Informed Consent/Understanding the Risks of Zika and Pregnancy- Electing to Continue Fertility Treatments

The Centers for Disease Control and Prevention (CDC) has alerted couples attempting pregnancy to be aware of the risks that the Zika virus can pose to a potential pregnancy. CCRM is urging patients to limit travel to areas where there is ongoing active transmission of the Zika virus in order to limit the risk of a potential Zika virus infection while in treatment at CCRM and during an entire potential pregnancy. By signing this consent you are acknowledging that you understand the risks, warnings and recommended preventative measures while seeking treatment at CCRM and during a pregnancy.

SYMPTOMS OF THE ZIKA VIRUS DISEASE AND RISK TO PREGNANCY

The Zika virus disease (Zika) is a disease caused by Zika virus that is spread to people primarily through the bite of an infected *Aedes* species of mosquito. Only about one in five people infected with Zika actually have symptoms. The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis (red eyes). The illness is usually mild with symptoms lasting from several days to a week. Severe disease requiring hospitalization is uncommon. Sexual transmission of Zika from a male to a female has been reported. No instances of Zika virus transmission during fertility treatment have been documented, but transmission of the Zika virus can be present in semen, and sexual transmission has occurred.

Zika infection during pregnancy can cause serious birth defects such as microcephaly (underdeveloped brain and skull) and has been associated with other birth defects (such as intracranial calcifications, other brain abnormalities, abnormal cerebral artery flow) as well as other pregnancy complications such as pregnancy loss and intrauterine growth restriction. Following a Zika infection, some individuals have developed Guillain Barre syndrome.

- Guillain Barre symptoms include weakness of the arms and legs that is usually the same on both sides of the body. In some cases, the muscles of the face that control eye movement or swallowing may also become weak. In the most serious cases, this muscle weakness can affect breathing and can lead to death.
- Microcephaly is a medical condition in which the circumference of the head is smaller than normal because the brain has not developed properly or has stopped growing. Microcephaly can be present at birth or it may develop in the first few years of life. It is most often caused by genetic abnormalities that interfere with the growth of the cerebral cortex during the early months of fetal development. Babies may also be born with microcephaly if, during pregnancy, their mother abused drugs or alcohol; became infected with a cytomegalovirus, rubella (German measles), varicella (chicken pox) virus, or possibly Zika virus; was exposed to certain toxic chemicals; or had untreated phenylketonuria (PKU, a harmful buildup of the amino acid phenylalanine in the blood). Microcephaly is associated with Down's syndrome, chromosomal syndromes, and neurometabolic syndromes.

PREVENTION

- The current Zika virus outbreak was identified in Brazil in May 2015, and knowledge about Zika virus infection, its potential adverse effects on pregnancy, and transmission is rapidly evolving. As of March 23, 2016, there were 39 countries and U.S. territories reporting active Zika virus transmission (*6*). Updates on areas with active Zika virus transmission are available online at http://wwwnc.cdc.gov/travel/notices. Avoid travel to Central and South America as well as the Caribbean, Puerto Rico and the U.S. Virgin Islands. These countries/regions where Zika has been identified and should be avoided for women/couples attempting pregnancy or/are pregnant. Because Zika continues to spread, geographic areas of concern are difficult to determine and likely to change over time.
- CCRM has informed me that current testing for Zika is limited and in many cases inconclusive.
- Mosquito bite prevention:

Patient Name: _____ DOB: _____ Partner Name: _____ DOB: _____

- Use of insect repellant
- Wear clothing which covers arms and legs
- Assure window screens and mosquito nets are used.
- Avoid leaving windows open

- Avoid travel to affected areas of concern – review the CDC website for affected areas prior to travel.

SEXUAL TRANSMISSION OF AN AFFECTED PERSON PASSING INFECTION TO OTHERS

- During the first week of infection, Zika virus can be found in the blood and passed from an infected person to another mosquito through mosquito bites. An infected mosquito can then spread the virus to other people.
- Zika virus can be spread during sex by a man infected with Zika to his sex partners.
  - It is thought that the virus is present in the semen of men who have had Zika for three months or longer.
  - We do know that the virus can stay in semen longer than in blood.
- To help prevent spreading Zika, use condoms the correct way during intercourse. This includes vaginal, anal, and oral (mouth-to-penis) intercourse. Avoiding intercourse is the best way to be sure that someone does not get sexually transmitted Zika.
- Pregnant women should talk to a doctor or healthcare provider if they or their male partners recently traveled to an area with Zika, even if they don't feel sick.

VACCINATION/TREAMENT AND TESTING

- There is currently no vaccine or medication for cure at this time and testing patients for the virus is limited. I/we understand that this information and future recommendations may change as more is known about this virus and the affects that it could have on me/us and my/our potential pregnancy.
- Patients and partners should immediately report any signs and/or symptoms consistent their physician.
- I/we understand that Zika testing is limited but will consult my physician should I have symptoms and need for testing.

CCRM POLICY FOR FREEZINTG EGGS/EMBRYOS OR SPERM

- Zika virus is not likely to be destroyed in the cryopreservation process. Due to the nature of freezing techniques and need to limit risk for inadvertent exposure, patients considered at risk will be required to freeze their embryos, eggs, or sperm for long term storage at Reprotech Limited.
- CCRM requires all couples who have traveled to countries/regions that the CDC has deemed at risk areas for Zika, postpone their treatment cycle for eight weeks to decrease the risk of a Zika exposure.
- If either partner had symptoms of Zika, the treatment cycle will be postponed for six months if the infection occurred in the male partner and eight weeks if the infection occurred in the female partner.
- If living in an area "at risk", Reprotech Limited storage is required. For persons living in "at risk" Zika areas; if the female has Zika symptoms the cycle will be delayed eight weeks from last day of symptoms. If the male partner has symptoms of Zika, the cycle will be delayed for six months from the last day of symptoms. Additional acknowledgement of risk documents will be required.

ACKNOWELDGEMENT

I/we understand that this is a voluntary process and there are options to my/our care including, but not limited to, postponing my/our cycle until more is known about Zika and the potential long term affects, postponing treatment for six months per current FDA guidance after residence in an area affected with Zika and avoiding intercourse without barrier contraception.

I/we understand that the ZIKA virus is not likely destroyed in the freezing/ cryopreservation process.

I/we understand that the Federal Food and Drug Administration has set guidelines for donor tissue use in reproductive practices to decrease the risk of a transmission of the Zika virus. Individuals are ineligible to donate sperm/eggs is they have had a medical diagnosis of Zika virus infection in the past six months; residence in or

travel to an area with active Zika virus transmission within the past six months; or within the past six months had sex with a male partner who, during the six months before this sexual contact, received a diagnosis of or experienced an illness consistent with Zika virus disease, or had traveled to an area of active Zika virus transmission.

I/we understand that having the proper evaluation, testing, as well as our physician's recommendations for treatment prior to and during pregnancy may lower the risk for the treatment cycle and for the potential resulting pregnancy.

I/we understand that should my partner or I travel to areas with active Zika transmission--as identified by the CDC-- during our treatment cycle, we will be required to delay our cycle for up to eight weeks, or if the male partner has symptoms the cycle will be delayed for up to six months.

I/we understand that CCRM cannot guarantee a normal health baby and recommends patients seek early pregnancy screening and serial fetal ultrasound examinations during pregnancy and work closely with our obstetrician and pediatrician if a pregnancy is achieved.

I/we understand the CDC is rapidly creating policy and recommendations in regards to Zika, which may result in risks not described in this document.

I/we understand that our physician can alert us to the risks, but it is our obligation to follow the recommendations described within this document.

I/We have read the Zika risks as described within this document, understand that we may request a consultation with our physician so we may fully and sufficiently understand the potential Zika risks to our offspring. An appointment with a physician may be scheduled. My/our signature(s) below indicates that I/we understand the risks stated.

Print Patient Name	Signature	DOB	Date
Government ID – Patient		ID Number	
Print Partner Name	Signature	DOB	Date
Government ID – Partner		ID Number	
Practice Representative		Date	

I/We confirm that I have read and fully understand the information contained in this consent and agreement and have been given an unrestricted opportunity to ask questions and receive answers to my/our satisfaction and understanding. I further understand that if I have any remaining or additional questions or concerns, I should contact a CCRM physician or nurse. I understand that participation is purely voluntary and that my refusal to participate or withdraw from the program at any time will not involve any penalty or loss of benefit to which I am otherwise entitled. I am of sound mind and understand that, if signing this document electronically subject to my agreement and understanding, that my electronic signature has the same force and effect in acknowledging my understanding and consent as set forth above, as if I had signed this consent and agreement in person before a notary public.

Original: 7.12.17; 9.14.17; 4.13.18; 4.2.19

CCRM Newport Beach, Inc. – "CCRM"
FERTILITY LABORATORIES SCIENCES – "FLS"

ACKNOWLEDGEMENT, AGREEMENT AND ASSUMPTION OF RISKS, RELEASE AND HOLD HARMLESS

NOTE: THIS WRITTEN CONSENT IS AN IMPORTANT DOCUMENT AND THE COPY PROVIDED TO YOU SHOULD BE RETAINED WITH OTHER VITAL RECORDS FOR FUTURE REFERENCE.

CCRM utilizes e-consents with DocuSign. DocuSign allows patients and/or their partner to review and sign consents at their leisure through their individual secure patient portal. You must read through all consents that are provided to you and assure that you understand the content, treatment process, benefits of treatment, and risks of the treatment for which you are consenting to. If you have questions or concerns in regards to the document you are signing, we encourage you to decline signature and to contact your physician's office to discuss. DocuSign authenticates your signature as understanding and consenting to the treatment process. It is important you are confident in electronically signing the documents for which you are provided. You do have the right to request to sign a paper copy. You have the option to print and retain a copy of the electronically signed consent(s). Should you be entering into treatment at CCRM with a partner, you and your partner separately will be sent, via your individual secured patient portal account, the same set of consents requiring individual signatures. It is imperative that you both discuss the treatment options to assure that all parties are in agreement with the treatment options presented to the both of you in the consent. Should you and your partner not agree on the treatment options, CCRM requires you to set up a regroup with your physician or treatment team to discuss. The initiation of your treatment will not begin until all parties are in agreement and consents are signed. Some consents are required to be signed in person by all parties with a CCRM staff member as a witness. Additionally, some consents may require a notary prior to initiation of treatment (these consents will be provided to you in paper format at your appointment).

Print Patient Name	Signature	DOB	Date
Government ID – Patient		ID Number	
Print Partner Name	Signature	DOB	Date
Government ID – Partner		ID Number	
Practice Representative		Date	

I/We confirm that I have read and fully understand the information contained in this consent and agreement and have been given an unrestricted opportunity to ask questions and receive answers to my/our satisfaction and understanding. I further understand that if I have any remaining or additional questions or concerns, I should contact a CCRM physician or nurse. I understand that participation is purely voluntary and that my refusal to participate or withdraw from the program at any time will not involve any penalty or loss of benefit to which I am otherwise entitled. I am of sound mind and understand that, if signing this document electronically subject to my agreement and understanding, that my electronic signature has the same force and effect in acknowledging my understanding and consent as set forth above, as if I had signed this consent and agreement in person before a notary public.

Original 6.26.17; Revised 9.14.17; 4.13.18; 4.2.19

Patient Name: _____ DOB: _____ Partner Name: _____ DOB: _____

MEDICAL RECORDS TO "CCRM Newport Beach, Inc. "
(From Other Physicians)

In determining your care and treatment with CCRM Newport Beach, our providers want to have a complete understanding of any past related care you and/or your partner have received from other physicians.

Following this page is a medical record release form for your use in requesting your records from your previous doctor(s).

Given medical record releases can take many weeks to process and to insure CCRM Newport Beach receives your records in time, please submit this form to your doctor as soon as possible and have the records sent directly to CCRM Newport Beach. **If you have a partner, he/she will need to complete a separate release form.**

Indicate the date of your CCRM Newport Beach appointment on your form in the corresponding field.

Records must be received no less than three business days before your appointment.

AUTHORIZATION TO RELEASE MY MEDICAL RECORDS TO "CCRM Newport Beach, Inc."

Patient Name: _____ Date of Birth: _____

CCRM Newport Beach Appointment Date: _____

I hereby authorize:

Person/Organization:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

To release the following medical records (check all that apply):

- ☐ All medical records, meaning every page in my record, including but not limited to: consult notes, ultrasound reports, operative reports, pap smear pathology report, semen analysis, pathology report, last IVF/IUI cycle records, HSG, mammogram radiology)
- ☐ All laboratory tests and results
- ☐ All imaging tests and results
- ☐ Other: _____

Unless stated otherwise in the section below, I understand the information referenced above may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health, or drug or alcohol use.

- ☐ I authorize the release or disclosure of only:_____
- ☐ I do not authorize the release or disclosure of this type of information

Records should be sent to:

CCRM Newport Beach
3501 Jamboree Rd #1100
Newport Beach, CA 92660

This authorization ends: ☐ upon fulfillment of this request, OR ☐ on this date _____,
OR ☐ is enforced until written notice is given by me indicating a termination of this authorization

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

Patient or Legally-Authorized Individual Signature Date

Printed Name of Signee Relationship (self, parent, guardian, etc.)

AUTHORIZATION TO RELEASE MY MEDICAL RECORDS FROM "CCRM Newport Beach, Inc. "

Patient Name: _____ Date of Birth: _____

For the date(s) of _____, CCRM Newport Beach may disclose the following health care information (check all that apply):

- ☐ All medical records, meaning every page in my record, including but not limited to: consult notes, ultrasound reports, operative reports, pathology reports, genetic testing, last IVF.IUI cycle records, HSG, mammogram radiology)
- ☐ All laboratory tests and results
- ☐ All imaging tests and results
- ☐ Other: _____

Unless stated otherwise in the section below, I understand the information referenced above may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health, or drug or alcohol use.

- ☐ I authorize the release or disclosure of only:_____
- ☐ I do not authorize the release or disclosure of this type of information

You may disclose this information to:

Person/Organization:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

Reason(s) for this authorization: ☐ at my request OR ☐ other (specify) _____
This authorization ends: ☐ upon fulfillment of this request OR ☐ on this date _____, OR ☐ is enforced until written notice is given by me indicating a termination of this authorization

Copying Fees: I understand that there may be a fee involved with the fulfillment of this request. Fees for the State of California are: $0.25 per page plus postage costs. Record copying will be completed within 10-14 business days of receipt of this form.

My Rights
I understand that this authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

_____
Patient or Legally-Authorized Individual Signature Date

_____
Printed Name of Signee Relationship (self, parent, guardian, etc.)

Informed Electronic Communication Consent

Email communication provides for a fast and easy way to communicate with your healthcare team for those issues that are non-emergent, non-urgent and/or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider/team relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with a physician, nurse or any staff member at "CCRM Newport Beach, Inc."

General Considerations

- Email communications will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard email communication services, such as AOL, Yahoo, Gmail and Hot Mail are not secure. This means that email messages are not encrypted and can potentially be intercepted and read by unauthorized individuals.
- Email devices and connections can fail, messages can be lost or sent to the wrong person. Messages can contain typing mistakes. Messages can contain viruses that can damage systems or steal information.

Healthcare Team Responsibilities

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider, nurse or staff member may route your email messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your email.
- Every attempt will be made to respond to your email message within two business days Monday through Friday and non-holidays. If you do not receive a response from our practice within two business days, please contact us by phone.
- Copies of emails sent and received from and to you are considered a part of your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- **Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For emergent or time sensitive situations, you should contact our practice by phone and state you have an urgent concern.**
- Our providers may give their professional email address to you for medical questions. Although they may reply after hours, you should not expect that they will be monitoring their email continuously. Again, if you have an issue that needs attention right away, please call our practice.
- To ensure our communications remain private, please protect the email address you give us. This is the only way we can trust the messages from your email are really from you, and the messages we send are not going to someone else.
- Email messages should be concise. Please contact the office by phone or arrange for an office appointment if the issue is too complex or sensitive to discuss via email.
- We cannot always know what information you consider especially private. We take care with all medical records, but we know that some facts are more sensitive than others. Because email cannot be considered to be 100% secure, please do not put extremely sensitive matters in messages without considering this.

- Please include your full name and the topic, i.e., medication question, in the subject line. Please include your full name and date of birth in the email itself. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return mail to the sender.
- We will only use your email address for important communications related to our practice. We will not give your email address to anyone that is not a part of our practice. Please do not send non-essential messages to us, because they slow down our ability to respond to the important ones. If your email address changes, you will need to let us know.

I have read and understand the above description of the risks and responsibilities associated with electronic communication with my healthcare team. I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss any questions regarding electronic communication with a representative of CCRM and have had all my questions answered.

In consideration for my desire to use electronic communication as an adjunct to in-person office visits and telephone communication with my healthcare team, I hereby consent to electronic communication via non-secure email services. I understand email communication is voluntary. I may revoke my consent to communicate electronically at any time by notifying CCRM in writing, but if I do, the revocation will not have an effect on actions my healthcare provider or team has already taken in reliance on my consent.

I agree and release my provider, nurse, any staff member and CCRM from any and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

Print Patient Name	Signature	DOB	Date
Government ID – Patient	ID Number	Authorized Email Address	
Print Partner Name	Signature	DOB	Date
Government ID – Partner	ID Number	Authorized Email Address	
Practice Representative		Date	

Financial Disclosure

Thank you for choosing "CCRM Newport Beach, Inc." for your fertility care. Please review this financial disclosure to provide consent on assignment of benefits and a release of billing information to your health insurance carrier. Please read carefully and sign below to provide your authorization on each item.

Release and Assignment of Benefits: I authorize the release of any medical information necessary to process insurance claims for surgical and/or medical services provided to me by CCRM. I also authorize payment of benefits directly to CCRM for services provided to me. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered.

Insurance: If you have insurance with an insurer with which we participate, but your plan does not provide benefits for your diagnosis or for the procedures/services provided, then full payment is required at each visit. Additionally, if you have insurance with an insurer with which we do not participate, then full payment is required at each visit. We expect all balances to be settled on the day it occurs. It is your responsibility to inform us of any insurance change prior to your appointment and a failure to do so may result in the services being your financial responsibility.

Referral: I understand that if my insurance requires a referral from my Primary Care Provider and I do not have the referral at the time of the appointment, I accept full financial responsibility for all charges incurred for services received on the day of service, if my insurance carrier denies the claim(s) for lack of and/or invalid referral.

Payment: I accept financial responsibility for payments for all services rendered. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check, or credit card.

Non-Covered Services: Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance carrier. Payment for these services must be made at the time of your visit.

Collection Agency: I understand and agree that any outstanding balance that is more than 90 days past due may be reviewed and referred for collections. If my account is referred for collections, I understand that I will be charged, and agree to pay, a collection fee of $20. I also agree to reimburse CCRM the fees of any collection agency, which may be based on a percentage at a maximum of 35% of my debt, and all costs and expenses, including court costs and reasonable attorneys' fees, CCRM incurs in such collection efforts.

By signing below, I attest I have read the above and authorize CCRM to release any information required to process my claim and I am financially responsible for charges not covered by my insurance carrier.

Print Patient Name	Signature	DOB	Date
Government ID – Patient		ID Number	
Print Partner Name	Signature	DOB	Date
Government ID – Partner		ID Number	

Health Care Needs

As you begin your treatment at "CCRM Newport Beach, Inc." we would like to take this time to inform you and your partner of the importance of routine physical examinations, Pap smears and mammogram with your primary providers. It is also essential that you be seen by any specialist(s) who are also involved in your care, such as a cardiologist, rheumatologist, neurologist, psychiatrist, etc. and inform them that you are undergoing infertility treatment. You should review management of any current medications prescribed by that provider and establish a healthcare plan during pregnancy. The physicians at the Practice, are subspecialists and do not provide health care outside of the area of reproductive medicine.

The Practice will require a copy of your latest annual/physical examination, including breast examination, and a copy of your Pap smear. We recommend that all patients have a baseline mammogram between the ages of 35 to 39 years of age and yearly mammograms beginning at the age of 40. It is important to note that if you have a family history of breast cancer, your risk for breast cancer may be greater. It is recommended that you complete a mammogram prior to treatment. If you need to update any of these examinations, you will need to contact your primary physician, healthcare provider, and/or obstetrician/gynecologist. Please be aware that neither your nursing team nor your Practice physicians are responsible for reminding you to update or send the above records to the Practice.

The Practice will require appropriate documentation of certain pre-conceptual laboratory tests, such as a blood count (CBC), chemistries, rubella IgG, varicella IgG, thyroid evaluation (TSH and free T4), and vitamin D level. Your Practice physician recommends that you be vaccinated in the event of non-or equivocal immunity and this should be administered by your primary physician. If you are found to be hypothyroid or vitamin D deficient, your Practice physician may prescribe medications to address the deficiency but you will need to follow-up with your provider for long-term care.

It is important for both partners to discuss with your primary care provider the need to update immunizations prior to attempting pregnancy. Pertussis and measles are on the rise in the United States and fetal exposure to these diseases could be detrimental to the developing child. Developing an immunity will help limit a potential exposure to a baby. Pregnant women have a higher risk of serious complications from influenza than non-pregnant women. The influenza injectable vaccine is recommended for women prior to, during, or after pregnancy.

By signing this informed acknowledgment, I am acknowledging the recommendations and will take full responsibility to assure my health care needs are addressed prior to attempting pregnancy. I understand that it is my responsibility to assure all health concerns have been managed and addressed appropriately with my primary care provider. Having the proper evaluation prior to pregnancy may lower the risk of medical complications to the potential pregnancy and/or your health. I understand that the Practice will not be responsible for any impact on my health, outcome of the treatment cycle(s), or effects on my potential pregnancy and/or resulting offspring if we deviate from the above recommendations. I have had an opportunity to discuss the importance of this testing with my physician or nurse and feel that my questions have been answered.

Print Patient Name	Signature	DOB	Date
Government ID – Patient		ID Number	
Print Partner Name	Signature	DOB	Date
Government ID – Partner		ID Number	
Practice Representative		Date	

HIPAA Form H102 **Notice of Privacy Practices- CCRM Newport Beach** **Effective Date: 06-14-2023**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. *If you have any questions, please contact the HIPAA Compliance Officer at (949) 222-1290*

WHO WILL FOLLOW THIS NOTICE

This notice describes CCRM Newport Beach and that of:

- Any health care professional authorized to enter information into your medical record.
- All departments and units of the health care system.
- Any volunteer in our organizations.
- All employees, staff and other designated personnel (e.g. students, contracted agency staff).
- Physicians on our staff, while they are practicing in our facilities.
- All Newport Fertility Center entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our facilities. We need this record to provide you with quality care and to comply with certain legal requirements. Physicians (personal, consultants, specialists) involved in your care may have different policies or notices regarding the doctor's use and disclosure of your medical information created and/or maintained in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you, via any medium (written, oral, or electronic). We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

• **Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell a dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to others who may be involved in your medical care, such as caregivers, clergy or others we use to provide services that are part of your care.

• **Payment.** We may use and disclose medical information about you so that the treatment and services you receive may be billed and collected from you, the party responsible for your bill, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

• **Health Care Operations.** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.

We may also combine the medical information we have with medical information from other health care agencies to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

• **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

• **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be important to you.

• **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

• **Individuals Involved in Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. Because our practice works with couples and families, your information may be shared with your partner or family members, Unless there is a specific written request from you to the contrary. Your medical and demographic information may coexist with your partner's due to the nature of our practice.

• **Disaster Relief.** We may disclose medical information about you to an entity assisting in a disaster relief effort (for example, the Red Cross) so that your family can be notified about your condition, status and location.

• **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes, when approved by the Institutional Review Board or Privacy Board.

• **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law. *[California: For example, disclosure of protected health information is required to the Department of Health Services for the purpose of birth defect monitoring. Access to this information is limited to authorized individuals. Also, California maintains a system for collecting information regarding cancer hazards and potential remedies].*

• **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, if you were involved in a violent crime, disclosure may be made to law enforcement.

SPECIAL SITUATIONS

• **Organ and Tissue Donation.** If you are an organ or tissue donor, we may release medical information to organizations that handle procurement or transplantation, or to a donation bank.

• **Fertility Treatment.** Medical information may be disclosed to your partner or spouse during fertility evaluation and treatment. Gestational carrier medical information may be disclosed to the intended parents as it may affect the intended parent's baby. Egg donor medical information may be disclosed to intended parents. Best efforts will be made to maintain anonymity for anonymous egg donors but this cannot be guaranteed.

• **Military and Veterans.** If you are a member of the armed forces or a veteran, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

• **Workers' Compensation.** We may release medical information about you to your workers' compensation program, for work-related injuries or illness

• **Change in ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group

• **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

• **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

• **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

• **Law Enforcement.** We may release medical information if asked to do so by law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the facility; and
- In emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

• **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

• **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

• **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

• **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

• **Right to Request Special Privacy Protections:** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision

• **Right to Request Confidential Communications**: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

• **Right to Inspect and Copy.** You have the right to inspect and receive a copy of the medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Health Information Management Department (Medical Records), Newport Fertility Center, 20072 SW Birch #230, Newport Beach, CA 92660. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and receive a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

• **Right to Amend.** If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the facility. To request an amendment, your request must be made in writing and submitted to the Health Information Management Department. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the hospital;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

• **Right to and Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, as those functions are described above.

To request this list or accounting of disclosures, you must submit your request in writing to the HIPAA Compliance Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, or if law requires the disclosure.

To request restrictions, you must make your request in writing to the HIPAA Compliance Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

• **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website at *newportfertility.com.*
To obtain a paper copy of this notice, contact the HIPAA Compliance Officer.

CHANGES TO THIS NOTICE • We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the facility. The notice will contain on the first page, in the top right-hand corner, the effective date. If the notice is changed, we will offer you a copy of the notice upon your request.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the facility, contact the Privacy Official at Newport Fertility Center, 20072 SW Birch #230, Newport Beach, CA 92660. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. *If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization*. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Universal Consent to Treat

General consent. I consent to and authorize testing and treatment by "CCRM Newport Beach, Inc.", nurses, employees, and others as ordered by my doctor and his/her consultants, associates and assistants, or as directed pursuant to standing medical orders or protocols. I understand that it may be necessary for representatives of outside health care companies or groups to assist in my care. I also understand that persons in professional training programs may be among the individuals who provide care to me. I understand that in connection with my treatment, photos or videos may be taken. Any tissue or body parts removed from my body may be retained or disposed of by CCRM at its sole discretion.

Consent to Test for HIV and Other Blood Borne Diseases. In the event a physician, other healthcare provider, employee or contractor of CCRM is directly exposed to my bodily fluids in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, I consent to CCRM testing me for infection with human immunodeficiency virus, hepatitis B virus, and hepatitis C virus.

Independent physicians. I acknowledge that the doctors taking part in my care may not work for CCRM as employees, servants or agents, and are instead engaged in the private practice of medicine. I further acknowledge that other doctors who may take part in my care, such as radiologists, anesthesiologists, emergency physicians or other specialists, are not employees, servants or agents of CCRM. I acknowledge that CCRM is not responsible for the judgment or conduct of any doctor who treats or provides a professional service to me.

No guarantee. I acknowledge that no guarantees or warranties have been made to me with respect to the treatment outcome to be provided by CCRM. I understand that all supplies, medical devices and other goods sold or furnished to me by CCRM are sold or furnished on an "AS IS" basis, and CCRM disclaims any expressed or implied warranties with respect to them. Regarding specific supplies and devices, manufacturers' warranties may apply, and I may request manufacturer's warranty information concerning such supplies and/or devices.

I have read and understand this information and authorize CCRM consent to treat.

Print Patient Name	Signature	DOB	Date

Government ID – Patient	ID Number

Print Partner Name	Signature	DOB	Date

Government ID – Partner	ID Number

Practice Representative	Date

Credit Card Authorization

In an effort to be a partner with you in controlling health care costs, our policy is to maintain a credit card on file for each patient. By maintaining a credit card on file, your account stays in current status and your continued care is not impacted. This authorization allows "CCRM Newport Beach, Inc." to use your credit card on file for services/testing which are $500 or less and are not pre-paid at the time the service/testing is provided.

Authorizations are especially important for us to have on file for circumstances including, but not limited to those described below.

1) Out-of-state patients

2) Phone consults with a physician

3) Patients with infertility/pregnancy insurance coverage –We will bill insurance for covered services with participating (In network) insurance companies. Your credit card on file will be used for any deductible and other balances that the insurance company states is patient responsibility.

4) All patients actively seeking treatment. Physicians often determine another blood and/or andrology test that may be helpful for the patient based on initial testing results. The test(s) may be added without the patient having to return to the office as they are run on the existing example. Your credit card on file will be used for such circumstance where the physician orders additional testing on an existing sample.

This authorizes CCRM to charge the credit card on file for any balances due on your account. We understand that we will always be advised of any charge made to your credit card via this authorization. CCRM will contact you by telephone if the amount to be charged exceeds $500 or if the date of service to which it relates is greater than six months.

I have read and fully understand the information contained in this Credit Card Authorization and have been given an unrestricted opportunity to ask questions and receive answers to my satisfaction and understanding. My signature serves as my authorization to use my credit card stored on file in accordance with the information provided herein.

Print Patient Name	Signature	DOB	Date

Government ID – Patient	ID Number	Last Four of Card Number

Patient Registration

Name:		Date:
Gender:	Marital Status:	DOB:
Address:		
City:	State:	Zip Code:
Home Phone:	Mobile Phone:	
Consent to Call: ☐Yes ☒No	Consent to Text: ☐Yes ☒No	
Email:		
Current OB/GYN and PCP:		
How did you hear about us?:		
Employer:		
Partner Name:		DOB:
Phone Number:	Email:	

Primary Insurance:	
Policy Holder:	Member ID:
Relation to Patient:	DOB:
Secondary Insurance:	
Policy Holder:	Member ID:
Relation to Patient:	DOB:

Emergency Contact:	
Relation to Patient:	Phone Number:

Race (optional):	Ethnicity (optional):
Pharmacy Name	
Pharmacy Phone:	Pharmacy Fax:

Authorization to Communicate Private Health Information

☐ I authorize "CCRM Newport Beach, Inc." to leave messages on my answering machine or voicemail for the following numbers (check all that apply):
☐ Home ☐ Mobile ☐ Partner's Number

☐ I authorize CCRM to share private health information with family or others listed below. This means CCRM will answer family questions, and confirm appointment information if the inquiry is made on behalf of the patient. Please list the names of individuals our practice is authorized to speak with concerning your private health information:

_____

Referral

Were you referred to us? If so, we would like to thank the person who referred you to our practice!
Referred by: _____

☐ I authorize CCRM to disclose my first and last name in a thank you note addressed to the person identified above.

Consent for Mutual Records

During the course of treatment at the Practice or Lab there may be portions of my spouse or partner's Protected Health Information (PHI) that will be included in my medical records and portions of my PHI that will be included in my spouse or partner's medical records. I hereby give my express permission and consent for my PHI to be included in my spouse or partner's medical records and for my spouse or partner's PHI to be included in my medical records. I understand and agree that any disclosures that the Practice or the Lab may make of my medical records or my spouse or partner's medical record will include my PHI and my spouse or partner's PHI.

By signing below, I attest I have read the above, provided correct demographics and authorize CCRM to communicate my PHI to the listed individuals and to have a mutual record with my spouse or partner.

Print Patient Name	Signature	DOB	Date
Government ID – Patient		ID Number	
Print Partner Name	Signature	DOB	Date
Government ID – Partner		ID Number	
Practice Representative		Date	

Authorization to Communicate Private Health Information

___Yes___No I authorize CCRM to leave messages on my answering machine or voicemail for the following number (check all that apply):

___ Home ___ Mobile ___ Work ___ Partner's Number

REQUIRED FOR TREATMENT, IF PATIENT HAS SPOUSE/PARTNER

___Yes___No I authorize CCRM to share private health information with my spouse or partner. This means CCRM will answer questions and confirm appointment information if the inquiry is made on behalf of the patient. It also means that during the course of my care, CCRM may discuss all information relating to my care including, but not limited to the following – medical history, planned diagnostic tests/procedures and the results thereof, recommended care/treatment plan and the results thereof, and all other services planned and/or rendered and the results/outcomes thereof.

Please list the name of your spouse or partner our practice is authorized to speak with concerning your private health information:

_____

___Yes___No I authorize CCRM to share private health information with family or others listed below. This means CCRM will answer family questions and confirm appointment information if the inquiry is made on behalf of the patient.

Please list the names of individuals our practice is authorized to speak with concerning your private health information:

_____

Referral

Were you referred to us? If so, we would like to thank the person who referred you to our practice.

Referred by: _____

__Yes __No I authorize CCRM to disclose my first and last name in a thank you note addressed to the person identified above.

Consent for Mutual Records

During the course of treatment at the Practice or Lab there may be portions of my spouse or partner's Protected Health Information (PHI) that will be included in my medical records and portion of my PHI that will be included in my spouse's or partner's medical records. I hereby give my express permission and consent for my PHI to be included in my spouse's or partner's medical records and for my spouse's or partner's PHI to be included in my medical records. I understand and agree that any disclosures that the Practice or the Lab may make of my medical records or my spouse's or partner's medical records will include my PHI and my spouse's or partner's PHI.

By signing below, I attest I have read the above and authorize CCRM to communicate my PHI to the listed individuals and to have a mutual record with my spouse or partner.

Patient Name(s): _____

Patient's Signature: _____ Date:_____

Dear Patient,

It is our mission to provide all patients with competent, quality care. We aim to assist you through this complex infertility treatment process in hopes of achieving a positive outcome. To result in this goal, it is critical to have and maintain a healthy, productive patient and medical team relationship. CCRM has been in practice for over 20 years, and we know that infertility can be overwhelming. CCRM is committed to providing a bias-free environment and provide equal care to all patients. The entire staff is devoted to a successful outcome and will treat all patients with respect. As with all human interactions, conflicts may arise. If this occurs, we ask for your respect and consideration to all CCRM staff when presenting your issues and, in return, we will help find a resolution. Our center has a **zero tolerance policy.** Hostile, threatening or belligerent behaviors to any staff member including the use of profanity or other abusive actions may result in immediate dismissal from CCRM. We feel strongly that hostile relationships are not conducive to our mission of patient care resulting in a positive outcome. CCRM physicians, patient representatives and mental health counselors are available to constructively resolve any issues or concerns. It is our hope that you understand that not all issues can be resolved as some are beyond our control.

In addition, we know that internet blogs or chat rooms can be another outside source of support in your infertility journey and can be a positive connection for many patients. We also know that these resources can be a negative experience for patients and our staff. We ask for your cooperation to not utilize these forums as a way to post negative comments about your physician, nurse, or CCRM. We request you to speak with our office directly so we may address your concerns and find a resolution. Each patient's care is unique and blogging may cause you to become confused about your individualized treatment as other patients may be prescribed different medications, protocols and procedures, which may not be applicable to you. Some patients feel more anxious because they are not undergoing the same treatment as another patient on the blogs.

We understand that treatment at the center is voluntary and you have come to CCRM for our expertise in infertility treatment. As a medical team of physicians and nurses, we are requesting that you allow us to prescribe your treatment based on our medical opinion of your unique situation. We want to work closely with you to create a plan of care; however, we strongly discourage you from dictating your medical care. When patients try to dictate their care, results of treatment may be compromised and actually, result in worse outcomes than if you allowed us to care for you in our usual manner. We cannot guarantee success, but you have our commitment that we will strive towards the most successful outcome possible.

Respectfully yours,
CCRM Management

Print Patient name Signature Date