9156
ABRAHAM HALFEN, M.D.	1111 MONTAUK HGWY, STE 204 WEST ISLIP, N.Y. 11795 TEL: 631-482-9020 FAX: 631-482-9027	16 COURT STREET, 27TH FLR BROOKLYN, N.Y. 11241 TEL: 718-935-9766 FAX: 718-935-9765

PLEASE PUT DOCTOR'S NAME AND APPOINTMENT DATE ON MEDICAL RECORDS.
THANK YOU.

_____
PRINT NAME

_____ _____
PATIENT SIGNATURE DATE

Preconceptional Genetic / Perinatal Screening For Patients Considering Assisted Reproductive Technology

PATIENT'S NAME: _____ AGE: _____

PARTNER'S NAME: _____ AGE: _____

Sperm Source: ☐ PARTNER ☐ DONOR

Genetic Family History:

Your answers to the following questions will help in the care of your pregnancy and determine whether a genetic consultation would be beneficial to your family. **These questions refer to you, your immediate family (parents, siblings and children) and your extended family (grandparents, aunts, uncles and cousins). Please remember that these questions are for all blood relatives living and dead.**

Have you, the prospective father, or any family member ever been diagnosed with any of the following? (please check all that apply)

CONDITIONS

_____ Autism

_____ Blindness/early vision loss

_____ Cleft lip and/or cleft palate

_____ Deafness/early onset hearing loss

_____ Heart Defect (from birth)

_____ Hemophilia or other bleeding disorder

_____ Kidney Disease
(do not include infection/stones)

_____ Muscular Dystrophy

_____ Neurological Diseases

_____ Neural Tube Defects/Spina Bifida

_____ Birth Defects (any kind)

SPECIFIC DISEASES

_____ Cystic Fibrosis

_____ Down Syndrome

_____ Fragile X Syndrome

_____ Gaucher / Tay Sachs / Canavan / Familial Dysautonomia

_____ Huntington Disease

_____ Neurofibromatosis

_____ **Phenylketonuria (PKU)**

_____ Sickle Cell Disease / Thalassemia

_____ Spinal Muscular Atrophy

Please answer the following questions as best you can:

Does anyone in either of your families have:

- a genetic defect, or chromosome abnormality not listed above? YES NO
- a significant history of a stroke or clot (embolism) event? YES NO
- early onset (before age 50 years) breast and/or colon cancer or ovarian cancer at any age? YES NO
- a diagnosis of mental retardation or developmental delay? YES NO

Have you or the prospective father had:

- a baby that died shortly after birth or in the first year of life? YES NO
- a stillborn child, or two or more first trimester miscarriages? YES NO

Are you and the prospective father blood-related in any way (i.e., cousins)? YES NO

Population Screening (all ethnic backgrounds included) is being offered for the following conditions:

Do you know if you have been tested for:

Cystic Fibrosis	YES	NO
Fragile X Syndrome	YES	NO
Spinal Muscular Atrophy	YES	NO

Ethnically Based Carrier Screening (diseases that are more common in certain ethnic groups)

Please indicate the ethnic background of yourself and the prospective father (check all that apply):

Patient	Prospective Father	
_____	_____	African American, African or Black
_____	_____	Eastern European (Ashkenazi) Jewish
_____	_____	French Canadian
_____	_____	Italian, Greek or Middle Eastern
_____	_____	Southeast Asian, Taiwanese, Chinese or Philippine

Carrier Screening:

Genetic disorders resulting from alterations (also known as mutations) of a single gene account for 10% of pediatric deaths. In approximately 80% of these cases, there is no family history of genetic disease. Parental genetic screening for these diseases can identify and potentially prevent these inherited conditions. If either or both parental genetic screening tests result in an abnormality, an increased risk of conceiving a child with this abnormality may exist. Positive results should be discussed with a physician and a certified genetic counselor.

Reproductive Specialists of NY utilizes reference laboratories to identify patients that may be a carrier for a variety of diseases. Based on the couple's ethnicity, these laboratories can devise reproductive risk ratios when each couple's test results are combined and analyzed together. This combined analysis provides the most accurate results. While carrier screening testing can be waived, Reproductive Specialists of NY strongly recommends that all patients take advantage of this technology as a tool for optimizing your chances for a successful IVF cycle and a healthy baby.

Reproductive Specialists of NY recommends, at a minimum, the ACOG (American College of Obstetricians and Gynecologists) + ACMG (American College of Medical Geneticists). Although not completely comprehensive, these recommendations encompass common autosomal recessive single gene disorders in our multi-cultural, multi-ethnic society.

Please choose ONLY one of the following:

1. **YES, I HEREBY REQUEST** genetic counseling from a board certified genetic counselor. I understand that this service will comprise of taking an in depth personal and family medical history and analysis of potential risk for certain hereditary conditions and diseases. Based on the information that I provide, information about diagnostic or predispositional genetic testing for which I may be indicated will be offered for my physician and me to consider. I acknowledge that the genetic counselor does not diagnose, provide treatment, or order any type of test, that my physician is solely responsible for providing these services. By signing my name below, I acknowledge the above statements.

   I have received a list of genetic counselors whom I can consult or I can choose to find my own genetic counselor.

   Printed Name:_____

   Signed: _____Date:_____

   Contact Phone #: _____

OR

2. **NO, I DECLINE** to have genetic counseling. I understand and accept the consequences of this decision. Should I elect to pursue genetic counseling at a later date (or when I am pregnant), my testing options and/or treatment alternatives may be limited due to the gestational age of the fetus.

   Printed Name:_____

   Signed: _____Date:_____

Genetic Counseling Contact Information

• Roosevelt Hospital	(212) 523-5895	1000 10th Avenue, Suite 11A	New York, NY 10019
• NYU Langone Medical Ctr.	(646) 754-2222	145 E. 32nd Street, 14th Fl.	New York, NY 10016
• Mount Sinai Medical Ctr.	(212) 241-6947	1428 Madison Avenue, 1st Fl.	New York, NY 10029
• SUNY Downstate Medical Ctr.	(718) 270-2924	470 Clarkson Avenue, 3rd Fl.	Brooklyn, NY 11203
• Methodist Hospital	(718) 780-5799	506 6th Street, 4th Fl.	Brooklyn, NY 11215
• Brooklyn Hospital	(718) 250-8032	240 Willoughby Street, Rm 3H	Brooklyn, NY 11201
• Stony Brook Genetics	(631) 444-2790	Stony Brook University Hospital	Stony Brook, NY 11794
• Winthrop Genetics	(516) 663-2657	Winthrop University Hospital	Mineola, NY 11501
• Teresa Dunn, PhD.	(631) 751-0212	CytoGenX Medical Genetic Laboratories	
• Mark Hughes, MD, PhD *Genesis Genetics*	(313) 579-9650	counselor@genesisgenetics.org	
• Amy Jordan, MS *Reprogenetics*	(973) 322-2858	www.reprogenetics.com/our-services/genetic-counseling	
• Integrated Genetics	www.integratedgenetics.com		

Reproductive Specialists of New York

GENETICS TESTING WAIVER

American College of Obstetrics and Gynecology (ACOG) recommends the following tests prior to conception:

Test Name	CPT Code	Diagnosis Code
Cystic Fibrosis	81220	If female: V26.31
Spinal Muscular Atrophy (SMA)	81401	If male: V26.34
Fragile X.	81243	

Not all insurance companies will cover such tests. Therefore, please choose from the following and *enter your initials* accordingly:

☐ I choose to have the above recommended tests done today, understanding that they may not be paid for by my insurance carrier, and understanding that I may be responsible for the cost(s) of these tests.

☐ I will check with my insurance company regarding coverage for these tests, and will make my decision at a future visit on whether I will do them or not. Should I ultimately decline these tests, I understand I will have to complete another waiver indicating the option below.

☐ I waive all such testing and instead choose to have testing done through my obstetrician if/when I conceive. I understand in choosing this option that, by not having these tests performed before conception, I risk a possible abnormal conception if I and/or my partner are positive for these genetic traits.

☐ I also understand the tests given are not comprehensive, no matter which genetics lab is used.

My signature below indicates that I have read and understood the attached information regarding optional pan-ethnic carrier genetics testing. I have decided that:

☐ I want pan-ethnic genetics testing. ☐ I do not want pan-ethnic genetics testing.

Patient's Name [printed]:_____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

Physician: _____ Date: _____