INSTITUTE FOR
REPRODUCTIVE HEALTH

For Appointments Call: (513) 924-5550 **Fax: (513) 924-5551**

Please familiarize yourself with our convenient office locations and hours to be able utilize your time and care efficiently.

CINCINNATI, OH
3805 Edwards Rd., Suite 450
Cincinnati, Ohio 45209
Office Hours: Weekdays 8:30 a.m.-4:30 p.m. (Only office open on weekend, hours vary)

Directions from Downtown and Kentucky

Take I-71 north to exit #6 (Smith/Edwards Rd). Take a right at the end of the ramp, then take a right at the first light. Take the first left, before the shopping area, around the tower and watch for Rookwood Tower parking entrance on the left.

Directions from North of Cincinnati

Take I-71 south to exit #6 (Smith/Edward Rd). Turn right at the end of the ramp and follow the signs to Rookwood Commons. Take the first left onto Williams/Edmondson Rd. Turn right at the second light. Take the first left, before the shopping area, around the Tower and watch for Rookwood Tower parking on the left.

WEST CHESTER, OH
7242 Tylers Corner, Suite C
West Chester, Ohio 45069
Office Hours: Monday, Thursday 7:30 a.m.- 3:00 p.m.

Directions from North of West Chester

Take I-75 South to Exit #22, Tylersville Road. At the top of the ramp, turn right. At the 3rd traffic light, turn right onto Wetherington Road. Make an immediate left onto Tylers Corner Road and into our parking lot (red building).

Directions from South of West Chester

Take I-75 North to Exit #22, Tylersville Road. At the top of the ramp, turn left. At the 4th traffic light, turn right onto Wetherington Road. Make an immediate left on Tylers Corner Road and into our parking lot (red building).

FLORENCE, KY
Houston North Office Condominiums
6900 Houston Rd, Building 600, #15
Florence, KY 41042
Office Hours: Monday-12:45-4:30 p.m., Wednesday- 8:30 a.m.- 4:30 p.m., Friday-12:45-4:30 p.m.

Directions from North of Florence

Take I 71/75 South to Florence Route 18 exit. This is exit #181. Turn right onto Route 18. At the second light turn right onto Houston Rd. Look for the brick office condos on the right side of the road just past Panera. Turn right into the second set of condos which are the Houston North condominiums. We are in building 600 #15.

Directions from South of Florence

Take I 71/75 north to Florence Route 18 exit. This is exit #181. Turn left onto Route 18. At the third light turn right onto Houston Rd. Look for the brick office condos on the right side of the road just past Panera. Turn right into the second set of condos which are the Houston North condominiums. We are in building 600 #15.

LOUISVILLE, KY
2401 Terra Crossing Blvd #325
Louisville, Kentucky 40245
Office Hours: Monday, Tuesday, Thursday, Friday- 8:30 a.m.- 5:00 p.m.

Directions from North of Louisville

From I-71 south, merge onto I-265/ KY-841 south via exit 9A for 5.94 miles. Take the Old Henry Road exit, Exit 29. Turn left on Old Henry Road for 0.4miles. Turn left onto Terra Crossing Blvd. The office is on the right.

Directions from South of Louisville

From I-65 north, take exit 125A to merge to I-265/ KY-841 for 17.1 miles. Take the Old Henry Road exit, Exit 29. Turn right on Old Henry Road for 0.2miles. Turn left onto Terra Crossing Blvd. The office is on the right.

INSTITUTE FOR
REPRODUCTIVE HEALTH

Dear Patient,

We would like to take this opportunity to welcome you to our practice. We look forward to meeting you and providing the highest quality reproductive care. In order to facilitate your appointment, we ask that you please take a few moments and complete the enclosed registration and medical history forms. Please send us a copy of your infertility benefits. This should be in your benefits book provided by your employer or online. By doing this prior to your office visit, we hope to make your visit as efficient as possible. Please email any requested documents to IRHNEWPATIENT@gmail.com .

The following is a short list of items for your information:

1) The first appointment will take approximately 45 minutes for the consultation and physical exam.

2) Please request all pertinent past medical records from your previous physician. A release of information is enclosed. After completing the form, RETURN IT TO YOUR PREVIOUS PHYSICIAN so they can forward your records to us. PLEASE DO NOT RETURN THIS FORM TO US.

3) Please arrive to your appointment at least 10 minutes early to turn in completed paperwork and complete appointment payment.

4) We ask you to be respectful of other patients waiting to get into our practice. If you cannot keep your scheduled appointment, please call with a minimum of 3 days' notice so we can offer that valuable appointment time to another patient.

Please feel free to contact our office with any questions or concerns at any time. Please plan to arrive 15 minutes prior to your scheduled appointment.

Sincerely,

Drs. Awadalla, Scheiber, Burwinkel, and O'leary
513-924-5550

INSTITUTE FOR
REPRODUCTIVE HEALTH

PAYMENT, INSURANCE NETWORK AND REFERRAL POLICIES

In order to keep our fees at a minimum, all co-payments, and private pays are made before the time of service. It is your responsibility to determine if charges are covered by your insurance. We ask that you please call your insurance company PRIOR to your first appointment to ascertain which laboratories and hospitals are in your network. As you may know, charges for testing or services provided may be denied if the appropriate facilities are not used. Please inform us of what your plan requires at your first visit. Also, if you change insurance plans, please notify us as soon as possible.

It may also be helpful to ask your insurance customer service representative to explain the extent of your infertility coverage prior to your appointment. Many companies cover the diagnosis but not the treatment of this condition (i.e. insemination, in vitro fertilization, etc.). We realize that some of this terminology is unfamiliar to you at this time. However, it is helpful for you to begin to become informed regarding your infertility benefits. Please visit our website for further clarification and information.

Because referrals are often required for a specialist's services, you must obtain an initial referral PRIOR to your first appointment being scheduled. You are also responsible for keeping track of how many visits have been used and notifying us when it is time for an updated referral.

The following is a short list of items to be aware of for your initial visit:

1) If your insurance requires a referral to a specialist, this must be obtained prior to your first appointment with us.
2) Please send a copy of the front and back of your insurance card.
3) Co-payment for the initial visit, and all visits thereafter are required by your insurance company the day of your appointment.
4) Self-pay patients must pay on date of service for your initial visit. We do accept Visa, Mastercard, Discover and American Express for your convenience as well as check or cash.

Before Cycling:

5) Self-pay patients must pay **TWO weeks** prior to calling with day one to start cycling.
6) Patients utilizing insurance must have approved prior authorization prior to calling with day one to start cycling. This can take up to 15 business days to be approved by insurance.
7) Patients utilizing insurance need to verify with insurance any possible requirements needed to utilize your benefit (Specifically, Aetna and United Health Care users).

We appreciate your understanding and cooperation in these matters, and apologize in advance for any inconvenience this may cause. Please don't hesitate to contact our billing office at (513) 924-5550 with any questions or comments.

Sincerely,

Ricia Holscher
Practice Manager

INSTITUTE FOR REPRODUCTIVE HEALTH **Date of Consult Appointment**_____

PATIENT'S INFORMATION ***(please fill out completely)***

First Name_____ Middle _____ Last _____

Address _____ City _____ State _____ Zip_____

Home Phone # (_____) _____ Cell Phone # (_____) _____ Email Address _____

Social Security #_____ Date of Birth ____/____/____ Marital Status_____ Race _____

Patient's Employer _____ Occupation _____

Address _____ Phone (_____) _____ Ext_____

Primary Care Physician_____ Referring Physician_____

How did you hear about our office? _____

INFERTILITY INSURANCE COVERAGE? YES ☐ NO ☐ **INVITRO INSURANCE COVERAGE? YES ☐ NO ☐**

PROOF OF INSURANCE PROVIDED? YES ☐ NO ☐ **SELF PAY? YES ☐ No**

Primary Insurance Co._____ Policy Holder Name _____ Policy Number _____

Group # or Name _____ Referral Required? Y/N_____ Claims Address _____

Approved Hospital & Laboratory Facilities (if required by insurance) _____

Secondary Insurance (if applicable) _____ Policy Holder Name _____ Policy Number_____

Group # or Name _____ Referral Required? Y/N_____ Claims Address _____

Approved Hospital & Laboratory Facilities (if required by insurance) _____

Employer _____

SPOUSE/PARTNER INFORMATION (OR NEXT OF KIN)

First Name_____ Middle _____ Last _____

Address _____ City _____ State _____ Zip_____

Home Phone # (_____) _____ Cell Phone # (_____) _____ Email Address _____

Social Security #_____ Date of Birth ____/____/____ Marital Status_____ Race _____

Employer _____ Occupation _____

Address _____ Phone (_____) _____ Ext_____

Primary Care Physician_____ Referring Physician_____

Primary Insurance Co._____ Policy Holder Name _____ Policy Number _____

Group # or Name _____ Referral Required? Y/N_____ Claims Address _____

Approved Hospital & Laboratory Facilities (if required by insurance) _____

Secondary Insurance (if applicable) _____ Policy Holder Name _____ Policy Number_____

Group # or Name _____ Referral Required? Y/N_____ Claims Address _____

Approved Hospital & Laboratory Facilities (if required by insurance) _____

PLEASE SIGN BELOW TO VERIFY THAT THE ABOVE INFORMATION IS CORRECT

Patient Signature _____ Date_____

Spouse/Partner Signature _____ Date_____

INSTITUTE FOR
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Female Personal Health History

Patient Name_____ Date of Birth_____

Height_____ Weight_____

Has your Primary Care Physician or OB/GYN discussed a reason why you may be having difficulty conceiving? If yes, please explain__

_____

_____

Are you allergic to any Medication?_____

If so, please describe the reaction:_____

Date of last Pap Smear:_____(This information is very important and must be provided. If you are unsure, please clarify with your Primary Care Physician or OB/GYN.)

Have you ever had a Mammogram?_____ If yes, date of last mammogram:_____

Have you gained or lost more than 20 pounds in the last two years? (If yes, please describe):_____

_____

Do you follow a particular diet, or do you have any special dietary habits?_____

Do you exercise regularly?_____ If yes, please describe_____

_____

Do you use, or have you ever used (check all that apply):

☐ Alcohol-How many glasses per week do you usually drink? Wine_____ Beer_____ Other_____

☐ Cigarettes-Number of packs per day_____

☐ Recreational Drugs (Marijuana, Cocaine, etc.)_____

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

☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Bleeding Problems
☐ Blood Clots
☐ Blood Transfusion
☐ Bowel Problems
☐ Breast Discharge
☐ Cancer
☐ Chlamydia
☐ Chronic Bronchitis
☐ Chronic Headaches
☐ Colitis
☐ Color Blindness
☐ Diabetes
☐ Dizziness/Fainting
☐ Endometriosis
☐ Epilepsy
☐ Gallbladder Problems
☐ Gonorrhea
☐ Hearing Problems Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Hirsutism (excess hair growth)
☐ Kidney Problems
☐ Liver Problems
☐ Neurological Problems
☐ Ovarian Cysts
☐ Parasitic Infection
☐ Pelvic Infection
☐ Pneumonia
☐ Rheumatic Fever
☐ Seizures
☐ Speech Problems
☐ Syphilis
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Urinary Problems

If you answered yes to any of the above, please describe:_____

_____

Menstrual and Pregnancy History:

Age at first period_____ Date of last menstrual period_____ Are your periods regular?_____

Usual number of days between periods?_____ Usual duration of your periods?_____

Do you have menstrual cramping?_____ Do you spot or bleed between periods?_____

Have you ever received X-Rays to the pelvic area?_____

Pregnancy	When? (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility Treatment Required?	Live Birth?	Is Current partner Father?
1st							
2nd							
3rd							
4th							

Have you ever been hospitalized? /Dates:_____

_____

Have you had any surgical procedures?

Date Procedure

1._____ _____

2._____ _____

3._____ _____

4._____ _____

Are you current taking any medication, either prescription or over the counter?

Medication Purpose Dosage

_____ _____ _____

_____ _____ _____

_____ _____ _____

Preferred Local Pharmacy:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone: ( )_____

_____ _____

Patient Signature Date

INSTITUTE FOR
REPRODUCTIVE HEALTH

Male Personal Health History

Patient Name_____ Date of Birth_____

Height_____ Weight_____

Are you allergic to any Medication?_____

If so, please describe the reaction:_____

Have you gained or lost more than 20 pounds in the last two years? (If yes, please describe):_____

_____

Do you follow a particular diet, or do you have any special dietary habits?_____

Do you exercise regularly?_____ If yes, please describe_____

_____

Do you use, or have you ever used (check all that apply):

☐ Alcohol-How many glasses per week do you usually drink? Wine_____ Beer_____ Other_____

☐ Cigarettes-Number of packs per day_____

☐ Recreational Drugs (Marijuana, Cocaine, etc.)_____

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

☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Bleeding Problems
☐ Blood Clots
☐ Blood Transfusion
☐ Bowel Problems
☐ Breast Discharge
☐ Cancer
☐ Chlamydia
☐ Chronic Bronchitis
☐ Chronic Headaches
☐ Colitis
☐ Color Blindness
☐ Diabetes
☐ Dizziness/Fainting
☐ Epilepsy
☐ Gallbladder Problems
☐ Gonorrhea
☐ Hearing Problems Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Hirsutism (excess hair growth)
☐ Kidney Problems
☐ Liver Problems
☐ Neurological Problems
☐ Parasitic Infection
☐ Pneumonia
☐ Prostate Infection
☐ Rheumatic Fever
☐ Seizures
☐ Syphilis
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Urinary Problems

If you answered yes to any of the above, please describe:_____

_____

_____

_____

_____

SEXUAL HISTORY **YES** **NO**

Are you circumcised?..... □ □

When you were a child, were both testes descended into the scrotum?..... □ □

At what age did you begin shaving regularly, or start to grow a beard?_____

How many times have you been married?_____

Have you ever tried to conceive a child with another partner?..... □ □

Have you ever produced a child with another partner?..... □ □

If yes, how long did it take to conceive?_____ When? (dates)_____

Do you have trouble getting an erection?..... □ □

Do you have trouble with ejaculations?..... □ □

If yes □ Premature ejaculations □ Retrograde ejaculations

Do you have any discharge from the penis?..... □ □

How many times per week do you and your partner usually have intercourse?_____

How many times per week do you have intercourse around ovulation?_____

Have you ever received X-Rays to the pelvic area?..... □ □

Have you ever been hospitalized?..... □ □

Date	Reason
1. _____	_____
2. _____	_____

Have you had any surgical procedures?

Date	Procedure
1. _____	_____
2. _____	_____
3. _____	_____

Are you current taking any medication, either prescription or over the counter?

Medication	Purpose	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Patient Signature Date

_____ _____

Reviewed by R.N. Date

INSTITUTE FOR
REPRODUCTIVE HEALTH

CONSENT TO MEDICAL TREATMENT

1. **CONSENT TO TREATMENT**: I hereby consent to the administration of medical, nursing or other treatment, drug therapy and/or testing as considered necessary for my condition as directed by Drs. Awadalla, Scheiber, Burwinkel, O'leary or assistants or designees as may be needed.
2. **RELEASE OF RECORDS**: I authorize the release of medical record information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I also understand my records may be seen by surveyors for accreditation and/or regulatory licensing purposes. I authorize the release of medical record information to the physician(s) or agency responsible for my follow-up care and/or to the healthcare facility to which I am transferred from the Institute for Reproductive Health.
3. **RELEASE OF INFORMATION TO SPOUSE OR PARTNER**: I understand that during the course of treatment my spouse or partner may have tests or procedures relevant to our care including, but not limited to infectious disease testing, sperm testing, hormone levels and ultrasounds. I authorize the disclosure of such information to my spouse or partner.
4. **CARE PROVIDERS:** I understand that my doctor(s), Sherif G. Awadalla, Michael D. Scheiber, Thomas H. Burwinkel, and Kathleen M. O'leary are medical doctors board certified in Obstetrics and Gynecology and Reproductive Endocrinology and Infertility. Only these doctor(s) will perform my planned surgical procedures/services at the Institute for Reproductive Health. I further understand that during my surgical procedures at the Institute for Reproductive Health, my conscious sedation will be administered and monitored by registered nurses, under the direction and supervision of my doctor.
5. **ADVANCED DIRECTIVES**: I understand that if I have an Advanced Directive (either a Living Will or Power of Attorney for Health Care) IRH does not honor Advanced Directives.
6. **FINANCIAL AGREEMENT:** I undersigned that, in consideration of the services to be rendered to the patient, he/she will pay the amount to the Institute for Reproductive Health any physician charges in accordance with their regular rates and terms.
7. **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to The Institute for Reproductive Health and/or my physician(s) and/or their designees, all insurance benefits otherwise payable to me.
8. **LOSS OR DAMAGE**: I agree to release the Institute for Reproductive Health from any responsibility or liability arising from the loss or damage to personal items or valuables brought to the Institute for Reproductive Health.
9. **PATIENT CARE AND SAFETY CONCERNS:** I understand that if I have any concerns about patient safety, I am encouraged to contact the management of IRH. If the concerns cannot be resolved at this level, I am encouraged to contact the Joint Commission on Accreditation of Healthcare Organizations.
10. **ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**: I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice. This notice is posted on cincinnatifertility.com.
11. **GENETIC SCREENING/TESTING:** I have been given written information and the opportunity to discuss genetic carrier screening with my physician. I understand that this screening is recommended as it may provide information about reproductive risks and the possibility of having a baby with certain genetic disorders. It is my responsibility to notify an IRH Staff Member if I wish to have the testing.
12. **HIV TESTING:** I understand that the guidelines of the American Society for Reproductive Medicine and the policy of IRH state that HIV testing should be completed for both partners and/or gamete donors and recipients prior to an attempt to become pregnant using Assisted Reproductive Technologies. This is a test for antibodies to the HIV virus, the causative agent for AIDS. I understand that if either partner is positive, there is a chance that the virus could be transmitted to the offspring. I voluntarily consent to the withdrawal of blood from me and the testing of that sample if ordered by my physician.

Patient: _____ Partner: _____

Patient Signature: _____ Partner Signature: _____

Date: _____ Date: _____

INSTITUTE FOR REPRODUCTIVE HEALTH INFORMED CONSENT

CORONAVIRUS (COVID-19)

I understand that the provider from whom I am seeking treatment is part of the Institute for Reproductive Health and affiliated with Ovation Fertility. This Acknowledgement of risks regarding COVID-19 (this "***Acknowledgement***") applies to all physicians, nurses, medical assistants, embryologists and other practitioners, physician practices, fertility laboratories, tissue storage repositories and management services organizations owned, directly or indirectly, or otherwise affiliated with, Ovation Fertility (each, a "***Provider***") . Both the patient and the patient's partner, as applicable, are parties to this Agreement and are referred to as "I". This Acknowledgement lays out the legal terms and conditions that apply to all treatment(s), procedure(s) or service(s) (referred to in this document as "*Services*") I will receive from any Provider.

Acknowledgement Regarding Coronavirus (COVID-19)

I acknowledge that I have discussed the implications of COVID-19 with my provider, have had an opportunity to ask questions and have asked the questions that I have. I understand that information regarding COVID-19 and the medical communities' understanding of this disease is rapidly evolving and that risk may come to light of which we (Providers and medical community) are presently not aware. I acknowledge that the guidance from the Center for Disease Control ("***CDC***"), the American Society for Reproductive Medicine ("***ASRM***")(the fertility industry's professional association) and the World Health Organization ("***WHO***") may change at any time based on new information regarding COVD-19.

I further understand that the CDC and ASRM have still not determined what risks, if any, (COVID-19) might have on patients undergoing infertility treatment or patients who become pregnant. Although there is no current evidence of maternal-fetal transmission of COVID-19, data is limited and prior data support that a febrile illness of any kind in pregnancy may pose risks including miscarriage, stillbirth, and preterm birth. Further, medications to treat COVID-19 are not currently tested/approved in pregnancy.

I further understand that if I elect to proceed with Services that may result in a pregnancy, at any point during my cycle should the medical data change, MY CYCLE MAY BE CANCELED. Should the CDC or ASRM, or Ohio or Kentucky State Government or representatives put forward a statement explicitly discouraging pregnancy, Provider will follow such guidance and will not proceed with any cycle which may result in a pregnancy. I further understand that there may come a point where Provider may not be able to support treatment cycles (e.g., illness of doctors or laboratory staff which would prevent Provider from rendering services or clinic being required to shut down by governmental agencies or regulations).

I understand, that I might have been or may become exposed to COVID-19 prior to or while receiving Services by Provider. I understand that despite the measures that Provider is taking I may become exposed to COVID-19 during my treatment with Provider or on account of such treatment. I understand that, at the present moment, the availability of testing is limited, and that the Provider does not have access to testing for COVID-19 for its patients. I further understand that should I be directly exposed to COVID-19, be diagnosed with COVID-19, or become symptomatic with any febrile illness which could possibly be COVID-19 (even in the absence of a positive COVID-19 test), Provider may elect not proceed with my cycle.

Patient	**Partner**
Signed: _____	Signed: _____
Name: _____	Name: _____
Date: _____	Date: _____

INSTITUTE FOR
REPRODUCTIVE HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I_____ authorize _____ to disclose the following protected health information from my medical record: (Check all that apply.)

☐ 1. My entire medical record including, but not limited to, progress notes, flow sheet, history and physicals, consults, operative reports, pathology reports, radiology reports and x-ray films, lab reports, nursing records, physician orders, patient communications, records on sexually transmitted diseases, AIDS or AIDS-related conditions, HIV test results, treatment records for drug or alcohol abuse, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date that may be contained in your files. **This authorization is not valid for any release of psychotherapy notes or records.**

☐ 2. My medical records as defined in part 1) but limited to the treatment dates from _____ to _____

☐ 3. Only the specific information listed below:

_____

_____

FROM*: _____

_____

_____

_____

TO: **Institute for Reproductive Health**
3805 Edwards Road, Suite 450
Cincinnati, OH 45209

* I understand that the above entity will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this Authorization. I also understand that once my information is disclosed under the terms of this Authorization, my information then may be re-disclosed by the recipient and no longer protected under federal or state privacy laws.

The purpose for the use or disclosure:

☐ Transfer of care to another physician
☐ Second opinion
☐ Personal request
☐ Continuity of care with another physician
☐ Insurance
☐ Legal purposes

This Authorization expires 60 days from the date signed and is subject to revocation by the patient at any time.

I understand that this Authorization is voluntary and that I have the right to revoke this Authorization at any time by delivering a written notice of revocation to the designated representative at the practice from which the records are coming. I understand that the revocation will have no effect on uses or disclosures that were made in reliance upon this Authorization prior to receiving the written notice of revocation. A photo static copy shall have the same authority as the original and may be used in place of the original.

_____ Date:_____
Signature of the Patient or Legal Representative

_____
If signed by Legal Representative, provide a description
of Legal Representative's Authority to sign on behalf of Patient

INSTITUTE FOR
REPRODUCTIVE HEALTH

The following is a checklist for the items needed for your initial visit. Please utilize the checklist to make your visit as productive as possible.

Checklist:

- ☐ Completed Forms
  - New Patient Contact Form (reviewed annually)
  - Couple's Personal Health History Forms (reviewed annually)
  - Consent to Medical Treatment Form (reviewed annually)
  - Consent for Genetic Testing
  - Credit Card Policy Form
- ☐ Provide a Copy of Current Insurance Card (it is your responsibility to update us of any insurance changes)
- ☐ Review Insurance Policy Regarding Infertility Coverage
- ☐ Provide Copy of Previous, Pertinent Medical Records
- ☐ Arrive 10 minutes prior to appointment

The following are expectations you should have to utilize our office to make your care as beneficial as possible.

Expectations:

- ☐ Your questions should be answered promptly. Please call our convenient nurse line.
  - The nurse line is a voicemail return service.
  - The voicemails are checked daily.
  - Voicemails are prioritized most critical to least critical to provide optimal care.
  - Most phone calls are returned within two hours, however days with high call volume return calls may take longer but will still be returned same day.
  - Throughout the week the line is checked at least every two hours starting at 8:30 a.m. until 4:00 p.m. Calls after hours are checked the next business day.
  - Saturday and Sunday calls are checked from 8:30 a.m. until 11:30 a.m.. Calls after hours are checked the next business day.
  - For Medical Emergencies, please utilize the oncall physician. This can be done by calling (513) 924-5550 and following the prompts for the oncall physician line.
- ☐ Your appointment should be timely and thorough.
  - Expect to meet with a physician AND medical staff to review treatment and have questions answered.
  - Please help staff keep the schedule timely by arriving 10 minutes early to appointments.
  - Please help staff keep the schedule by keeping an inventory of your medications and their expiration dates.
  - If you need to cancel your appointment, please provide three days notice.
- ☐ Your travel distance should be considered.
  - Expect staff to ask what office is convenient for your schedule.
  - Please familiarize yourself with our offices and hours to utilize them to the best ability.