



Clinical Excellence. Compassionate Care.



Dear prospective patient:

Thank you for choosing Conceptions for your women's health needs. As leading specialists offering clinical excellence and compassionate care for women's health and fertility, you can feel confident you made the right choice selecting Conceptions.

To schedule an appointment, please contact one of our two Colorado locations. Once you are scheduled, please complete the enclosed new patient packet and *SEND US THE INFORMATION, ALONG WITH A COPY OF YOUR INSURANCE CARD (front & back), PRIOR TO YOUR APPOINTMENT.* We also recommend you contact your insurance company to determine benefit coverage.

Lastly, in order to meet the individualized needs of each patient, we ask that you please be on-time for your appointment as it may be necessary to rescheduled if you are tardy. Otherwise, if you need to change or cancel your appointment, please contact us at least twenty-four(24) hours before your appointment. Thank you.

Cordially,

Bruce H. Albrecht, M.D.
Mark R. Bush, M.D.
Michael S. Swanson, M.D.

PATIENT INFORMATION

Date: _____

CIRCLE YOUR PHYSICIAN: Bruce H. Albrecht, M.D.

Mark R. Bush, M.D.

Michael S. Swanson, M.D.

Name of Patient: Mr./Mrs./Miss/Ms. _____
Last Name First Name M.I.

Address: _____
City State Zip

Date of Birth: _____ SSN: _____ - _____ - _____ Home Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Occupation: _____ Circle One: Male Female Circle One: Married Single

Referring Physician's Name: _____ Primary Care Physician's Name: _____

Email: _____ (**Initial**) Yes, I authorize Conceptions to contact me via e-mail in regards to my medical and financial care only.

Have you or any members of your family been here before? Yes No If yes, who? _____

Name of nearest relative/close friend not living with patient _____ Phone (____) _____

In order to avoid delay or error in the processing of any insurance claims, it is essential that this section be **COMPLETELY FILLED OUT** and to present **your Insurance card(s) at your first visit.**

PATIENT'S INSURANCE INFORMATION

Primary Insurance Company _____ Phone (____) _____

Claims mailing address _____

If new insurance, effective date: _____

Policyholder's name _____ Relationship to patient _____

I.D. Number _____ Group Number _____

Pharmacy Insurance Company _____ Phone (____) _____

Claims mailing address _____

Policyholder's name _____ Relationship to patient _____

I.D. Number _____ Group Number _____

LOCAL PHARMACY _____ Phone (____) _____

Secondary Insurance (if applicable)

Insurance Company _____ Phone (____) _____

Claims mailing address _____

If new insurance, effective date: _____

Policyholder's name _____ Relationship to patient _____

I.D. Number _____ Group Number _____

SPOUSE/PARTNER INFORMATION

Name: Mr./Mrs./Miss/Ms. _____
Last Name First M.I. Relationship

Date of Birth: _____ SSN: _____ - _____ - _____ Home Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Occupation: _____ Circle One: Male Female Circle One: Married Single

Primary Insurance Company _____ Phone (____) _____

Claims mailing address _____

If new insurance, effective date: _____

Policyholder's name _____ Relationship to patient _____

I.D. Number _____

Group Number _____

I authorize payment of medical benefits to undersigned physician or
supplier for these services and all future claims

I authorize the release of any medical information necessary to
process this claim and all future claims.

BRUCE H. ALBRECHT, M.D.

MICHAEL S. SWANSON, M.D.

MARK R. BUSH, M.D.

CONCEPTIONS REPRODUCTIVE ASSOCIATES



CREDIT & INSURANCE POLICY

The following information has been provided to eliminate any misunderstandings of our financial expectations and your insurance benefits. Our payment guidelines and questions for you to verify your benefits with your insurance provider have been listed below. If you have any questions or concerns, please contact.

- Payment is required at the time of service, unless you have **written** documentation of benefits from your insurance company. This includes co-pays, co-insurance and deductibles.
- Current insurance ID cards are needed at each visit.
- There is a \$25.00 charge for returned checks.
- Patients are responsible for the cost of collection efforts. If payments are not made according to the above guidelines, patients are responsible for any attorney fees and all costs involved in referring the account to our collection agency.
- Patients are responsible for knowing their insurance benefits. Please call your insurance company using the questions below and verify your benefits. Conceptions will not file claims for procedures that are not a covered benefit; payment for these procedures are due at the time of service.

BENEFIT QUESTIONS

- Do I need a referral?
- Do I need precertification?
- Is the visit problem-oriented or preventive?
- Does my insurance cover preventive care?
- What limits, if any, apply to coverage?

We sincerely appreciate the opportunity to provide you with quality health care. Please feel free to contact us with any questions you might have concerning your account.

I understand it is my responsibility to know my benefits and comply with the Conceptions credit policies.

Signature _____ Date _____



PREPARING FOR YOUR EVALUATION

To make sure you gain the greatest possible benefit from your initial consultation at Conceptions, we are providing the following information. You may wish to use this sheet as a checklist in preparing for your visit.

OBTAINING PREVIOUS RECORDS

It will be extremely important for you to have sent to us, prior to your initial visit, all medical records, x-rays, slides and test results that could have any bearing on your treatment. This includes records from all physicians, clinics and hospitals that have carried out previous gynecologic evaluations. We will need all hysterosalpingogram xrays, CT (pituitary) scans, slides of endometrial biopsies, records of all medications used, operative reports from laparoscopies and tubal or other pelvic surgeries, laboratory tests, ultrasound studies, and so on. This can best be accomplished by obtaining complete copies of your records, rather than just summaries. If you have had any of the above tests, we will be able to find them through a detailed review of your prior office or clinic visits, operative reports and test results.

Your previous health-care providers will need your written permission to release this information. To make this process easier for you, we are providing a "Request for Medical Records & Permission for Release of Information" form for you to complete, sign, and send to your providers.

CALLING AHEAD

About two weeks before the date of your appointment, please call to confirm whether or not all of the records you requested have arrived. If not, you will want to follow-up to make sure they have been sent. We can begin your evaluation without these records, however, the more information we can have prior to this initial appointment, the more efficiently we can assess your health care needs and develop a treatment plan.

ABOUT YOUR FIRST APPOINTMENT

You can expect your first appointment to take as long as 1 hour. Please complete the new patient packet, be sure to sign both signature boxes, and send us the completed forms prior to your appointment. We will need a photograph of you to keep in your records. If you have a recent photo we can keep, please bring it with you. Otherwise, if you do not bring a photo please expect us to take a Polaroid at the time of your appointment. This is extremely useful for us until we get to know you better.

INSURANCE

If your insurance company allows you to see only the physicians on their list, please check with your company to be sure the doctor you will be seeing is a participating provider. If you have an Insurance plan that requires a PCP referral or requires notification of services by the member it is the patients responsibility to make sure this is in place. Any services denied for no referral or notification by the member will be the responsibility of the patient.

Lastly, no matter what kind of insurance you have, we will need to make a copy of your wallet card verifying your coverage.

BE SURE TO BRING THE INSURANCE CARD WITH YOU. Whether or not you have insurance, the ultimate responsibility for payment is yours. For further discussion of our financial policies, please see the enclosure entitled "Credit & Insurance Policy."

For the first visit, if you do not have insurance, we require payment at the time of service. Charges for the Office visit range from approximately \$200 to \$420. We accept personal checks, cash, Visa, MasterCard, and Discover. We do offer a Cash discount if paying by check or cash at the time of service.



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REQUEST FOR MEDICAL RECORDS & PERMISSION FOR RELEASE OF INFORMATION

PLEASE SEND THIS REQUEST FORM TO PREVIOUS PHYSICIAN FOR MEDICAL RECORDS

Records Requested from: Dr. _____

(Address) _____

Last name First name Middle name Maiden name

Street address City State ZIP

() _____

Telephone Last name under which records may be found (if different) Birthdate

Please send my records to (check one):

____ 271 West County Line Road ____ 300 Exempla Circle, Suite 370

Littleton, CO 80129-1901 Lafayette, CO 80026-3384

FAX: 303-794-2054 FAX: 303-449-1039

Please send the following items to the address checked above. Please provide a complete copy of all medical records, rather than a summary. Thank you for your time and promptness.

Records of care from _____ to _____ to include anything that could have a bearing on my fertility.

____ Medical records/ operative reports ____ Laboratory reports ____ Hysterosalpingogram x-rays and reports
____ Biopsy slides ____ Other (please specify) _____

I hereby grant permission for release of these records.

(Name)

(Date)

(Witness)

(Date)

APPOINTMENT DATE _____

PLEASE RETURN A COPY OF THIS FORM WITH THE PATIENT'S RECORDS



FEMALE MEDICAL HISTORY (Page 1/6)

Date of appointment: _____

Name _____ DOB _____ Age _____
(Last) (First) (M.I.)

Marital status _____ Partner's name _____ Age _____

How did you hear about us? _____

Why did you make today's appointment? What problems/health needs would you like to discuss? _____

What was the first day of your last menstrual flow? _____

How old were you when you started your periods? _____

How many days between the first day of one period and the first day of the next period? _____

Do you have any bleeding or spotting between your periods? Yes No

How many days does the flow last? _____ How many are heavy? _____

How many pads/tampons do you use per 24 hours on your heavy days? Pads _____ Tampons _____

Do you use a pad and tampon together? Yes No

Do you soak through? Yes No If yes, how often? _____

Do you have menstrual cramps? Yes No If yes, how many days? _____

Mild Moderate Severe

If you use over-the-counter or prescription medication to relieve menstrual cramps, please list: _____

Medication	Dose	How often
------------	------	-----------

Number of pregnancies _____ Births _____ Miscarriages _____ Elective abortions _____



FEMALE MEDICAL HISTORY (Page 2/6)

Name: _____

Living children _____

Year	Vaginal delivery Yes/No	Cesarean Yes/No	Full-term Preterm	Birth Weight Sex	Complications

Circle if you have ever had:

- | | | | |
|----------------------------------|------------------|-----------------------|---------------------|
| Uterus removed | Ovarian cysts | Pain with intercourse | Chlamydia |
| Ovaries removed | Pelvic pain | Trichomonas | Uterine fibroids |
| Endometriosis | PMS | Syphilis | Uterine hyperplasia |
| Polycystic ovary syndrome (PCOS) | Gonorrhea | Uterine polyps | Abnormal mammogram |
| Uterine cancer | Genital warts | D&C | Hot flashes |
| Ovarian cancer | Genital herpes | Intrauterine device | Vaginal dryness |
| Cervical cancer | Mycoplasma | Vulvar cancer | Yeast Infection |
| Cervix biopsy | PID | Cone Biopsy | Infertility |
| Cervix frozen | Cesarean section | LEEP of cervix | |

Did your mother take DES when pregnant with you? Yes No
(DES, diethylstilbestrol, is a medication that was used to prevent miscarriage.)

What do you use for birth control? Nothing Trying to conceive The Pill # of years _____

IUD Diaphragm Spermicide Rhythm Condoms Partner with vasectomy Tubal ligation

Depo Provera Other _____

What have you used for birth control in the past?

Date of last mammogram _____ Was it normal? Yes No

How often do you examine your breasts? _____

Date of last Pap smear _____ Was it normal? Yes No

Have you had any abnormal Pap smears? Yes No When? _____

What is the frequency of your sexual activity? _____ per week _____ per month



FEMALE MEDICAL HISTORY (Page 3/6)

Name: _____

Do you have any pain with sexual intercourse? Yes No

Do you or your partner use lubricants when engaged in sexual activity? Yes No

What is your sexual preference? Heterosexual Lesbian Bisexual

Have you ever been abused sexually, physically or emotionally? Yes No

Surgical History List types and date/year of surgery _____

Medical History Circle if you have ever had any of the following:

- | | | | | |
|-----------------------------|----------------------------|--|---|--|
| Skin cancer | Abnormal chest x-ray | Diabetes | Eczema | Asthma |
| Osteoporosis | Psoriasis | Blood clots in legs or lungs | Thyroid problems | Cataracts |
| Emphysema | Migraines | Contact lenses/glasses | Lung cancer | Seizures |
| Glaucoma | Tuberculosis | Stroke | Eating disorder | TIA (mini-stroke) |
| Dentures | Colon polyps | Hay fever | Hearing loss | Crohn's disease/
ulcerative colitis |
| Degenerative arthritis | Gout | Gallstones | Herniated disk | Abdominal aneurysm |
| Hemorrhoids | Rheumatoid arthritis | Abnormal EKG | Hepatitis/liver disease | Chronic back pain |
| Angina (chronic heart pain) | Hiatal hernia | AIDS | HIV positive | Heart attack |
| Irritable bowel | Anemia | Heart failure
(enlarged/weak heart) | Spastic colon | Pancreatitis |
| Bleeding problem | Leukemia | Heart murmur | Stomach or
colon cancer | Pacemaker |
| Ulcers | Alcoholism/alcohol trouble | Rheumatic fever | Fecal incontinence | Diagnosed or
treated depression |
| High blood pressure | High cholesterol | Abnormal kidney | Kidney stones | |
| Fibrocystic breasts | Breast cancer | Breast lump removal | Drug abuse:
Cocaine, marijuana,
other _____ | |

Childhood diseases/Vaccinations
 German measles(rubella) _____
 Measles _____
 Mumps _____
 Chickenpox _____
 Polio _____



FEMALE MEDICAL HISTORY (Page 4/6)

Name: _____

Social:

What is your occupation? _____

What do you do for exercise? _____

How many days per week? _____ For how many minutes? _____

How much do you currently smoke? _____

How many years have you or did you smoke? _____ When did you quit? _____

How much alcohol do you use? _____ drinks per day / week / month

Do you use any recreational drugs? Yes No If yes, which ones? _____

How much caffeine do you drink per day? Coffee _____ Tea _____ Soda _____

Do you follow a special diet? Yes No If yes, what kind? _____

Do you take calcium supplements? Yes No If so, what kind and how much? _____

Do you take vitamins or other supplements? Yes No What and how much? _____

In the last year, have you considered suicide? Yes No

Have you ever attempted suicide? Yes No

What is your ethnic heritage? (This may be relevant to your medical care.)

(German, Italian, Hispanic, African-American, Jewish, Ashkenazi Jewish, etc.)

What is your religious preference? _____

Medications:

List all prescription medications you take, the dose, how often, and why: _____

List any non-prescription (over-the-counter) medications you take, the dose, how often, and why: _____

Allergies and adverse reactions:

If you have had an adverse reaction to medication, chemicals, insect bites, insecticides, foods, etc., list what caused the reaction and the type and severity of the reaction: _____



FEMALE MEDICAL HISTORY *(Page 5/6)*

Name: _____

Have you ever received a blood transfusion? Yes No If so, why? _____

Have you ever been turned down as a blood donor? Yes No If so, why? _____

What is your blood type? _____

Are you immune to rubella (German measles)? Yes No Unknown

Family History:

Have you had any relatives with cancer of the breast, colon, female organs, lung, prostate, skin, or any other type of cancer?
If so, please list below:

Relationship to Patient	Type of Cancer

Family Tree:

Please list the names and ages of your relatives. Also, please list any health problems that relative may have. If deceased, please indicate age at death, cause of death, and any other health problems. For assistance, please refer to the list of health problems under Medical History on Page 3.

If family medical history is not relevant because you are adopted, please check here and skip this section:

First name	Relationship	Present age, if living	Age at death	Health problems and/or cause of death
	Mother			
	Mother's mother			
	Mother's father			
	Father			
	Father's mother			
	Father's father			



FEMALE MEDICAL HISTORY (Page 6/6)

Name: _____

List all of your sisters, brothers, and children:

First name	Relationship	Present age, if living	Age at death	Health problems and/or cause of death

Please give details of any family history you think may be relevant to your situation: _____

Notes: _____

HIPAA NOTICE OF PRIVACY PRACTICES

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 about this notice, please contact: Central Privacy Office at (720) 344-4915

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

TREATMENT. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

PAYMENT. We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

HEALTH CARE OPERATIONS. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND HEALTH RELATED BENEFITS AND SERVICES. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

RESEARCH. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to 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 Health 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 Health Information in response to court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar

process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency 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 Health 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if 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

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the address shown below.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the address shown below.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the address shown below.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the address shown below. **We are not required to agree to your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to the address shown below. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

You must make all requests in writing addressed to:
(Be sure to include your physician's name.)

Conceptions Reproductive Associates
Attn: Privacy Officer
271 W. County Line Rd Littleton, CO 80129