Procreate
Fertility Center of Virginia

Patient's Name: _____

NEW PATIENT HISTORY FORM

Physician who referred you: _____

Physician Phone: _____ Physician Fax: _____

Would you like a letter sent? Yes No

DEMOGRAPHIC INFORMATION

Legal Name: (Last, First, Middle) _____

Preferred Name, Pronoun: _____

Occupation: _____ Age: _____ Date of Birth: _____

Best Phone#: _____ Best Phone Type: Mobile Home Work (Ext#: _____)

Weight: _____ Height: _____

REASON FOR VISIT

_____

_____

INFERTILITY HISTORY

How long have you been trying to get pregnant? _____ years _____ months

Have you attempted pregnancy prior to this relationship? Yes No

PAST FERTILITY EVALUATION

Semen Analysis	___No___ Yes	Result / date _____
HSG (X-ray of tubes)	___No___ Yes	Result / date _____
Ovulation Predictor	___No___ Yes	Result / date _____
TSH	___No___ Yes	Result / date _____
Day 3 FSH, Estradiol	___No___ Yes	Result / date _____
AMH	___No___ Yes	Result / date _____

Have you had any of the following treatments?

Clomiphene (Clomid) or Letrozole (Femara)	___No___ Yes	Result / date _____
Gonadotropins	___No___ Yes	Result / date _____
Prior Inseminations (IUIs)	___No___ Yes	Result / date _____

Procreate Locations: Chesapeake: 700 Oak Grove Road, Chesapeake, VA 23320 Phone: 757-977-8500
Newport News: 600 Thimble Shoals Blvd, Ste 301, Newport News, VA 23606 Phone: 757-451-9944
Virginia Beach: 2865 Lynnhaven Drive Suite 3A, Virginia Beach, VA 23451 Phone:757-512-7302

Patient's Name: _____

PRIOR IN VITRO FERTILIZATION (IVF)

Location	Date	Dose	Peak Estrogen	# Eggs Retrieved	% Fertilization (Embryos available)	# Embryos Transferred, Stage	Outcome	Frozen Embryos?

OBSTETRICAL HISTORY

Date	Time to conceive	Length of pregnancy (weeks)	Gender	Birth weight	Outcome (e.g. miscarriage, ectopic, abortion, live birth)	Pregnancy Complications

GYNECOLOGIC and MENSTRUAL HISTORY

Age of onset of periods _____ Date of last menstrual period (LMP)_____

Length of menses _____days Number of days between menses_____days/months

How many pads/tampons do you use on the heaviest day of your period? _____

Do you have pain during your period? ___ No ___ Yes

If yes, does it affect your daily activities? ___ No ___ Yes

Do you have pain between periods? ___ No ___ Yes

Do you bleed between periods? ___ No ___ Yes

Any history of any sexually transmitted infections? _____

Date and result of last Pap Smear _____

Any history of abnormal Pap Smears? _____

Have you had surgery or laser of the cervix? ___ No ___ Yes

Date and result of last mammogram _____

Do you have any problems with intercourse? ___ No ___ Yes

Do you bleed during or after intercourse? ___ No ___ Yes

Do you have pain during or after intercourse? ___ No ___ Yes

In-utero exposure to DES (diethylstilbestrol) ___ No ___ Yes

Have you used an IUD? ___ No ___ Yes

Have you had a tubal ligation? ___ No ___ Yes

PAST MEDICAL HISTORY (Please list any medical problems below)

1. _____
2. _____
3. _____
4. _____

SURGICAL HISTORY *(*Please list all surgeries including dates, hospitalization duration, and location)

1. _____
2. _____
3. _____
4. _____

MEDICATIONS (including complementary and alternative therapy, herbs, vitamins)

1. Vitamin/Folate Yes No
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES TO MEDICATIONS; TYPE OF REACTIONS

_____
_____
_____

SOCIAL HISTORY (Please select one):

Married Widowed Separated Divorced Single Single in committed relationship

How much caffeine do you drink per day? _____ cups of coffee / tea / soda

Do you smoke? _____ Use any recreational substances? _____

If yes, how much? _____ for _____ years

How much alcohol do you drink per week? _____

What kind? _____

PATIENT'S ETHNICITY

□ Non- Hispanic White □ Non- Hispanic Black □ Asian/ Pacific Islander □ Hispanic □ Jewish

Patient's Name: _____

Partner's ethnicity (if applicable):

☐ Non- Hispanic White ☐ Non- Hispanic Black ☐ Asian/ Pacific Islander ☐ Hispanic ☐ Jewish

Are you interested in pre-genetic conception screening? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please mark any of the following disorders YOU currently have or have a history of:

Central Nervous System
- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Difficulty with memory

ENT:
- ☐ Visual disturbances
- ☐ Sinus problems

Cardiovascular:
- ☐ High blood pressure
- ☐ High blood pressure in pregnancy
- ☐ Chest pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ History of Rheumatic Fever
- ☐ Heart valve disease
- ☐ Given prophylactic antibiotics
- ☐ Mitral valve prolapse

Respiratory
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough
- ☐ Tuberculosis

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Hepatitis/Liver disease
- ☐ Diarrhea
- ☐ Constipation

Psychiatric
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Depression
- ☐ Eating disorders

Gynecologic
- ☐ Bladder infections (cystitis)
- ☐ Incontinence
- ☐ Kidney infections
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Herpes
- ☐ Syphilis
- ☐ Warts (HPV)
- ☐ Decreased sex drive
- ☐ Pelvic inflammatory disease (PID)
- ☐ Pelvic pain
- ☐ Endometriosis
- ☐ Breast discharge
- ☐ Hot flashes / Night sweats

Musculo-Skeletal
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematous
- ☐ Bone fractures

Hematological
- ☐ Anemia
- ☐ Blood clotting disorder
- ☐ Bleeding tendency
- ☐ Sickle cell anemia or trait

Endocrine
- ☐ Diabetes
- ☐ Diabetes in pregnancy
- ☐ Thyroid disease
- ☐ Heat or Cold intolerance (circle)
- ☐ Excessive hair growth
- ☐ Other: Rapid weight gain/loss (circle)
- ☐ Excessive thirst or hunger (circle)
- ☐ Acne/Skin Problems

Constitutional
- ☐ Flu-like symptoms or fatigue
- ☐ Increase or decrease in appetite (circle)
- ☐ Weight gain or loss (circle)
- ☐ Fevers or chills
- ☐ Fatigue

Patient's Name: _____

FAMILY HISTORY

Fill in the appropriate squares to identify all illnesses or conditions which you know have occurred in your blood relatives or partner.

	Self	Father	Mother	Brothers	Sisters	Sons	Daughters	Grandparents	Partner
Uterine Cancer	○	○	○	○	○	○	○	○	○
Colon Cancer/Rectal Cancer	○	○	○	○	○	○	○	○	○
Colon Polyp	○	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○	○
Prostate Cancer	○	○	○	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○	○	○	○
Other Cancer	○	○	○	○	○	○	○	○	○
Heart Defects	○	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○	○
Asthma	○	○	○	○	○	○	○	○	○
Dementia	○	○	○	○	○	○	○	○	○
Tuberculosis (TB)	○	○	○	○	○	○	○	○	○
Seizure Disorder	○	○	○	○	○	○	○	○	○
Stroke/TIA	○	○	○	○	○	○	○	○	○
High Cholesterol	○	○	○	○	○	○	○	○	○
Abnormal Bleeding (Bleeding Disorder)	○	○	○	○	○	○	○	○	○
Blood clots	○	○	○	○	○	○	○	○	○
High blood pressure	○	○	○	○	○	○	○	○	○
Anemia	○	○	○	○	○	○	○	○	○
Endometriosis	○	○	○	○	○	○	○	○	○
Hepatitis	○	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○	○	○	○
Alcohol Abuse	○	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○	○
Eating Disorders	○	○	○	○	○	○	○	○	○
Other Psychiatric/Mental illness	○	○	○	○	○	○	○	○	○
Anesthesia complications	○	○	○	○	○	○	○	○	○
Kidney disease	○	○	○	○	○	○	○	○	○
Miscarriages	○	○	○	○	○	○	○	○	○
Mental Retardation	○	○	○	○	○	○	○	○	○
Down Syndrome	○	○	○	○	○	○	○	○	○
Cystic Fibrosis	○	○	○	○	○	○	○	○	○
Stillbirth	○	○	○	○	○	○	○	○	○
Thalassemia/Sickle cell	○	○	○	○	○	○	○	○	○
Cleft Lip or Palate, Spina bifida	○	○	○	○	○	○	○	○	○
Tay Sachs, Guacher, Canavans Disease	○	○	○	○	○	○	○	○	○
Neurofibromatosis	○	○	○	○	○	○	○	○	○
Other	○	○	○	○	○	○	○	○	○

Patient's Name: _____

PARTNER HISTORY

Legal Name: _____ Preferred Name, Pronoun: _____

Birth date: _____ Age_____ Occupation _____ Relationship duration _____

Has partner initiated a pregnancy in a previous relationship? ___No ___Yes

If yes, please give outcome of pregnancy (live birth/ miscarriage, termination) _____

Any pregnancy with birth defects/Genetic disorder/stillbirth/ miscarriage? _____

Has partner had infertility in a previous relationship? ___No ___Yes

Any history of the following? (Urological)

Prostatitis	___No ___Yes
Epididymitis	___No ___Yes
Orchitis	___No ___Yes
Previous vasectomy	___No ___Yes
Testicular tumor	___No ___Yes
Injury to testes	___No ___Yes
Undescended testicles	___No ___Yes
Gonorrhea	___No ___Yes
Chlamydia	___No ___Yes
Syphilis	___No ___Yes
Nonspecific urethritis	___No ___Yes
Difficulty with erection	___No ___Yes
Difficulty with ejaculation	___No ___Yes
Exposure to radiation	___No ___Yes
Exposure to chemicals	___No ___Yes
Exposure to toxic substances	___No ___Yes
Exposure to high temperatures	___No ___Yes

Gynecological history of female partner

Age of onset of periods _____
Date of last menstrual period (LMP) _____
Length of menses ____ days
Number of days between menses _____ days/months
How many pads/tampons do you use on the heaviest day of your period? _____

Do you have pain during your period?	___ No ___ Yes
If yes, does it affect your daily activities?	___ No ___ Yes
Do you have pain between periods?	___ No ___ Yes
Do you bleed between periods?	___ No ___ Yes

Any history of any sexually transmitted infections?
_____

Date and result of last Pap Smear _____
Any history of abnormal Pap Smears? _____

Have you had surgery or laser of the cervix?	___ No ___ Yes
Date and result of last mammogram	_____
Do you have any problems with intercourse?	___ No ___ Yes
Do you bleed during or after intercourse?	___ No ___ Yes
Do you have pain during or after intercourse?	___ No ___ Yes
In-utero exposure to DES (diethylstilbestrol)	___ No ___ Yes
Have you used an IUD?	___ No ___ Yes
Have you had a tubal ligation?	___ No ___ Yes

PARTNER MEDICAL HISTORY

Weight_____ Height _____

PAST MEDICAL HISTORY (Please list any medical problems below)

1._____

2._____

3._____

PAST SURGICAL HISTORY (Please list any surgical procedures including dates and location)

1._____

2._____

MEDICATIONS (including supplements, hormones, steroids)

	Medication	Reason	Dates/Duration/Last time taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

ALLERGIES

_____

_____

SOCIAL HISTORY

How much caffeine does your partner drink per day? _____ cups caffeine / tea / soda

How many cigarettes does your partner smoke per day? _____ cigarettes For how long? ____years

How much alcohol does your partner drink per week? _____ What kind? _____

How often do you use marijuana? _____

Any other substances? _____

Use this area for additional comments (if needed):

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient's Signature Date

Procreate
Fertility Center of Virginia

MEDICAL RECORDS FAX: 877-296-5848

REFERRAL FAX (5 Pages or less): 757-451-9694

MEDICAL RECORDS RELEASE FORM

PATIENT INFORMATION:

NAME:_____ DOB:_____ SSN:_____

ADDRESS:_____

CITY: _____ STATE:_____ ZIP: _____

By signing this form, I authorize Procreate Fertility Center of Virginia to release confidential health information about me. Please select which information you would like released.

PLEASE RELEASE THE REQUESTED RECORDS **FROM** THE FOLLOWING ORGANIZATION:

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records Requested:

ALL RECORDS

History and Physical

Progress Notes

Consultation Visits

Laboratory Results

Ultrasounds, Imaging, etc.

Surgical Reports

Other: _____

Patient Signature: _____ Date: _____

Rev: 2019 08 30

HIPAA ACKNOWLEDGEMENT/RELEASE FORM

Name: _____ DOB: _____

Last 4 of SSN: _____

Address: _____

City: _____ State: _____ Zip code: _____

I acknowledge that I was provided with a copy of Procreate Fertility Center of Virginia notice pursuant to the federal regulations known as the HIPAA Privacy Rule. I give permission to share my health information, including diagnosis and medical history, medication history, records and billing information as follows.

I authorize Procreate Fertility Center of Virginia to release my confidential financial and/ or health information.

Please select which information or both you would like released.

Medical
Financial

This authorization will become effective as of _____.
Date

Please release the requested records to the following person:

Person Name: _____ Password: _____

You must provide to the individual

Signature: _____ Date: _____

Procreate Fertility Center will only release information if the password you supplied can be provided

With my signature below, I request Procreate Fertility to **VOID** my previously given authorization.

_____

Signature Date

Rev: 2019 08 30

Zika Virus

Zika virus is primarily transmitted through the bite of infected *Aedes* species mosquitoes. However, Zika virus can also be sexually transmitted from a man infected with the virus to his sexual partners. Zika virus infection during pregnancy is linked to adverse pregnancy and birth outcomes, including pregnancy loss, microcephaly, and brain and eye abnormalities of the baby.

Below you will find the recommendations for women and men with possible Zika virus exposure who are interested in conceiving.

- Women who have had Zika virus disease should wait at least 8 weeks after symptom onset to attempt conception
- Men who have had Zika virus disease should wait at least 6 months after symptom onset to attempt conception
- Women and men with possible exposure to Zika virus but without clinical illness consistent with Zika virus disease should wait at least 8 weeks after exposure to attempt conception

Please answer the questions below to evaluate your risk for possible exposure to Zika virus.

1. Have you traveled or resided in an area of active Zika virus transmission in the past 8 weeks? (https://www.cdc.gov/zika/index.html)
   Yes _____ (initial) No_____ (initial)

2. Have you had sex (vaginal intercourse, anal intercourse, or fellatio) without a condom with a man who traveled to or resided in an area of active Zika virus transmission?
   Yes _____ (initial) No_____ (initial)

Please be advised that we do not recommend attempting conception if you have any of the above risk factors for Zika virus. Please notify a provider at Procreate if you have any concern for possible exposure or active infection.

I, _____, acknowledge that I have read the above form, completed the form to the best of my knowledge, and have had all questions answered to my satisfaction about Zika virus.

Patient signature _____Date_____

Provider signature _____Date_____

Rev: 2019 08 30

Procreate
Fertility Center of Virginia

Procreate Locations:
Chesapeake: 700 Oak Grove Road, Chesapeake, VA 23320 Phone: 757-977-8500
Newport News: 600 Thimble Shoals Blvd, Ste 301, Newport News, VA 23606 Phone: 757-451-9944
Virginia Beach: 2865 Lynnhaven Drive Suite 3A, Virginia Beach, VA 23451 Phone:757-512-7302

Patient Financial Agreement

Procreate Fertility Center is committed to providing you with the best possible care. The following are financial policies we have established for our practice. If you have any questions regarding these policies, please speak with our billing department. Services are provided to you with the understanding that you are responsible for all associated costs regardless of insurance coverage.

- **Self-Pay Patients:** Payment in full will be collected prior to any planned procedures or office visits. We accept checks and most major credit cards. We do not accept cash.

- **Patients with Insurance Coverage:** Coverage for services depends on each patient's individual plan. It is the patient's responsibility to understand their eligibility and benefits. We are happy to provide you with more information on the services we provide but recommend that you review your specific benefits with your insurance membership representative. Please note, as healthcare providers, our relationship is with you, not your insurance company.
    - **No coverage for infertility services:** You will be considered a self-pay patient for all services related to infertility testing and treatment.
    - **Coverage for infertility testing only:** We will bill your insurance as a courtesy for all diagnostic services and consultations related to testing. You will be responsible for any amounts determined by your insurance to be patient responsibility or non-covered services. Services for treatment purposes will be considered self-pay charges.
    - **Coverage for infertility testing AND treatment:** We will bill your insurance as a courtesy for diagnostic services and consultations related to testing. We will bill services for treatment provided they are specific treatment methods covered by your insurance plan. You will be responsible for any amounts determined by your insurance to be patient responsibility or non-covered services.
    - **Medical Diagnosis:** Patients seeking care to achieve pregnancy will be considered infertility patients for all visits pertaining to conception. Most visits will be coded as infertility testing or infertility related. Claims will be coded appropriately based on the reason for visit and any diagnosis provided by the physician. Claims will only be billed with medical or gynecology diagnoses if the reason for the visit is to receive care for these conditions. The same diagnoses will be provided for ancillary services (such as lab services, semen analysis, surgery, outside testing and referrals).

- **Insurance Requirements:** It is your responsibility to provide Procreate Fertility Center with complete and current insurance information.
    - Prior to your first appointment, you must provide Procreate staff with your insurance information. We will need a copy of your insurance card. Patients without verified insurance information will be considered self-pay patients. All charges must be paid in full prior to services being rendered.
    - Prior to services, you must verify that we are participating providers for your insurance plan. You may do this by contacting your insurance company or reviewing your insurance provider directory. Our staff can assist as well, provided we have your insurance information before your first appointment.
    - If you have any changes to your insurance, please notify Procreate staff as soon as possible. Any charges billed without updated insurance information will be the patient's responsibility.
    - All copays, coinsurances, deductible amounts and non-covered charges are due on the date of service. Our staff can assist you with an estimate, however, your insurance will make the final determination based on their processing of the claim.

Initials: _____

- Patients are responsible for understanding any referral, authorization or pre-certification requirements. We will assist in obtaining necessary authorizations, but it is still your responsibility to understand your benefits.
- In the event that your insurance pays less than estimated, you will be billed for the remaining amounts attributed to patient responsibility. You may request an explanation of benefits from your insurance company for any services.
- Insurance claims will only be filed for covered services to contracted insurance companies. Patients may request an itemized statement to submit to their insurance company.

- **Patient Statements:**
  - Payment in full is expected upon receipt of your patient statement.
  - It is our policy to submit statements to patients in a timely manner. However, there is often a delay between your date of service and when your insurance processes your claim.
  - If you have questions regarding the way your claims were processed, please contact your insurance membership representative or review your explanation of benefits (EOBs).
  - If you do not contact our office, we will send your unpaid charges to an outside collection agency. These agencies may report unpaid charges to national credit reporting agencies.
  - If you have questions about your statement after reviewing your insurance benefits, please contact our billing department. We are available Monday-Thursday from 9:00am-4:30pm and Friday from 9:00am-12:00pm. You may also send a secure message to the office staff through the patient portal.

- **Surgery Scheduling:**
  - Patient amounts for surgery will be estimated prior to your surgery date. Payment in full is expected at your preop appointment.
  - Surgery estimates provided by our office pertain to the surgeon's professional fees only. You may also receive bills from the facility, anesthesiologist, pathologist. Please work with these entities directly regarding anticipated charges and any resulting bills.
  - Surgery deposits collected are an estimate based on your insurance benefits at the time of the quote. Your insurance will make the final determination of patient responsibility based on the surgeon's operative report and claims filed. In the event that your insurance pays less than estimated, you will be billed for the remaining amounts. You may request an explanation of benefits from your insurance company for any services.

- **Cycle Packages and Discounts:** In an effort to provide patients with affordable options, certain non-covered services may be bundled into a cycle package.
  - Payment in full is responsible prior to the baseline start.
  - No portion of a discounted package will be billed to insurance.
  - Certain lab charges for hormone labs may be included in the package. Other labs, specific to a patient's diagnosis and condition may be additional or billed to insurance.
  - Medications are not included in any cycle packages. These charges are paid directly to the pharmacy.
  - Package discounts are applied to the entire package. If a cycle is not completed, the discount will be pro-rated based on the amount of services provided. Any services not received will be credited less any original discounts.
  - If a cycle is not successful, no refunds are available for services rendered. Any outstanding charges will still be due regardless of the outcome of the cycle.
  - New treatment cycles will not be initiated if patient retains an unpaid balance for prior services.

- **Non-claim Charges/Fees:**
  - Returned checks will be subject to a $30.00 returned check fee.

Initials: _____

- Completing and submitting forms (FMLA, disability, grants, etc.) are not billable to insurance and will be subject to a $25.00 administrative fee.
- We attempt to confirm all appointments ahead of time. If you are unable to keep your scheduled appointment we require a 24-hours' notice. Adhering to a 24-hour cancellation period enables us to accommodate other patients in your scheduled time slot. If you are a no-show, or if you cancel without a 24-hours' notice, we reserve the right to assess a **$30.00 Fee**. We understand that emergencies do arise, but patients with more than two cancellations may be required to pay a deposit to reschedule their appointment.
- Surgeries which are cancelled or rescheduled without ten (10) business days' notice in advance will be subject to a **$250.00 Fee** requirement prior to rescheduling a new date and time.
- Telephone/E-Visit consultations are usually not covered by insurance. Telephone/E-Visit consultations must be paid in full prior to transferring the call to the physician. Fees vary based on the reason for the consultation and can be estimated ahead of time. You may file a claim to your insurance.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows a fee (whether regulatory or statutory) to be associated with medical record request processing, excluding those that are needed for continuing care purposes. To process and fulfill your request for a copy of your medical record. The fee charged is detailed below:
  - Administrative Fee: $20.00
  - Pages 1 - 50: $0.37 per page
  - Pages 51 +: $0.18 per page

- **Ancillary Services:** Your overall care is contingent upon Procreate staff collaborating with other entities. At times, certain services will be rendered by other healthcare providers.
  - **Self-Pay Patients:** We work with several labs, pharmacies, etc. to provide you with the most affordable and comprehensive services available. We will send your order to the providers we normally work with. We can also provide you with an order to have services rendered by a provider you choose if they can provide the same services.
  - **Insurance patients:** Often, your insurance will determine which lab, pharmacy, etc. that you must use. It is your responsibility to inform us if your insurance requires a specific provider. For example, your insurance may prefer LabCorp over Sentara for lab work (or vice versa).
  - Any bills you incur from ancillary providers are your responsibility and payable to them directly. If they need additional information from our office in order to process claims on your behalf, please speak with our billing department.

I assign benefits of my insurance contract and authorize payment directly to Procreate Fertility Center. I authorize Procreate Fertility Center to release medical information as necessary for my claims to be processed by insurance. I have read and understand the financial policies above and acknowledge that it is my responsibility to pay for services rendered regardless of insurance coverage. Self-Pay patients are responsible to pay at time of services. Patients with insurance are responsible for paying co-payment at time of services.

_____

Patient Name Date

_____

Patient Signature Date

_____

Staff Witness Signature Date

Initials: _____

Disclosure of Physician Ownership in Fertility Pharmacy of America

Dear Patient:

Your care is our priority and Procreate is dedicated to keeping you informed. Fertility medications (please see them listed below) can have serious adverse effects and complications. Initiation of therapy with these medications requires a strict ongoing care provided by the prescribing provider including multiple office visits, lab studies, and monitoring your response to the medication by using serial ultrasounds. Failure to comply with recommended monitoring may result in life threatening complications.

These medications are often not covered by insurance and are often not carried in local pharmacies. Once you are prescribed the medication you will be able to fill the medication at any pharmacy you choose.

Fertility Medications

Follistim, Gonal F, Menopur, Omnitrope, Novarel, Pregnyl, Cetrotide, Antagon,
Human Chorionic Gonadotropin, Clomid, Femara

Procreate has an ownership interest in **Fertility Pharmacy of America**.

You have the option to purchase your prescription from an alternative pharmacy, including the following possible pharmacies:

- Your local CVS or Walgreens Pharmacy
- Freedom Fertility Pharmacy
- Mandell's Clinical Pharmacy
- Other local Pharmacies

If your insurance covers these medications, it may require you to use a specific specialty pharmacy. Please check with your insurance carrier.

You will not be treated any differently by Procreate Fertility if you do not choose to purchase your prescription from Fertility Pharmacy of America.

By signing below, you acknowledge that this disclosure has been made and that you have read and understand this disclosure.

Patients Name: _____

Patient Signature: _____ Date: _____

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