California Fertility Partners

Dear Patient:

Welcome to our practice. California Fertility Partners is dedicated to the evaluation and treatment of infertility caused by a wide spectrum of reproductive disorders. It is our goal to provide you with the finest medical care available, in an attentive and personalized manner. For many individuals infertility is a very personal and private issue, and the process of going through an infertility program can be both stressful and emotionally draining. We strive to create a supportive atmosphere to help guide you through this process.

Our facility combines clinical offices, laboratory facilities, and a surgical suite in one professionally designed complex. Our vision was a calm, warm, environment in which to obtain leading edge medical care. The clinical areas include state of the art ultrasound exam rooms that are conveniently arranged across from our nursing offices to decrease your time for monitoring procedures.

Reproductive Technology Laboratories (RTL) is a licensed endocrine and andrology laboratory located immediately adjacent to our reception area. RTL performs hormonal assays and sperm processing for IUI and IVF on a daily basis, as well as an extensive array of sperm and blood tests.

The surgical suite contains a certified operating room where IVF and other surgical procedures are performed. There is a large and well-equipped recovery room where post-operative patients receive one on one nursing care. Adjacent to the operating room is our IVF laboratory where all embryos are cultured, micromanipulation procedures are performed, and frozen embryos are stored.

Prior to your initial consultation, we ask that you have your previous medical records sent to us. It is helpful to obtain copies of x-rays, IVF laboratory data, and other pertinent laboratory tests. When you arrive for your initial appointment, please check in with the receptionist and hand in your completed questionnaire. Your consultation with a physician will last approximately one hour and may include a pelvic ultrasound exam. After your consultation, you will meet with one of our specially trained nurses who will help organize your prescribed treatment plan.

Our offices are located at 11818 Wilshire Boulevard, Suite 300, on the southeast corner of Wilshire and Westgate, two blocks west of Barrington. If you are arriving via the 405 freeway, exit onto Wilshire Blvd – West, and turn left on Westgate. Parking is available in the secured lot (in the spaces marked CAL-FERT) located directly behind the building when entering off Westgate. Metered parking is available on Wilshire and Westgate.

If you would like additional information about the treatment options available, please visit our website: www.californiafertilitypartners.com, or call us at 310-828-4008. We look forward to seeing you.

Sincerely,

California Fertility Partners

California Fertility Partners

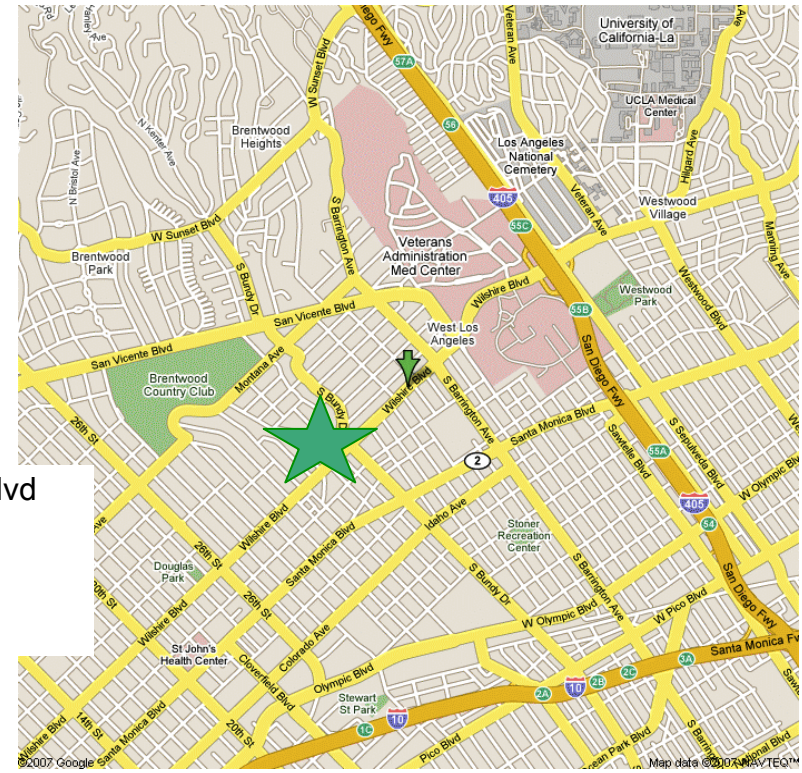
DIRECTIONS

Our state of the art facility is conveniently located at 11818 Wilshire Boulevard, Suite 300, in Brentwood. We are just WEST of the 405 Freeway and UCLA campus. Free parking is available in back of our facility a secured lot. Please be sure to park in the "Cal Fert" spots on the NORTH side of the lot (otherwise your car may be towed). There is also metered but time limited parking on Westgate and Wilshire. Our facility occupies the top floor of a three storey Mediterranean style building. Signage is discrete, so please look for our orange/yellow building with a green canopy over the front entry.

From the EAST (or 405 Freeway):
Take Wilshire Boulevard to Westgate and turn LEFT, then turn LEFT into the passage behind our building. The secured parking lot is on your RIGHT. Please park along the NORTH fence in spaces marked "CAL FERT." Our handicap accessible entrance faces Wilshire and is at the WEST end of the building. A touchpad to the right of the door will allow you to contact our staff who will buzz you in.

From the WEST (or Santa Monica):
Take Wilshire Boulevard to Westgate and turn RIGHT, then turn LEFT into the passage behind our building. The secured parking lot is on your RIGHT. Please park along the NORTH fence in spaces marked "CAL FERT." Our handicap accessible entrance faces Wilshire and is at the WEST end of the building. A touchpad to the right of the door will allow you to contact our staff who will buzz you in.

From the NORTH and SOUTH:
Take 405 Freeway and exit onto Wilshire Blvd WEST – then follow the directions above.



11818 Wilshire Blvd
Suite 300
Los Angeles, CA
90025

www.californiafertilitypartners.com

California Fertility Partners/Reproductive Technology Laboratories

Office Use Only:
Account # _____

11818 Wilshire Boulevard, Suite 300
Los Angeles, CA 90025
(310) 828-4008/Fax (310) 828-3310

Date: _____ Appt with: _____ REFERRED BY: _____

How did you learn about our practice? ☐ Primary Care MD ☐ Ob/Gyn MD ☐ Nurse

☐ Therapist ☐ Web Page ☐ Insurance Listing ☐ Friend ☐ Support Group

☐ Advocacy Group ☐ Other (please indicate) _____

Name of Patient: _____ SS#: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Confidential Phone for Messages: (____) _____ Home: (___) _____

Mobile (___) _____ Work (___) _____ Email: _____

Occupation: _____ Employer: _____

Work Address: _____ Height: _____ Weight: _____

Allergies (Drug, food, chemicals, etc): _____

Name of Spouse/Partner: _____ SS#: _____

Date of Birth: _____ Age: _____ Occupation_: _____

Work Address: _____

Primary Insurance Co: _____ Group #: _____ Policy ID#:_____

Insurance Telephone: (___) _____

Both Patient and Spouse/Partner are to read and initial after EACH of the following statements:

All services are payable to CFP or RTL at the time services are rendered ___ (Patient) ____ (Spouse/Partner). Should insurance not cover services rendered at CFP or RTL, I/WE are financially responsible _____ (Patient)____ (Spouse/Partner). In the event my/our accounted is turned over for judicial collections, I/WE are responsible for all court and attorney fees ____ (Patient) ____(Spouse/Partner). I/WE have been provided with a separate form detailing an arbitration procedure in the event of a dispute between CFP/RTL and me/us ____(Patient) ____(Spouse/Partner). It is my/our responsibility to notify this office if any of the above information changes ____(Patient) ____(Spouse/Partner).

_____ _____

Patient (signature) **Spouse/Partner (signature)**

Primary Care Physician's Name &Telephone: _____ (____)_____

Please fill out this medical questionnaire before your appointment. Once it has been completed either mail it back or bring it in with you the day of the appointment.

Demographic Information and Medical History of Patient

_____

Last Name First Middle *(Unmarried Name if appropriate)*

Years in current marriage/cohabitation/partnership: _____

Have you ever had any serious medical problems? _____ Yes _____ No

If yes, please list medical problems and year of diagnosis:

_____ Year: _____
_____ Year: _____
_____ Year: _____

Have you ever had any surgeries? _____ Yes _____ No

If yes, please fill out the information below:

Year of surgery	Type of surgery

Medications, Drugs and Supplements

Do you currently take any prescription or over the counter medication(s) or herbal supplements?
_____ Yes _____ No

Name of drug/supplement	Dose	Year started

Are you allergic to any medications? _____ Yes _____ No

If yes, please list name of drug(s): _____

Family History

Do you have a family history of fertility problem(s)? _____ Yes _____ No

If yes, specify which relatives and what specific problem(s):

_____
_____
_____

Please list any siblings you have, their ages and offspring:

_____
_____
_____
_____

Do you know how old your mother was at menopause? _____

Do you have a family history of any specific illnesses? _____ Yes _____ No

If yes, please list the relative name and type of disease:

Which relative(s)	Type of disease
_____	_____
_____	_____
_____	_____

Gynecological History

Age at menarche (first period)? _____

When was your last period? _____

When was your previous period? _____

Do your periods come on a regular basis? _____ Yes _____ No

How often? Every _____ days

Do you get cramps with your periods? _____ Yes _____ No

If yes, how would you rate them? _____ Mild _____ Moderate _____ Severe

Have you ever used birth control? _____ Yes _____ No

If yes, give details below:

Type	Year started	Year stopped

_____ _____ _____
_____ _____ _____
_____ _____ _____

How long have you been trying to get pregnant? _____

Have you ever been pregnant? _____ Yes _____ No

If yes, please give details below:

Year of pregnancy	How did conception occur	Outcome of pregnancy
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Fertility History

Have you ever been told that you have any of the following problems?

Circle Yes or No:

tubal disease	**Yes / No**	**bad cervical mucus**	**Yes / No**
problems ovulating	**Yes / No**	**endometriosis**	**Yes / No**
abnormal hormone levels	**Yes / No**	**sperm problems**	**Yes / No**

Have you ever had any of the following fertility tests?

	No	Yes	When	Results
HSG (hysterosalpingogram)	_____	_____	_____	_____
PCT (post coital test)	_____	_____	_____	_____
S/A (semen analysis)	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Endometrial biopsy	_____	_____	_____	_____
FSH (follicle stimulating hormone)	_____	_____	_____	_____
Serum Progesterone	_____	_____	_____	_____
Thyroid hormone	_____	_____	_____	_____
Prolactin	_____	_____	_____	_____

Have you had any previous fertility treatment before today?

A) Fertility Drugs? _____ Yes _____ No

If Yes, please specify
Medication: _____ date: _____ / _____ / _____
Medication: _____ date: _____ / _____ / _____
Medication: _____ date: _____ / _____ / _____

B) Intrauterine inseminations? _____ Yes _____ No

If Yes, please specify
date: _____ / _____ / _____
date: _____ / _____ / _____
date: _____ / _____ / _____

C) In vitro fertilization (IVF) attempts? _____ Yes _____ No
If Yes, please specify

Details: _____ date: _____ / _____ / _____
Details: _____ date: _____ / _____ / _____
Details: _____ date: _____ / _____ / _____

<u>Demographic Information and Medical History of Partner</u> *(if applicable)*

Has your spouse/partner fathered children in other relationships?

_____ Yes _____ No _____ Don't know _____ doesn't apply

If yes, how old was he? _____ (if more than one pregnancy list more than one age)

Does your partner have any serious medical illnesses? _____ Yes _____ No

If yes, please explain: _____
_____

Does your partner take any medication on a regular basis? _____ Yes _____ No

If yes, please list names of medications: _____
_____

Has your partner ever seen a urologist? _____ Yes _____ No

If yes, please explain:

Name of urologist? _____
When? _____
Why? _____

Has your partner ever had <u>any</u> surgeries? _____ Yes _____ No

If yes, please fill out the information below:

<u>Year of surgery</u>	**<u>Type of surgery</u>**
_____	_____
_____	_____
_____	_____

To : All patients of California Fertility Partners/Reproductive Technology Laboratories
From : Drs. Marrs, Ringler, March & Baek

Genetic/Medical Screening

Introduction

This questionnaire is designed to help us determine the likelihood of your gametes (oocytes/sperm) carrying heritable disorders to your offspring. The table (see back) indicates the prevalence of carriers of some of the more common genetic disorders in the general population, and in the Ashkenazi Jewish population (in which high incidences of several disorders have been established). Our objective is to minimize the likelihood that your offspring will be affected by any genetic/ heritable disorder, and to minimize the likelihood that your offspring will carry genes for the disorder. While current genetic tests can identify the great majority (>95%) of carriers of the more common mutations, none are 100% accurate, and some are still very insensitive (<10%). Similarly, while the attached questionnaire will help identify heritable traits, the absence of reported abnormalities by you and/or by your spouse/partner cannot currently guarantee genetic normality of gametes. Your physician will review your responses to the questionnaire and will, in conjunction with his/her knowledge of your medical history, recommend whether you would benefit from a consultation with a geneticist/genetic counselor and/or further testing.

Through our own laboratories, CFP can provide comprehensive screening for disease-causing mutations. Such screenings are sometimes appropriate for oocyte donors, sperm donors or for intended parents determined to be at increased risk through responses to the following questionnaire. However, our experience to date with the comprehensive mutation screening panels (for >100 genetic disorders) has established that most patients, regardless of ethnicity, will be shown to be a carrier of some mutation(s). The great majority of these mutations occur at a very low frequency in the population (that is, the likelihood of your partner being a carrier is very low) and, if a participant (sperm or oocyte provider) in an assisted reproductive cycle is found to be a carrier for a particular mutation, the likelihood of correctly determining that the other participant (i.e. oocyte or sperm provider) is also a carrier can be very low. Should you have an interest in comprehensive screening for disease-causing mutations, please discuss this with your physician at the time that your responses to the questionnaire are reviewed.

If you are using an egg donor for your cycle, CFP has requested that the egg donor agencies facilitate genetic screening before the donor is released to us. Similarly, donors with the larger sperm banks will have undergone genetic screening before their sperm can be released. However, not all egg donor agencies and sperm banks conform to the same screening standards. **Therefore, when you are comparing agencies/banks as sources for oocytes/sperm, it is important that you verify with them that the donors from those facilities have undergone genetic counseling/ screening in accordance with current ASRM/SART guidelines.**

Background

Effect of ancestry on risk of genetic disorder

Carrier screening for specific genetic conditions often is determined by an individual's ancestry. For example:

- Certain autosomal recessive diseases are more prevalent in individuals of ***Eastern European Jewish*** (Ashkenazi) descent. Most individuals of Jewish ancestry in North America are descended from Ashkenazi Jewish communities and are, therefore, at increased risk for having children with any of these conditions (see table).
- Tay-Sachs, cystic fibrosis and Canavan disease are **ALSO** more common in persons with ***Cajun, French Canadian or Irish American*** background.
- Thalassemia and other hemoglobin abnormalities are more common in persons of ***Italian, Greek*** (ß-Thalassemia)***, Middle Eastern, Hispanic, Southern Chinese, Asian Indian, Taiwanese, Filipino*** or ***Southeast Asian*** (α-Thalassemia) descent.
- Sickle cell anemia is more common in ***Africans*** and in ***African-Americans***.

Family history as a determinant of genetic risks to offspring

There are additional genetic disorders which can be screened from blood (e.g. Huntington's disease, muscular dystrophy), but there are also many genetic complications which can be inherited, but are unrelated to ethnic origin, and/or cannot currently be reliably screened by genetic testing of blood. These conditions include, but are not limited to: hemophilia, bleeding disorders, insulin dependent diabetes, phenylketonuria (PKU), neuromuscular disease, neural tube defects (e.g. open spine, spina bifida, anencephaly) and heart defects. In addition, family histories of autism, mental retardation and/or learning disabilities of unknown etiology raise the likelihood that screening would identify a Fragile X mutation (which can be diagnosed). Family histories of neuromuscular disorders increases the likelihood that a patient would be a carrier of one of the gene mutations associated with spinal muscular atrophy (SMA). Occurrence of any of these conditions in an individual, sibling or child can therefore increase the likelihood of recurrence in offspring.

The table on the following page summarizes the more common autosomal recessive inherited disorders for which carriers can be identified by testing. In the population at large, the frequencies of carriers for the more common disorders are highest for cystic fibrosis and for spinal muscular atrophy. In the Ashkenazi Jewish population, the carrier frequencies are highest for Gaucher's disease and for cystic fibrosis.

Questionnaire

The following questionnaire is designed to identify possible risks of your child(ren) inheriting genetic disorders, and to identify what tests could help establish risk of your child(ren) inheriting specific disorders. Your responses will help establish what (if any) categories of tests should be conducted before you pursue pregnancy. The responses will also establish whether you would benefit from a consult with a genetic counselor, in which instance the counselor would be provided with a copy of this completed questionnaire.

If you are using an oocyte or sperm donor, your responses will help us determine whether the genetic testing of the donor needs to be extended to meet the screening standards of California Fertility Partners.

Overview of the more common autosomal recessive inherited disorders – ranked by order of frequency

		Non-Jewish population		Ashkenazi Jewish		
Disease	Description	Carrier frequency	Carrier Detection	Carrier frequency	Carrier Detection	Client Price
Comprehensive screening for disease-carrying mutations (see comments in introduction)						$350-$700
Gaucher's disease	Variable severity secondary to Deposition in spleen, liver and bones	Unknown	70% by >30 mutations	1:15	95% by DNA (5 mutations)	$130
Cystic-Fibrosis	Chronic pulmonary disease, Pancreatic insufficiency	Varies by ethnicity	>90% (varies by ethnicity)	1:26 to 1:29	97% by DNA (86 mutations)	$125
Spinal muscular atrophy (SMA)	Degeneration of spinal cord motor neurons, resulting in progressive muscular atrophy	1:40	95% by competitive amplification/DNA analysis (multiple mutations)	Unknown		$454
Fragile X	Most common inherited cause of mental retardation	1:250 [1:5 in POF/ premature menopause]	96% by DNA (2 mutations)	Unknown		$316
Tay-Sachs	Neurologic deterioration, Death in early childhood	1:300	98% by HexA 50% by DNA	1:30	98% by HexA 50% by DNA (8 mutations)	$130
Familial dysautonomia	Impairment of sensory and autonomic nervous system	Unknown	<10%	1:30 to 1:32	99% by DNA (2 mutations)	$130
Canavan's disease	Neurologic deterioration, death During early childhood	Undetermined	60% by DNA	1:40 to 1:57	98% by DNA (4 mutations)	$130
GSD1A (Glycogen Storage Disease Type 1A)	Hypoglycemic episodes that lead to severe hepatomegaly, growth retardation, bleeding disorders and death	Undetermined	99% by DNA (2 mutations)	1:71	99% by DNA (2 mutations)	$165
MSUD (Maple Syrup Urine Disease)	Amino acid buildup leads to mental retardation, physical disabilities, coma and death	Undetermined	99% by DNA (4 mutations)	1:81	99% by DNA (4 mutations)	$138
Fanconi anemia group C	Pancytopenia, developmental delay, and failure to thrive	Unknown	60%	1:89	99% by DNA (single mutation)	$130
Niemann-Pick type A	Lysosomal storage disease with degenerative course similar to Tay-Sachs	Unknown	<10%	1:90	95% by DNA (3 mutations)	$130
Bloom disease	Pre and postnatal growth restriction, susceptibility to malignancies	Unknown	<10%	1:100	95% by DNA (single mutation)	$130
Mucolipidosis type IV	Neurodegenerative disorder with marked developmental and growth retardation	Unknown	<10%	1:127	<10%	$175

Confidential Genetic/Medical Questionnaire

By completing the following questionnaire, you will help us identify medical/genetic risk factors that may affect your children. Your answers may indicate that certain follow-up tests may be appropriate. Please answer all questions as accurately as possible. All information will be retained only in your chart and will be strictly confidential.

Patient (female) name:_____ Date of birth :___/___/_____

Partner's (male) name:_____ Date of birth:___/___/_____

	Ethnicity/Ancestors/Genetic	Patient		Partner	
		Yes	No	Yes	No
1	Do you or your partner have ancestors of any of the following origins? 1. Eastern European (Ashkenazi) Jewish 2. French Canadian 3. Cajun 4. Irish American If 'Yes' to any of the above, have you ever been tested for any of the following? 1. Cystic fibrosis 2. Tay-Sachs disease 3. Familial dysautonomia 4. Fanconi anemia 5. Bloom syndrome 6. Gaucher disease 7. Mucolipidosis 8. Niemann-Pick disease 9. Canavan disease				
2	Do you or your partner have ancestors of any of the following origins? 1. Italian 2. Greek 3. Middle Eastern 4. Hispanic 5. Southern Chinese 6. Asian Indian 7. Taiwanese 8. Filipino 9. Southeast Asian If 'Yes' to any of the above, have you ever been tested for any of the following? 1. Thalassemia 2. Any other blood/hemoglobin abnormality				
3	Do you have any African or African-American ancestors? If 'Yes', have you been tested to determine if you are a carrier of sickle cell anemia?				
4	Any other chromosome/genetic testing? Please specify:				

Family Medical History

The following questions apply to you and your parents, children, brothers, sisters, aunts, uncles, cousins and other relatives. If you have any doubt about the response to a particular question, please mark the 'Not sure' box.

	Do you or your partner have a personal or family history of:	Patient		Partner	
		Yes	No	Yes	No
5	Miscarriage?				
6	Any serious medical conditions (such as diabetes, seizures, high blood pressure) that may have required surgery or medical attention? Please specify:				
7	Any physical birth defects (such as heart defects, cleft lip, club feet, extra fingers or toes), even if they have been repaired? Please specify:				
8	Babies who were stillborn or died; children or young adults who died?				
9	Down syndrome or any other chromosome disorder?				
10	Neural tube defects (such as open spine, spina bifida, anencephaly)?				
11	Heart disease, including high blood pressure, arrhythmia, heart attack, heart failure, high cholesterol, atherosclerosis, coronary heart disease?				
12	Diabetes, thyroid or any other hormone disorder?				
13	Bleeding disorders (such as hemophilia or von Willebrand disease)?				
14	Blood clotting disorders such as thrombosis (blood clots in the veins, or strokes)?				
15	Insulin dependent diabetes, phenylketonuria (PKU), lupus, or any other chronic condition?				
16	Anemia or thalassemia?				
17	Mental retardation or low I.Q.?				
18	Learning problems, attention deficit disorders or autism?				
19	Joint or muscle problems (such as weakness, neuromuscular disease, muscular dystrophy or multiple sclerosis)?				
20	Seizures or epilepsy?				
21	Kidney disease such as polycystic kidneys, missing or abnormal kidneys, kidney failure or kidney stones?				
22	Any type of cancer, including leukemia, lymphoma or other blood cancers?				
23	Alcoholism or heavy alcohol use?				
24	Depression, suicide or suicide attempts?				
25	Other mental illness such as bipolar (manic depressive) disorder, Tourette syndrome, obsessive-compulsive disorder or schizophrenia, or anyone having treatment by a therapist or psychiatrist?				
26	Asthma or eczema?				
27	Premature menopause/premature ovarian failure (POF)?				
28	Muscular wasting and/or weakness?				

We have answered these questions to the best of our knowledge:

_____ _____ ____/____/_____

(Patient signature) (Partner signature) Date

Notice of Privacy Practices

California Fertility Partners

Reproductive Technology Laboratories

B. Daniel Sikich, Administrator 310-857-6251

Effective Date: April 14, 2003

Revised Date: May 20, 2009

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. If we receive any payment for these communications, we will tell you who is paying us, and we will also tell you how to stop them if you prefer not to receive them. We will not make such disclosures you are a current health plan enrollees and the

communication describes 1) a provider's participation in the health plan's network, 2) the extent of covered benefits, or 3) concerns the availability of more cost-effective pharmaceuticals. We may make communications tailored to your needs if you have a chronic and seriously debilitating or life-threatening condition. (If we are remunerated for such communications, we will tell you and inform you how to stop them.) We will not otherwise use or disclose your medical information for marketing purposes without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of 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.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

20. Fundraising. We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. 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. We reserve the right to accept or reject your request, and will notify you of our decision.

2. 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 e-mail 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.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website at www.lainfertility.com.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

California Fertility Partners

Reproductive Technology Laboratories

B. Daniel Sikich, Administrator 310-857-6251

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient

Name and Address of Patient: _____

California Fertility Partners

California Fertility Partners

Richard P Marrs, MD
Guy E Ringler, MD
Kelly J Baek, MD
Charles M March, MD
Bronte A Stone, PhD, HCLD

A Message To Our Patients About Arbitration

Our current insurance carrier has requested that we present the attached arbitration agreement for your consideration. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration, rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid.

We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California Courts.

By signing this agreement, you are changing the place where your claim will be presented. You can still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators) who then selects a third neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians because the time it takes to conduct an arbitration hearing is far less than for a jury trial. Furthermore, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems are associated with lack of communication. Therefore, if you have any questions about your care, please ask us.

Sincerely,

Richard P. Marrs, MD

Guy E. Ringler, MD

Kelly J. Baek, MD

Charles M. March, MD

11818 Wilshire Blvd. Suite 300 Los Angeles, CA 90025 | T: 310.828.4008 | F: 310.828.3310

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physician's or Authorized Representative's Signature (Date)

_____

Print or Stamp Name of Physician, Medical Group or Association Name

By: _____ _____

Patient's or Patient Representative's Signature (Date)

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

1-07