



Directions to Denver Fertility/Albrecht Women's Care

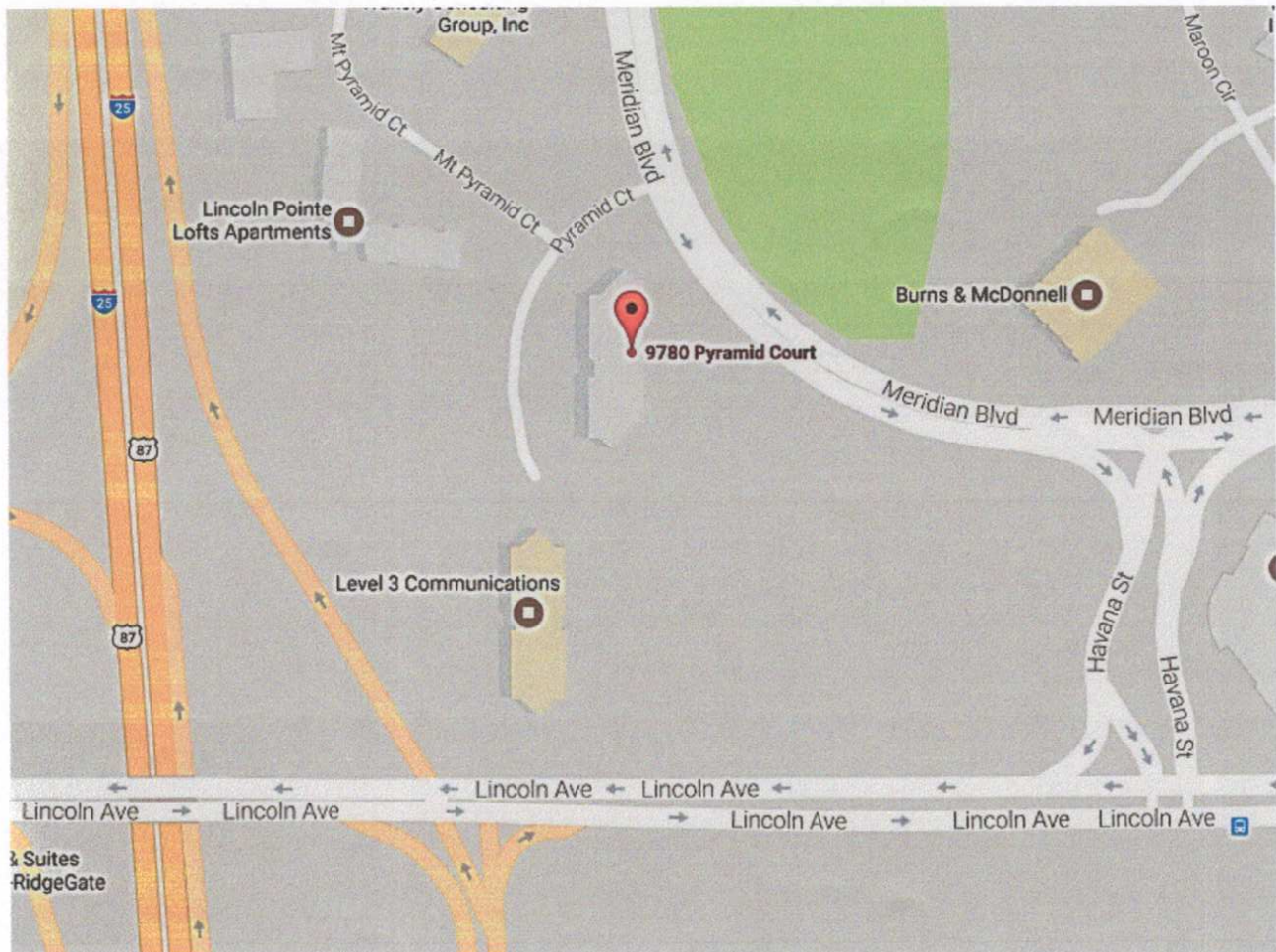
9780 Pyramid Court, Ste. 260

Englewood, CO 80112

720-420-1570

We are located on the northeast corner of I-25 and Lincoln Avenue.

- ✓ From I-25, go east on Lincoln Ave.
- ✓ Turn left (north) on Havana St. and stay in the left lane.
- ✓ Turn left at the light - Meridian Blvd (you will veer west).
- ✓ Turn left on Pyramid Ct.
- ✓ We are the first building on the left.
- ✓ Suite 260





SEMEN ANALYSIS PREPARATION/INSTRUCTIONS

SCHEDULING

- You **MUST** schedule an appointment.
- Analysis appointments can be scheduled Monday, Tuesday, or Thursday from 7:30a-1:00p (We are closed for lunch from 12-1)
- Please call **720-420-1570** for an appointment.

PREPARATION

- You should have between 2-5 days of abstinence prior to the analysis (this includes ejaculation by any means).

COLLECTION

- It is recommended that the specimen is collected at Denver Fertility/Albrecht Women's Care; however, if home collection is desired, a sterile collection container can be obtained from your physician or from our office.
- The specimen is obtained by masturbation. **No lubricant, including saliva, may be used.**
- The entire ejaculate must be collected in a sterile screw-cap container. Because most condoms contain spermicidal chemicals, their use for this purpose is to be avoided.
- Labeling is extremely important. It is mandatory that all of the following information be written on the container.
 - a. **NAME**
 - b. **DATE OF BIRTH**
 - c. **PARTNER'S NAME**
 - d. **DATE AND TIME OF COLLECTION**
- To ensure best viability of semen specimen, delivery is recommended within 60 minutes of collection. Temperature extremes during transit must be avoided (<70 or >100 degrees F). Patients can place the container in a paper bag or keep close to their person (ex. inside shirt or pocket or between legs).

REGISTRATION

- You must complete the bottom of this form as well as our patient registration packet.
 - The registration packet can be found on our website www.albrechtwomenscare.com.
- You will need to provide us with your insurance card (if applicable) and photo ID.
- If this test is not covered by your insurance, payment at the time of service is required.
- Cash-pay price for the analysis is \$140.

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Partner's Name _____ Referring Physician: _____

Current Medications: _____

Do you smoke? **YES NO** If yes, for how long? _____ Do you drink alcohol? **YES NO** If yes, how much? _____

Do you use recreational drugs? **YES NO** If yes, what? _____

Date: _____ Time of Collection: _____ Days Of Abstinence Prior To Collection: _____

Was the specimen collected by masturbation? **YES NO**

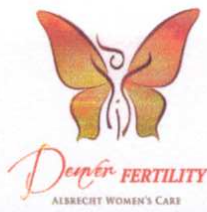
Is the entire ejaculate in the cup? **YES NO** If no, was first or last portion lost? _____

Was specimen collected at AWC? **YES NO** If no, explain transportation and time delivered: _____

All of the above information is true and correct.

Patient Signature

Date



PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____ DOB: _____
First M.I. Last

Address: _____
Street / Apt # City State Zip

Primary Phone: _____ Alternate Phone: _____

Employer: _____ Occupation: _____

Email: _____

Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary Care Physician: _____ OB/GYN Physician: _____

How did you hear about our office? ☐ Referring Physician: _____ ☐ Patient/Friend: _____

☐ Other: _____ ☐ Our Website ☐ Online Review ☐ Google ☐ Social Media
☐ Online Ad ☐ TV ☐ 5280 Magazine ☐ Women's Edition Magazine

PHARMACY

Name: _____ Phone (REQUIRED): _____

Address: _____

SPOUSE/PARTNER INFORMATION or EMERGENCY CONTACT

Name: _____ DOB: _____

Primary Phone: _____ Relationship: _____

INSURANCE

Primary Insurance: _____ Secondary Insurance: _____

Claims Address: _____ Claims Address: _____

Phone Number: _____ Phone Number: _____

ID Number: _____ ID Number: _____

Group Number: _____ Group Number: _____

Effective Date: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder Name: _____

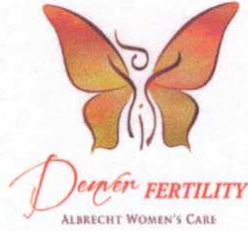
DOB: _____ DOB: _____

SSN: _____ SSN: _____

The above information I have given is true and correct. I understand that I am ultimately responsible for payment of all services. If billing my insurance; I authorize payment of medical benefits to undersigned Denver Fertility/Albrecht Women's Care for their services and all future claims. I authorize the release of any medical information necessary to process this claim and all future claims.

Patient Signature

Date



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI may be made by alternative means; for example, sending correspondence to the individual's email instead of the individual's home address.

I give Denver Fertility/Albrecht Women's Care permission to contact me by the following means;

CHECK ALL THAT APPLY

■ Telephone: _____

- ☐ OK to leave a message with detailed information
- ☐ OK to leave a message with other family members
- ☐ OK to discuss my health information with spouse or partner; Name: _____
- ☐ Do not leave a message

■ Email: _____

- ☐ OK to contact me via email and/or email me with detailed information
- ☐ Do not contact me by email

■ Written Communication

- ☐ OK to send mail to my home address
- ☐ OK to send mail to my work/office address
- ☐ OK to fax to this number: _____

■ Other: _____

IF YOU ARE A MINOR:

- ☐ OK to release information to parent or guardian; Name: _____
- ☐ Do not release information to anyone other than myself

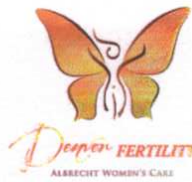
NOTE: Uses and disclosures may be permitted without prior consent in case of an emergency.

Print Patient Name

Date of Birth

Patient Signature

Date



Notice and Acknowledgement of Privacy Practices

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that Denver Fertility/Albrecht Women's Care and all staff members continually undergo training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We are required by law to maintain the confidentiality of health information that identifies you. The Department of Health and Human Services has established a "Privacy Rule" to help insure that your personal information is protected from unnecessary distribution. The Privacy rule has also been created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or other health care operations. We strive to achieve the very highest standards of ethics, integrity, and quality in performing services for our patients. As our patient, we want you to know that we respect the privacy of your personal medical records, and we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. None of your private information will be released to anyone without your expressed written consent. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us prevent an inappropriate use of PHI. We also want you to know that we support your full access to your personal medical records. Other businesses that we deal with may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients). In cases such as these, we may have to disclose some personal health information for purposes of treatment, health care operations, or payment. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information. Should you refuse to disclose your personal health information to us, we have the right to refuse to treat you under the law. Should you disclose your information to us, but refuse it to your insurance company, you will be responsible for the full balance on your account at the time of service.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE PERSONAL HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice including, but not limited to; our doctors, nurses, medical assistants, laboratory personnel, or indirectly with any provider we refer you to, may use or disclose your PHI in order to treat you. Additionally, we may need to disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and for what range of benefits. We may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for costs; such as families or insurance companies. Also, we may use your PHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations; our practice may use your PHI to evaluate the quality of care you receive from us or to contact cost-management and business planning activities for our practice.
4. **Appointment Reminders/Emails.** Our practice may use and disclose your PHI to contact you or a family member who answers the phone (or to leave a voicemail) to remind you of an upcoming appointment. We may also send you emails that others may have access to.
5. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

USE AND DISCLOSURE OR YOUR PHI IN CERTAIN CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purposes of:

- Maintaining vital records, such as births and deaths
 - Reporting child abuse or neglect
 - Preventing or controlling disease, injury or disability
 - Notifying a person regarding potential exposure to a communicable disease
 - Notifying a person regarding a potential risk for spreading a disease or condition
 - Reporting reactions to drugs or problems with products or devices
 - Notifying individuals if a product or device they may be using has been recalled
 - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence)
 - Notifying your employer under limited circumstances related primarily to workplace injury, time off work, illness or medical surveillance
2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law.
 3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We also may disclose your PHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.
 4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations
 - Concerning a death we believe has resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons, material witness, fugitive or missing person
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)
 5. **Deceased Patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.
 6. **Organs and Tissue Donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
 7. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
 8. **Military.** Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
 9. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
 10. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
 11. **Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

I acknowledge that I have read this Notice of Privacy Practices; which describes ways in which Denver Fertility/Albrecht Women's Care may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the office if I have a question or complaint. I understand that this information may be disclosed electronically by Denver Fertility/Albrecht Women's Care. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in this document.

Print Patient Name

Date of Birth

Patient Signature

Date



FINANCIAL POLICY

Thank you for choosing Denver Fertility/Albrecht Women's Care. We are committed to providing you with quality and affordable healthcare. The following information is provided to help you understand our financial policies.

Required Information. Prior to any services being provided, we must obtain a current insurance card, a photo ID, and a completed patient information packet. If you do not have insurance or an up-to-date and correct insurance card, you will be responsible for payment at the time of service.

Insurance Benefits. We participate with most insurance plans. We recommend that you check with your insurance company to determine what your insurance benefits are prior to your first appointment; as knowing your benefits is your responsibility. If we do not participate with your insurance, payment in full is due at the time of service.

Co-Payments and Deductibles. All co-pays and deductibles must be paid at the time of service and are a part of your contract with your insurance company.

Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by your insurance company. If this is the case, you must pay at the time of service.

Claims Submission. We will submit claims on your behalf to your insurance company. Occasionally, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. If you do not wish to have your services submitted to your insurance, you can opt for the self-pay discount. This discount is **ONLY** available when paid at the time of service. If you choose this option, we will not be able to bill your insurance company at a future date.

Insurance Coverage Changes. If your insurance changes, it is your responsibility to notify us of any changes.

Self-Pay Discount. If you do not have insurance or your insurance will not cover services, we offer a self-pay discount. This discount will **ONLY** be given if paid at the time of service.

Credit Card Policy. At the time of your first visit, you will be asked for a credit card number to be placed on file in your electronic medical record (EMR). This information will be held securely in your EMR. After the insurance company has paid their portion of the charges and notified us of the remaining balance owed by you, your credit card will be charged. A copy of the charge and a receipt will be sent to you for your records. This policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. We will charge you the portion that your insurance company has determined is your responsibility. If the balance is large, the billing office will contact you prior to charging your credit card. Co-pays are still due at the time of service and must be paid at that time.

Non-Payment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our billing office. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. Patients will be responsible for the cost of collection efforts such as; referring the account to a collection agency or attorney fees. If your account remains unpaid, you and your immediate family members may be discharged from the practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, we will only be able to treat you for emergency problems.

Missed Appointments. Our policy is to charge for missed appointments that are not canceled within a reasonable amount of time. These charges will be your responsibility and will be billed directly to you, not your insurance company.

I acknowledge that I have read and understand the above information regarding the financial policies of Denver Fertility/Albrecht Women's Care.

Printed Patient Name

Signature

Date