Rosalind Franklin University Health Clinics would like to thank you for your inquiry into Reproductive Medicine and Immunology. We are committed to a complete understanding of the role of the immune system in pregnancy and using this knowledge to help infertile couples achieve a successful pregnancy.

Our mission is to understand and advance the study and treatment of the immunological aspects of the reproductive process. While attempting pregnancy, we co-manage you with your reproductive endocrinologist, primary gynecologist, or other provider that may be caring for you. Once pregnancy occurs, we co-manage with your obstetrician.

Dr. Joanne Kwak-Kim (MD) has gained international recognition as an authority in the field of reproductive immunology. Her expert understanding of the role of the immune system in pregnancy and pregnancy loss has helped thousands of patients.

Please read and complete the enclosed packet in its entirety. All forms should be sent, along with the past 12 months of medical history (if available) and current physician referral information, to the address listed below. After all forms are received and reviewed, you will be contacted to set up an initial appointment. This appointment may consist of a physician consultation, blood tests, or ultrasound evaluation, depending on your needs assessment. Once initial evaluations are completed, you will be contacted regarding follow-up treatment and planning. In addition, all information will be forwarded to your referring physician, as indicated by you.

Treatment protocols are often a combination of physician services and ancillary services. To the best of our ability, we will inform you of the planned treatment after the initial evaluation. However, it may be necessary to change the treatment protocol as a result of changes during treatment. The following is a list, not inclusive, of many of the common services that you will receive and be billed for while receiving treatment.

- Physician Visit or Consultation
- Physician or Nurse Phone Consultation
- Physician Interpretation of Tests
- Physician Medical Records Review
- Supervision of Home Care Services
- Ultrasound Scans
- Laboratory Tests

In addition to your insurance or you being billed by Rosalind Franklin University Health Clinics, all clinical laboratory tests will be performed and billed by the Clinical Immunology Laboratory at Rosalind Franklin University of Medicine and Science.

Please return all forms to the address below, or call with any questions you might have. We look forward to helping you along your journey to parenthood.

Reproductive Medicine and Immunology

Rosalind Franklin University Health Clinics

830 West End Court, Suite 400, Vernon Hills, IL 60061

Phone (847) 247-6900 Fax (847) 247-6951

www.rfuclinics.com

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

Reproductive Medicine and Immunology Patient Registration Packet

PATIENT INFORMATION

Problems that led you to Reproductive Medicine and Immunology (**Place an "x" by all that apply**)

	Recurrent pregnancy loss		Repeated IVF failures
	Second/third trimester pregnancy loss		Poor ovarian response
	History of preterm delivery		Premature ovarian failure
	History of preeclampsia		Autoimmune disease and reproductive issue
	History of intrauterine growth restriction		Failed immunological treatment history
	Infertility of unknown etiology		
	Other (*please list*):		

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

Last Name: _____ First Name: _____ Middle Initial: _____

Apt. /Ste. #: _____ Street Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: (_____) _____ Marital Status: ☐ Single ☐ Married

Work Phone: (_____) _____ Other Phone: (_____) _____

E-mail Address: _____ Social Security #: _____-____-_____

Occupation: _____

Emergency Contact Name: _____ Phone: (_____)_____

I authorize that any information regarding my case, treatment or financials can be discussed with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

RESPONSIBLE PARTY (Please complete if different from patient)

Last Name: _____ First Name: _____ Middle Initial: _____

Apt./Ste. #: _____ Street Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: (_____) _____

Work Phone: (_____)_____ Other Phone: (_____)_____

Social Security #: _____-____-_____ Date of Birth: _____/_____/_____

INSURANCE INFORMATION

Name of Policy Holder: _____ Identification Number: _____

Primary Insurance: _____ Group Name and Number: _____

Insurance Co. Address: _____ Provider Services Phone #: _____

Name of Policy Holder: _____ Identification Number: _____

Secondary Insurance: _____ Group Name and Number: _____

Insurance Co. Address: _____ Provider Services Phone #: _____

Do you have a pharmacy insurance card? Yes ☐ No ☐

If yes, ID number: _____ Group number: _____

PHARMACY INFROMATION

Name of pharmacy: _____ Address: _____

Telephone number: _____ Fax number :_____

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

Authorization for Treatment

Name of Patient::_____ Date of Birth: _____/_____/_____

I, as the patient or responsible party (for patient named above), authorize Rosalind Franklin University Health Clinics (Health Clinics) to administer medications, immunizations, and to perform such diagnostics and medical procedures as deemed medically necessary for my care based on the judgment of the physician(s) and other health care provider(s) of the Health Clinics. I understand that I have the opportunity to discuss treatment options with the physician(s) and other health care provider(s).

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party (*please print*): _____

REFERRAL INFORMATION

Please tell us how you heard about Rosalind Franklin University Health Clinics. This information is very important, especially if you were referred to us by your primary care doctor. Thank you for sharing this information with us.

1. If you were referred by your primary care doctor or specialist, please provide your doctor's first and last name, office telephone number and address on the lines below. (This helps coordinate follow-up care with your doctor.)

Doctor's Name _____ Phone (_____)_____

Address _____

City _____ State _____ ZIP_____

2. If you were not referred by your doctor, were you referred by: (please check one)

____Hospital Please list hospital _____

____Newspaper Please list newspaper _____

____Insurance Directory Please list insurance company _____

____Internet Please list Web site_____

____Yellow Pages ____Road Sign ____Referral from Current Patient ____Referral from Friend/Family Member

____Other Please list other source_____

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

Financial Responsibility Agreement

Rosalind Franklin University Health Clinics (Health Clinics) is committed to your care, and we thank you for choosing us to serve you today. As part of the treatment, you will incur costs for the services and supplies rendered to treat you. As the patient, or guarantor for the patient, you will be responsible for payment in full. Because we value you as our customer, we attempt to work with you to resolve these costs. If you have any questions related to your financial situation, please contact the Patient Financial Services Department at (847) 247-6932.

We have found through recent claims processing experience that many insurances classify the treatment protocols used at Reproductive Medicine and Immunology as experimental and/or investigational. They cite the findings and recommendations in the current edition of American College of Obstetrics and Gynecology Technical Bulletin 212, *Early Pregnancy Loss,* as the basis for their determination. This does not mean that the therapies used at Reproductive Medicine and Immunology are ineffective or harmful, but that, at present, insufficient scientific evidence, in the form of large-scale, double-blinded, randomized clinical trials, exists to clearly demonstrate the efficacy of the protocols. Since insurance plans do not generally cover experimental medical services, it is likely that certain services provided at Reproductive Medicine and Immunology will be denied. It is your responsibility to acquire a determination of benefits coverage from your insurance plan regarding the services that you will receive.

We accept most insurance plans; however, you are responsible for verifying that we are a participating member with your insurance. If you have an HMO, you have responsibility for obtaining the necessary referral(s). All co-payments will be due at the time of registration. As a courtesy, we will bill your insurance directly for payment. Payments for services classified as non-covered by your insurance provider are your responsibility. (For example, the terms of your specific insurance policy may classify a phone consultation or special reports as a "non-covered service," in which case we would bill you directly for the cost of this service.)

If there is a dispute with your insurance, we have the right to bill you prior to resolution. It is important at each visit that you provide us with the most current information regarding your insurance.

If you do not have insurance, we are committed to providing you ways to make payment in full for services received. We accept cash, personal checks, and credit cards as forms of payment. We offer a 15% discount for payment in full at the time of service. In order to be eligible for this discount, you must have no outstanding balance due. If you are unable to make payment in full at the time of service, we will bill you for the balance due. A Financial Hardship Program is offered to qualifying individuals based on income level, as well. Discounts are based upon your level of income relative to Federal Poverty Guidelines. If you believe you may qualify, please ask for an application.

As a final alternative, we use a collection agency to collect on past due balances. If you fail to make payment on your account, you will be responsible for the costs incurred by the collection agency. This includes, but is not limited to, the fee assessed by the agency to the Health Clinics for their services and legal fees, if necessary.

By signing this acknowledgement, you (or guarantor for the patient) accept responsibility for payment of the services and supplies rendered by the Health Clinics. You certify that you have read and understand your responsibilities and provided accurate and complete information.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party (*please print*): _____

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

Non-Covered Services Waiver Form

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. This form lists some services with their frequency and estimated cost that your insurance may or may not cover. We are giving you this information so that you can make an informed choice about such services and understand that you may have to accept responsibility for payment.

I am requesting the following services be provided to me by Rosalind Franklin University Health Clinics.

Application and frequency of the following services are based on individual treatment plans. Therefore, the frequency may fluctuate.

CPT Codes	Services(s)	Frequency	Estimated Cost
99442	11-20 min phone w/Dr.Kwak-Kim	Monthly	$108.00
99443	21-30 min phone w/Dr.Kwak-Kim	Monthly	$180.00
98967	11-20 min phone w/o Dr.Kwak-Kim	Monthly	$ 39.00
98968	21-30 min phone w/o Dr.Kwak-Kim	Monthly	$ 91.00
99358	Prolonged E&M 60 min	Monthly	$280.00
99359	E&M additional 30 min	Monthly	$137.00
99080	Special Reports	3 letters	$ 77.00

Please be advised that when you communicate with a provider via emails, portal, or phone messages frequently there is a charge assessed because it involves the provider's time in reviewing your chart and data collection. This charge is billed to your insurance company as a courtesy. However, it is usually not covered and the patient is responsible.

In making this request, I acknowledge that these services may not be a covered benefit of my health insurance policy and that I will not receive the benefit of my insurance policy, which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by my insurance policy, I may be responsible for the cost of that professional service.

I also understand that if authorization for this care has been denied by my insurance, or if reimbursement is denied upon submittal of a claim form, I may appeal the written notification of the denial issued by my insurance company.

Unless the decision to deny is overturned as the result of an appeal or dispute, I agree that I will be personally responsible for the payment IN FULL of the billed charges for the services.

_____ _____

Patient Name (Print) Patient /Parent Signature

_____

Date

If you have any questions regarding this form, please contact Freida in the billing office at 847-247-6932.

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

Acknowledgement of Receipt of Notice of Privacy Practices

The HIPAA Privacy Rule requires that "covered entities" (e.g. hospitals and clinics) deliver a copy of their Notice of Privacy Practices to their patients at their first visit. It also requires that we seek a written acknowledgement from our patients that we did, in fact, deliver that notice.

Accordingly, the Rosalind Franklin University Health Clinics asks you to acknowledge that we delivered to you a copy of our "Notice of Privacy Practices" by signing this form.

I acknowledge receipt of the Rosalind Franklin University Health Clinics Notice of Privacy Practices on the date indicated below.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party (*please print*): _____

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

Notice of Privacy Practices – Effective 4/16/2013

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

INTRODUCTION

Rosalind Franklin University Health Clinics is required by law (the federal HIPAA Privacy Rule) to maintain the privacy of protected health information (PHI) and to provide you with this notice of our legal duties and privacy practices regarding PHI. We are required to abide to the terms of this notice. We may change at any time the terms of this notice for all PHI we maintain. If we do so, we will revise this notice to reflect the new terms and have it available for you upon request.

PERMITTED USES AND DISCLOSURES

At times, other federal laws and the laws of the State of Illinois impose stricter limits on the use and disclosure of PHI than the HIPAA Privacy Rule. In those cases, the HIPAA Privacy Rule states that we must follow the laws that provide you with the greater amount protection over your PHI. Subject to those stricter limits, we may use and disclose your PHI as follows:

Treatment. We may use or disclose your PHI for treatment activities of a health care provider. For example, we may use your PHI to provide medical care to you and we may disclose PHI to another physician who is providing medical care to you.

Payment. We may use or disclose your PHI for activities relating to obtaining reimbursement for the health care services you received. In addition, we may disclose your PHI for similar activities of another health care provider or a group health plan that relates to you. For example, we may use your PHI to bill you or your insurance company, as appropriate, for services rendered.

Health Care Operations. We may use or disclose your PHI for certain activities relating to the operation of the Health Clinics as a health care provider. In addition, we may disclose your PHI for those activities relating to the operation of another health care provider or a group health plan with which you have a relationship. For example, we may use and disclose your PHI for activities relating to quality assessment, training of health care professionals, fraud and abuse detection, and compliance programs.

Other Permitted Uses and Disclosures.
We may use and disclose your PHI so long as certain conditions that relate to your privacy and public necessity are met:

* to **Persons Involved in Your Care or Payment of Your Care**, but you will have the opportunity to object and, if you do object, we will abide by your wishes.
* to **Business Associates** who perform functions for us and who have promised in a written agreement to safeguard your PHI.
* as **Required by Law**, so long as the specifics of the use or disclosure is no more than that required by the law.
* for **Public Health Activities**, such as reporting disease, injury, and vital statistics.
* to **Report Adult Abuse, Neglect, and Domestic Violence**, under certain conditions.
* to a **Health Care Oversight Agency** that oversees the health care system.
* for **Judicial and Administrative Proceedings**, so long as there is a lawful court order or other legal demand.
* for certain **Law Enforcement Purposes**, such limited PHI relating to fugitives, crime victims, suspicious deaths, crimes on our premises, and crimes in emergencies.
* certain information about **Decedents** to coroners, medical examiners, funeral directors, and organ/tissue donation entities.
* for **Research Purposes**, so long as an oversight board approves the request under strict guidelines, is preparatory work that does not leave the Health Clinics, or is about decedents.
* to **Avert a Serious Threat to Health or Safety**, as necessary under the circumstances.

* for certain **Specialized Government Functions**, such as Armed Forces personnel, national security activities, correctional facilities, and government health benefit programs.
* for **Workers' Compensation** programs.
* to contact you and provide information **Useful Information**, such as appointment reminders and health-related benefits and services that may be of interest to you.
* to contact you about the Health Clinics' efforts to **Raise Funds**, but you have the right to opt out of receiving these fundraising communications.
* a **Limited Data Set**, which deletes certain information about you, so long as the PHI is only used for research, public health, or health care operations purposes and the recipient agrees in writing to safeguard your PHI.

Your Written Authorization. Other than the uses and disclosures discussed above, we will not use or disclose your PHI without your written authorization. This includes uses or disclosures made for marketing purposes, that constitute a sale of your PHI, and of most psychotherapy notes. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure that occurred prior to this Health Clinics receiving your revocation.

YOUR RIGHTS

A brief summary of your rights are as follows. For additional information regarding these rights, you may contact the office listed at the end of this notice.

Access. You have the right to inspect and obtain a copy of your PHI records. To do so, you must seek access in writing. A reasonable fee may be charged for copying and postage, if applicable.

Amendment. You have the right to seek an amendment to your PHI records. To do so, you must make your request in writing. Even if the PHI record is determined to be accurate and complete, you have the right to submit a statement of disagreement.

Accounting. You have the right to obtain a list of certain disclosures that occurred regarding your PHI. To do so, you must seek your accounting in writing. Some disclosures would not be mentioned on that list, such as those associated with treatment, payment, and health care operations and disclosures you personally authorized in writing.

Further Restrictions. You have the right to seek further restrictions on how we use or disclose your PHI. To do so, you must make your request in writing. Although we are not required to agree to most of those requests, we will review them and, if we do agree, we will document it and abide by it. We are required to agree to a request to restrict a disclosure of your PHI to a health plan for payment or health care operations purposes when the PHI relates to a health care item or service for which we have been paid in full by you or by other alternative means.

Confidential Communications. You have the right to request that we communicate with you using alternative means or at alternative locations. To do so, you must make your request in writing. If the request is reasonable, we will accommodate it.

Copy of this Notice. You have the right to receive a paper copy of this notice upon request, even if you previously agreed to receive this notice electronically.

File a Complaint. You may file a complaint with us and to the U.S. Department of Health and Human Services if you believe we have violated your privacy rights and we will not retaliate against you in any way. To file a complaint with us, you should contact the office listed at the end of this notice.

Notice of Breach. You have the right to receive notifications of breaches of your unsecured PHI.

FURTHER INFORMATION

If you have any questions, desire to file a complaint, or seek further information about matters contained in this notice, you may contact:

Lisa Sarris Cowhey
Privacy Officer
Rosalind Franklin University Health Clinics
3471 Green Bay Road
North Chicago, IL 60064
Tel: (847) 578-8846

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

SPOUSE INFORMATION

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

Last Name: _____ First Name: _____ Middle Initial: _____

Apt../Ste. #: _____ Street Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: (_____)_____

Work Phone: (_____)_____ Other Phone: (_____)_____

E-mail Address: _____ Occupation _____

Weight: _____ Height: _____ Blood Type (ABO/RH): _____ Race: _____

Cardiovascular	Yes	No	Uncertain
Anemia	☐	☐	☐
Blood Disorder	☐	☐	☐
Cerebrovascular Accident	☐	☐	☐
Chronic Hypertension	☐	☐	☐
Heart Disease	☐	☐	☐
Hemoglobinopathy	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Past Albumin Tx	☐	☐	☐
Past Blood Transfusion	☐	☐	☐
Past Gammaglobulin Tx	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Thrombophlebitis	☐	☐	☐
Transient Ischemic Attack	☐	☐	☐
Varicositis	☐	☐	☐

	Yes	No	Uncertain
Addiction			
Alcohol	☐	☐	☐
History of Drug Abuse	☐	☐	☐
Smoking	☐	☐	☐
Infertility			
Abnormal Sperm Form	☐	☐	☐
Decreased Motility	☐	☐	☐
Oligospermia	☐	☐	☐
Neurologic			
Cerebrovascular Accident	☐	☐	☐
Migraine Headache	☐	☐	☐
Neurologic/Seizure Disorder	☐	☐	☐
Psychiatric Disease	☐	☐	☐

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

SPOUSE INFORMATION (Continued)

Name _____

Pulmonary	Yes	No	Uncertain
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Pulmonary Embolism	☐	☐	☐
Tuberculosis	☐	☐	☐
Surgery			
Ligation of Varicocele	☐	☐	☐
Vasectomy	☐	☐	☐
Other	☐	☐	☐

Autoimmune Disease	Yes	No	Uncertain
Autoimmune Thyroiditis	☐	☐	☐
Dermatomyositis	☐	☐	☐
Fibromyalgia	☐	☐	☐
Lupus Erythematosus	☐	☐	☐
Myasthenia Gravis	☐	☐	☐
Photosensitivity	☐	☐	☐
Raynaud Disease	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Other	☐	☐	☐

Endocrine	Yes	No	Uncertain
Diabetes	☐	☐	☐
Endocrinopathy	☐	☐	☐
History of Growth Hormone Tx	☐	☐	☐
Maternal PKU	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐
Renal Disease			
Asymptomatic Bacteriuria	☐	☐	☐
Chronic Renal Disease	☐	☐	☐
Cystitis	☐	☐	☐
Pyelonephritis	☐	☐	☐
Other	☐	☐	☐

Liver Disease	Yes	No	Uncertain
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Hepatitis C	☐	☐	☐
Other	☐	☐	☐
Gastrointestinal			
Gastric/Duodenal Ulcer	☐	☐	☐
Reflux Esophagitis	☐	☐	☐
Other	☐	☐	☐

ROSALIND FRANKLIN UNIVERSITY HealthClinics VERNON HILLS

SPOUSE INFORMATION (Continued)

Name _____

Have you ever received genetic studies? ☐ Yes ☐ No If yes, please list your karyotype: _____

Genetic History	Patient	Family	**Genetic History (Continued)**	Patient	Family
Cerebral Palsy	☐	☐	Muscular Dystrophy	☐	☐
Congenital Anomaly	☐	☐	Neural Tube Defect	☐	☐
Cystic Fibrosis	☐	☐	Sickle Cell Disease or Trait	☐	☐
Down's Syndrome	☐	☐	Tay-Sachs Disease	☐	☐
Hemophilia	☐	☐	Test for Fragile X	☐	☐
Mental Retardation	☐	☐	Thalassemia A or B	☐	☐

Family History	Yes	No	Uncertain	If yes, please explain.
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Genetic or Inherited Disease	☐	☐	☐	
High Blood Pressure or Other Heart Disease	☐	☐	☐	
Kidney Disease	☐	☐	☐	

Allergies Yes ☐ No ☐	**Current Medications** Yes ☐ No ☐
If yes, please list.	If yes, please list.

Please list other concerns you may have:

_____

_____

_____