



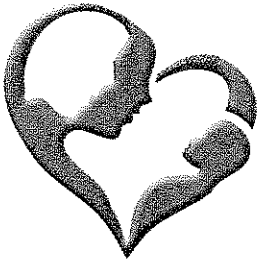
Utah Fertility Center

Dr. Russell A. Foulk, M.D. is the medical director of the Utah Fertility Center/Idaho Center for Reproductive Medicine. Dr. Foulk is international renown in all areas of reproductive medicine and advanced reproductive technologies.

He graduated at the top of his class while receiving his doctorate of Medicine from the University of California, San Diego, School of Medicine. During his post-graduate training in Ob/Gyn at U.C. Irvine medical Center and his fellowship in Reproductive Medicine at U.C. San Francisco, he received a prestigious National Institute of Health grant, published numerous papers and presented before many national organizations. While on faculty at U.C. San Francisco, his research endeavors focused on implantation physiology, in which he shares two patents on unique immunologic proteins expressed by placental cells. He continues his research interests through multi-center investigative trials and basic research into the mechanisms of implantation.

Dr. Foulk is an associate clinical professor at the University of Washington, dept. of OB/Gyn and the University of Nevada, School of Medicine. He routinely teaches medical students, residents and general education courses. He often presents at international meetings and local conferences. Nationally, he has appeared as a fertility expert on the Oprah Winfrey show twice, the Montel Williams show, the Leeza Gibbons show, Inside Edition and German national television. In September 2001, the British Broadcasting Company profiled Dr. Foulk's expertise in a medical program on reproductive ethics. He has been quoted in the Associated Press, Reuters, Wall Street Journal and many of the nation's newspapers. He is a member of a dozen national and state medical societies and is the past president of the Pacific Coast Reproductive Society.

On a personal note, Dr. Foulk has been married for twenty-seven years. He and his wife have five children, ages thirteen to twenty-five. He is active in his community and church affairs.



Utah Fertility Center

Welcome to the Utah Fertility Center. We offer a comprehensive diagnostic treatment plan with advanced analysis and evaluation of both male and female causes of infertility.

Our center is made up of several professionals with expertise in all areas of reproductive medicine. We use a team approach to provide treatments for infertility. The team is directed by Russell A. Foulk, M.D., a board certified Reproductive Endocrinologist. He is joined by Cristin Slater, M.D., also a board certified Reproductive Endocrinologist.

Anne-Marie Martin MSN, WHNP is a Women's Health Nurse Practitioner and a coordinator for our Utah patients undergoing clomid cycles, intrauterine insemination cycles, IVF cycles, ovum donor cycles, and gestational carrier cycles. She works full-time at our Utah office in Pleasant Grove, Utah. Anne-Marie graduated from Brigham Young University with a Bachelor of Science in Nursing. After working as a registered nurse in a Newborn Intensive Care Unit in Salt Lake City, she returned to academia to pursue a Master of Science in Nursing. Anne-Marie specialized in Women's Health and graduated from the University of Utah in 2004. She joined the UFC team in 2005 with prior reproductive medicine experience. As a nurse practitioner, Anne-Marie offers preventative healthcare for women and coordinates and provides care to all patients utilizing assisted reproductive technology

Our office hours are Monday through Friday, 8:00am to 5:00pm. Please phone the office at 801-492-9200 for scheduling, financial and medical concerns. We understand that treatment of infertility can be stressful and we want you to know that there is always someone available to help you.

Infertility treatments can be expensive and often are not covered by your insurance company. To help us maintain this vital health care service at the most affordable cost, please read or enclosed billing policies.

*WITH PATIENCE, PERSISTENCE AND TEAMWORK MOST OF
OUR PATIENTS WILL ACHIEVE THEIR ULTIMATE GOAL –
THE BIRTH OF A CHILD*



Patient Information

*Please fill out all information completely including addresses and phone numbers of employers, etc...for accurate billing and insurance purposes.

Patient				Partner			
Social Security Number				Social Security Number			
Name (First, Middle Last)				Name (First, Middle Last)			
Address				Address			
City, State, Zip				City, State, Zip			
Home Phone	Work Phone	Cell Phone		Home Phone	Work Phone	Cell Phone	
Date of Birth	Age	Sex	Married/Single/Together	Date of Birth	Age	Sex	Married/Single/Together
E-mail Address				Email-Address			
Emergency Contact Information							
Contact	Relationship			Daytime Phone	Evening Phone		
Patient's Employment				Partner's Employment			
Company Name		Occupation		Company Name		Occupation	
Address				Address			
City, State, Zip				City, State, Zip			
Primary or Patient's Insurance				Secondary or Partner's Insurance			
Insurance Company Name				Insurance Company Name			
Address				Address			
City, State, Zip				City, State, Zip			
Policy ID Number		Group Number		Policy ID Number		Group Number	
Subscriber Name				Subscriber Name			
Referring Physician/ Other Form of Referral							
Name				Address			
City	State	Zip	Phone	Fax			

Your records are considered confidential information and we will not release any information without your consent and signature. If needed, I hereby authorize Utah Fertility Center to release information to myself, my insurance carrier, or my physician.

Payment is due on the Date of Service. In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 33% of the unpaid balance. In the event legal action becomes necessary to collect the unpaid balance, the undersigned further agrees to pay all reasonable attorneys fees and court costs.

Patient Signature _____ Date _____

Partner Signature _____ Date _____

Female Patient History

Name _____ Date _____
 Weight _____ Height _____ Blood Type (if known) _____
 When was the first day of your last period? _____
 Are your periods regular? _____ If yes, how many days between periods? _____
 If no, how many times per year do you menstruate? _____
 What is the usual duration of your menses? _____
 What medications do you regularly take? (Prescriptions and/or over the counter drugs) _____

Do you, or have you ever, used:

Alcohol? How many drinks per week? _____

Cigarettes? How many packs per day? _____

Illicit or recreational drugs? _____

How long have you been trying to get pregnant? _____

Past history (if applicable):

	Year	Born alive?	Miscarriage?	Abortion?	Ectopic?	Fert Drugs Required?	Current Partner?
1 st pregnancy	_____	_____	_____	_____	_____	_____	_____
2 nd pregnancy	_____	_____	_____	_____	_____	_____	_____
3 rd pregnancy	_____	_____	_____	_____	_____	_____	_____
4 th pregnancy	_____	_____	_____	_____	_____	_____	_____
5 th pregnancy	_____	_____	_____	_____	_____	_____	_____

Has your partner ever fathered a child? _____

Have you ever been treated for infertility? _____

If yes, please review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone: _____

Allergies? (circle) yes or no If yes, please list: _____

Have you ever been treated for cancer? _____

Family history of blood clotting disorders? _____

If yes, please explain: _____

Have you ever been treated for cancer? _____

- | | | |
|----------------------|--------------------------------|-----------------------------------|
| Anemia | Gonorrhea | Pneumonia |
| Appendicitis | Heart disease | Poor sense of smell |
| Blood transfusion | Hepatitis | Rheumatic fever |
| Breast discharge | Herpes | Scarlet fever |
| Cancer _____ | Hirsutism (excess hair growth) | Seizures |
| Breast soreness | High blood pressure | Syphilis |
| Chlamydia | Immunization: German measles | Thyroid problems |
| Chronic bronchitis | Kidney infection | Tuberculosis |
| Chronic headaches | Liver problems | Ulcers |
| Colitis | Loss of balance | Vaginitis (trichomoniasis, yeast) |
| Color blindness | Measles: German | # of episodes _____ |
| Diabetes | Measles: Regular | Visual disturbances |
| Dizziness | Neurological problems | |
| Endometriosis | Nongonococcal urethritis | |
| Epilepsy | Ovarian Cysts | |
| Gallbladder problems | Parasitic infection | |

Countries of origin: Mother's family: _____

Father's family: _____

Ethnic background (circle): African-American Asian Asian-Indian Caucasian Hispanic
Jewish American-Indian Mediterranean Middle-Eastern Other: _____

Ethnic Group (Check all that apply)	Have you ever been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell traits	_____	_____	_____	_____
Chinese, Southeast Asian, Mediterranean (Greek or Italian) or Hispanic	Thalassemia	_____	_____	_____	_____
Caucasian, Jewish	Cystic Fibrosis	_____	_____	_____	_____
Jewish	Bloom Syndrome	_____	_____	_____	_____
	Canavan Familial Dysautonomia (FD)	_____	_____	_____	_____
	Fanconi Anemia (type C)	_____	_____	_____	_____
	Gaucher Disease (Type 1)	_____	_____	_____	_____
	Glycogen Storage (Type 1a)	_____	_____	_____	_____
	Maple Syrup Urine Disease	_____	_____	_____	_____
	Mucopolysaccharidosis (Type IV ML IV)	_____	_____	_____	_____
	Niemann - Pick Type A	_____	_____	_____	_____
	Tay Sachs	_____	_____	_____	_____

Other inherited disorders? _____

Would you like to be tested for the test recommended for your specific ethnic group? (circle) Yes No

Are you related to your spouse (consanguinity)? _____

Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed (circle)? Yes No

Male Patient History

Date _____

Name _____

Weight _____ Height _____ Blood Type (if known) _____

Are you, or have you ever been, exposed to any of the following during employment or military service? If so, please explain,

Heat _____ Toxic fumes _____

Chemicals _____ Nuclear radiation _____

Other _____

What medications do you regularly take? (Prescriptions and/or over the counter drugs)

Do you frequently take saunas or steam baths? _____

Do you, or have you ever, used:

Alcohol? How many drinks per week? _____

Cigarettes? How many packs per day? _____

Illicit or recreational drugs? _____

Have you ever been treated for infertility in the past? _____

If yes, please review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone: _____

Allergies? (circle) yes or no If yes, please list: _____

Have you ever been treated for cancer? _____

Family history of blood clotting disorders? _____

If yes, please explain: _____

Do you, or have you ever, had (circle all that apply):

Anemia

Appendicitis

Bleeding disorder

Blood transfusion

Chlamydia

Chronic bronchitis

Chronic headaches

Colitis

Cystic fibrosis

Diabetes

Dizziness

Epilepsy

Gallbladder problems

Gonorrhea

Heart disease

Hepatitis

High blood pressure

Kidney infection

Liver problems

Loss of balance

Measles:German

Measles:Regular

Mumps

Mumps w/testes involvement

Neurological problems

Nongonococcal urethritis

Parasitic infection

Pneumonia

Prostatitis

Scarlet fever

Seizures

Syphilis

Testes infection

Testes injury

Testes tumor

Thyroid problems

Tuberculosis

Visual disturbances

Cancer (specify) _____

Countries of origin: Mother's family: _____

Father's family: _____

Ethnic background (circle): African-American Asian Asian-Indian Caucasian Hispanic
Jewish American-Indian Mediterranean Middle-Eastern Other: _____

Ethnic Group
(Check all that apply)

Have you ever been tested for:

Yes No Date Result

African, African/American

Sickle cell traits

Chinese, Southeast Asian,
Mediterranean (Greek or Italian)
or Hispanic

Thalassemia

Caucasian, Jewish

Cystic Fibrosis

Jewish

Bloom Syndrome

Canavan Familial Dysautonomia (FD)

Fanconi Anemia (type C)

Gaucher Disease (Type I)

Glycogen Storage (Type 1a)

Maple Syrup Urine Disease

Mucopolipidosis (Type IV ML IV)

Niemann - Pick Type A

Tay Sachs

Other inherited disorders? _____

Would you like to be tested for the test recommended for your specific ethnic group? (circle)

Yes

No

Are you related to your spouse (consanguinity)? _____

Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed (circle)? Yes No



Utah Fertility Center

1988 West 930 North Suite - B Pleasant Grove, Utah 84062

Phone # (801 492-9200)

Request for Confidential Communication of Protected Health Information.

I, _____ give UFC permission to disclose medical
(Patient's Name - Please Print)

information and/or test results to _____.

Please list the relationship to the patient: _____.

(Patient's Signature)

(Date)

I, _____ give UFC permission to disclose medical
(Patient's Name - Please Print)

information and/or test results to _____.

Please list the relationship to the patient: _____.

(Patient's Signature)

(Date)



Utah Fertility Center

1988 W. 930 N #B. Pleasant Grove, UT 84602 / (801) 492-9200, fax 801-492-3764

Russell A. Foulk, MD
Cristin C. Slater, MD
Scott J. Whitten, MD
Anne-Marie Martin, WHNP
Reproductive Endocrinology and Fertility

Authorization to Release Medical Records

Patient Name: _____

Date of Birth: _____ SS# _____

FROM: _____

TO: **Utah Fertility Center**
1988 W. 930 N. Suite B., Pleasant Grove, UT 84062
Ph: 801-492-9200, FAX: 801-492-3764

I hereby authorize and request the release of the following information:

_____ All Medical Records

_____ Medical record information for visit date of _____ to _____.

_____ Progress Notes

_____ Lab Reports

_____ Hospital and or Operative Reports

_____ Other _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV(AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment, and infertility treatment. I give authorization for these records to be released.

Signature: _____ Date: _____



UTAH FERTILITY CENTER
1988 W 930 N STE B / Pleasant Grove, UT 84062 / 801-492-9200

Notice of Privacy and Security Practices

This following information explains how your personal health information might be used or discloses and how you can attain access to this information. Please review this information carefully.

Uses and Disclosures

Medical Action: Your health information may be used by UFC or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Health Care Operations: Your protected health information may be used as necessary to support the day-to-day activities and management of UFC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Law Enforcement Officials: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting and Officials: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.



UTAH FERTILITY CENTER
1988 W 930 N STE B / Pleasant Grove, UT 84062 / 801-492-9200

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Consent to Use and Disclosure of Protected Health Information Use and Disclosure of Your Protected Health Information

Your protected health information will be used by UFC or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You can read the UFC Security and Privacy Policy for a more complete description of how your protected health information may be used or disclosed. You may review the policy prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. UFC may or may not agree to restrict the use or disclosure of your protected health information. If UFC agrees to your request, the restriction will be binding on the practice.

Cancellation of Consent

You may abrogate this consent to the use and disclosure of your protected health information. You must cancel this consent in writing. Any use or disclosure that has already occurred prior to the date on which your cancellation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

UFC reserves the right to modify the privacy practices outlined in the notice.

Signature



UTAH FERTILITY CENTER
1988 W 930 N STE B / Pleasant Grove, UT 84062 / 801-492-9200

I have reviewed this consent form and give my permission to UFC to use and disclosure my health information in accordance with it.

Name of Patient (Print or Type)

Patient Signature

Date _____

BILLING OFFICE POLICIES

Utah Fertility Center

We look forward to providing you the most cost-effective treatments available to achieve your dream of parenthood. In order to keep our services the most affordable, we ask that you proactively follow our billing policy. The average cost of a New Patient appointment is \$230, with possible additional charges.

It is imperative that we have a current copy of your insurance card in file. As a service, we will bill to participating contracted insurance carriers for covered services. Non-covered services are to be paid at the time of service. We will do our best to inform you whether benefits are or are not covered, but bear in mind these quotes are only from experience and cannot guarantee what your Insurance will allow. Every employer determines what benefits they want to make available to their employees. We recommend you call your insurance carrier directly to get your current benefits, asking the following questions:

- 1) Do I need a referral from my primary care physician to obtain a consultation or service from Dr. Foulk?
- 2) Are diagnostic infertility tests covered? (Example – Day 3 hormone levels, Hystero-Salpingogram, semen analysis, etc.)
- 3) Is treatment for infertility covered? (Example – Intrauterine inseminations, In Vitro Fertilization)

If your insurance carrier requires a referral, please make sure you have the appropriate referral **BEFORE** you seek care from our office. You are responsible for keeping track of the number of visits used and/or expiration date on your referral. If you do not obtain the necessary referrals, no benefits will be paid by your insurance and you will be responsible in full for the services rendered. Insurance carriers will not back date referrals, so make sure you have the referral prior to seeking care.

Please realize that insurance carriers have the right to request your medical records at any time. You gave them that right when you signed up with them. This office will not participate in any form of insurance fraud. Also realize that the law of limits allows your insurance carrier to audit your claims for up to seven years after the date of service and to ask for all money paid incorrectly to be refunded back to the insurance carrier.

Our business policies are a necessary part of the financial resources required to maintain this vital health care service for our patients. If you have disputes with your insurance carrier, you, the insured will get a quicker and more accurate response than our office. Please understand your insurance coverage is a **contract between you and your insurance company** and while we will continue to provide this service; you are ultimately responsible for your account.

Thank You!

(Signature)

(Date)

(Signature/Partner)

(Date)

UTAH FERTILITY CENTER

AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION AND RELEASE

PATIENT NAME: _____

Date of Birth: _____ MR#: _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

Name, age, likeness

WHO IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION?

Utah Fertility Center (UFC)

REASON THE INFORMATION WILL BE USED OR DISCLOSED [if the patient initiates the authorization, the statement "at the request of the individual" is sufficient]:

To be posted on bulletin board in public areas of UFC offices

If the purpose listed above includes "marketing," RPMG will not receive payment as a result of using or disclosing this information. This does not include payment for any services provided to you.

EXPIRATION DATE OR EVENT: Five years from date of this authorization

Notice to Patient

You may refuse to sign this authorization.

The patient or the patient's representative must read and initial the following statements:

1. I understand that I may refuse to sign this form. **Initials** _____
2. I understand that I will get a copy of this form after I sign it. **Initials** _____
3. I understand that I may revoke this authorization at any time by notifying Genie Andrews in writing at the address below, but if I do the revocation will not have any effect on actions the Practice has already taken in reliance on this authorization. **Initials** _____

I authorize UFC to use or disclose any medical information specified in this Authorization.

I understand that I shall receive no compensation for this authorization and release and waive any right/title and/or interest of any kind that I may have in the information or images produced.

Signature of Patient or Patient's Representative

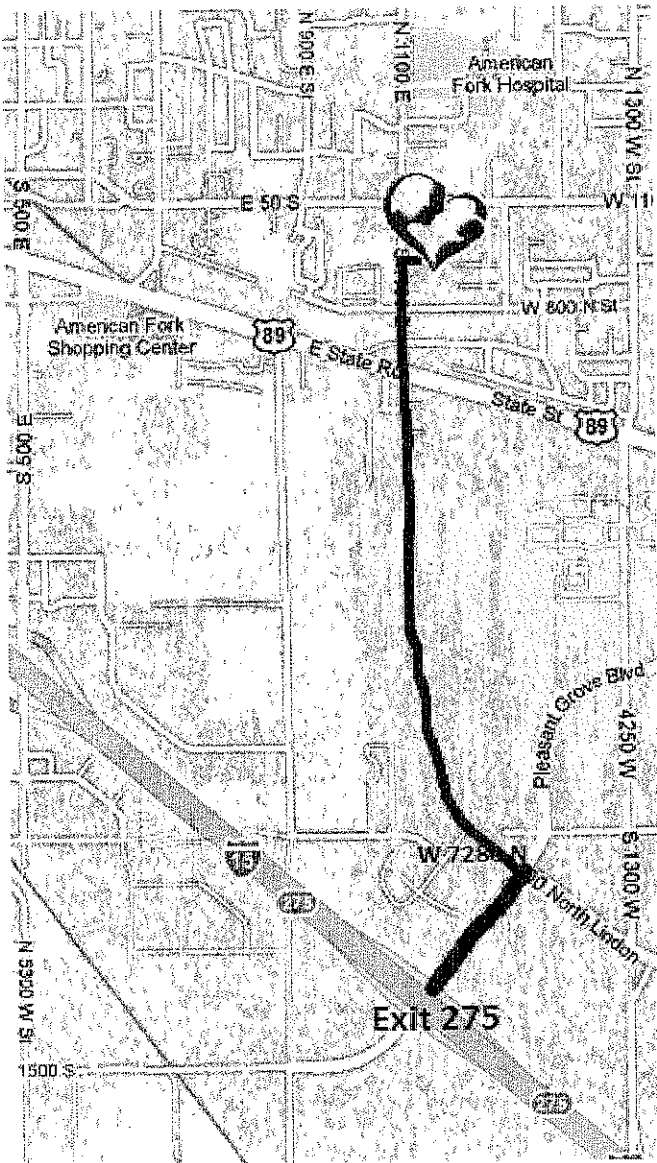
Date

***NOTE: Form Must Be Completed Before Signing**

Utah Fertility Center
1988 West 930 South
Pleasant Grove, Utah 84032
801-492-9200

Map to the Utah Fertility Center

1988 W 930 N Suite B Pleasant Grove, UT 84062



Please keep this map to find your way to our center.

Mapquest and Google Maps will take you to the **wrong** location.

If you get lost please call us at
801-492-9200

-Take exit 275

-Take a **left** at the first light onto
N 2000 W

-Turn **right** into 930 North and
our parking lot is on the left

-If you see the **hospital**, you have
gone **too far**.