Reproductive Medicine Associates of New York, LLP

Preparing for Your Initial Consultation

The team at Reproductive Medicine Associates of New York (RMA of New York) is dedicated to supporting our patients in all aspects of their care, including preparation for initial consultation. In the attached packet you will find the following information:

i. **Initial consultation checklist** to help organize the paperwork and obtain any records that you may want to bring to your consultation (see below).

ii. **RMA of New York Notice of Privacy Practices** (conforming to the Health Insurance Portability and Accountability Act of 1996) for your records.

iii. **Patient demographic form** to complete and bring with you to your consultation.

iv. **Patient consent for use of electronic mail** to review, sign, and bring to your consultation.

v. **Family history and genetic questionnaire** to complete and bring to your consultation. Please complete as much as possible; any outstanding questions or clarifications can be reviewed with the physician and/or nurse during consultation.

vi. **Universal Medication form** to complete and bring to your consultation. Please be sure to include all medications, prescriptions, over-the-counter, herbals, vitamins and injections on the list.

vii. **Patient acknowledgement of RMA of New York privacy policy** to complete and provide at your consultation.

viii. **Patient fact sheet on genetic screening** from the American Society of Reproductive Medicine for your records.

ix. **General information sheet about RMA of New York** for your records.

Initial Consultation Checklist

- ☐ Completed **Patient Demographic Form**
- ☐ Completed **Patient Consent for Use of Electronic Mail**
- ☐ Completed **Patient Intake Form**
- ☐ Completed **Acknowledgement of Receipt of Privacy Practices**
- ☐ Relevant **Medical Records**
- ☐ **Insurance card** for self. RMA of New York will make a copy to keep on file
- ☐ Bring completed forms & relevant medical records to your initial consultation or email them to new@rmany.com
- ☐ **Government issued photo ID** – RMA of New York's policy is to use your legal name for all records

Reproductive Medicine Associates of New York

Manhattan
635 Madison Avenue, 10th Floor
New York, NY 10022 P: (212) 756-5777

Westside
200 W. 57th Street, Suite 900
New York, NY 10019 P: (212) 256-8200

Downtown
594 Broadway Suite 1011
New York, NY 10012 P: (212) 906-7900

Brooklyn
26 Court Street, Suite 2710
Brooklyn, NY 11210 P: (718) 532-8700

Long Island
400 Garden City Plaza, Suite 107
Garden City, NY 11530 P: (516) 746-3633

Westchester
311 North Street, Suite 310
White Plains, NY 10605 P: (914) 997-6200

Mexico
Prolongación Paseo de la
Reforma # 2693 – Torre B –piso 10°
Colonia Lomas de Bezares
Mexico D.F: 11910
P: 011-52-55-2167-6425

Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

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

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

RMA of New York is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the reception area. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the reception area. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail, email or facsimile.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or email. If you choose to send photos of your family to our office, we may display them in areas that have public access.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include billing, collections, software support and quality assurance. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract. In addition, business associates are individually required to abide by the HIPAA rules.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Psychotherapy Notes: HIPAA-defined psychotherapy notes recorded by RMA of New York will only be used or disclosed with authorization by you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you regarding financial remuneration for services received at RMA of New York.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.

HITECH Reporting Requirements: Per the Health Information Technology for Economic and Clinical Health (HITECH) Act; a part of the American Reinvestment and Recovery Act (ARRA) of 2009; RMA of New York is required to, and abides by the requirement to, report suspected breaches of unsecured PHI to both the potentially affected individuals and the Secretary of the Health and Human Services Department.

Your Health Information Rights

Although your health record is the physical property of RMA of New York that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to RMA of New York in writing. The practice may charge $40 for additional requests for records after the first.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. RMA of New York will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be $10.00. We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. You have the right to restrict certain disclosures of Protected Health information to a health plan where you pay out of pocket in full for the healthcare item or service. We ask that you submit these requests in writing.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

Notification of Breach: Individuals will receive notifications of any breaches of unsecured Protected Health Information.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (212) 756-5777 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Danielle O'Brien

Telephone Number: (212) 756-5777

Reproductive Medicine Associates of New York, LLP

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Date: _____ / _____ / _____
(MM) (DD) (YYYY)

Signature of Patient or Representative: _____

Patient's Name: _____
(Printed)

Name of Personal Representative: _____
(Printed) (If Applicable)

Relationship to Patient: _____
(If Applicable)

Signature of Partner _____
(If applicable)

Partner's Name: _____
(Printed)

Reproductive Medicine Associates of New York, LLP

Email Consent

Patient Name _____ (First) _____ (Last)

Patient SS# _____ -- _____ -- _____ Patient DOB _____ (MM) / _____ (DD) / _____ (YYYY)

1. RISK OF USING E-MAIL

Reproductive Medicine Associates of New York (RMA of New York) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an e-mail, or e-mail may inadvertently be delivered to a spam folder or unintended mailbox.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have the right to archive and inspect e-mails transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

RMA of New York will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, RMA of New York cannot guarantee the security and confidentiality of e-mail communication and, if you wish to use e-mail, you agree that RMA of New York will not be liable for improper disclosure of confidential information that is not caused by RMA of New York's intentional misconduct. Thus, the patients must consent to the use of e-mail includes agreement with the following conditions:

a. RMA of New York will not forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
b. Although RMA of New York will endeavor to read and respond promptly to an e-mail from the patient, RMA of New York cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.
c. If the patient's e-mail requires or invites a response from RMA of New York staff and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
d. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
e. The patient is responsible for protecting his/her password or other means of access to e-mail. RMA of New York is not liable for breaches of confidentiality caused by the patient or any third party.
f. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.
b. Inform RMA of New York of changes in his/her e-mail address.
c. Put the patient's name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to RMA of New York.
f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only via written communication to RMA of New York.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. (Please initial one option below):

☐ I understand the risks associated with the communication of e-mail between RMA of New York and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that RMA of New York may impose to communicate with patients by e-mail. Any questions I may have had were answered. I have provided my email address below.

☐ I do not consent to communicate with RMA of New York via email. However, if I should initiate email with RMA of New York physicians, nurses and/or other staff, after signed consent date, I hereby have revoked this consent and have now agreed to communication via email.

To be completed on day of visit:

Patient Signature _____

Date _____ (MM) / _____ (MM) / _____ (YYYY)

If agree to email communication, please provide:

Email _____

Witness Signature _____

Date _____ (MM) / _____ (MM) / _____ (YYYY)

Patient Information Form

Reproductive Medicine Associates of New York, LLP

***Please provide your legal name (i.e. full name as listed on your social security card, passport, or driver's license).**
RMA NY takes its responsibility of working with reproductive tissue seriously and therefore requires all files to be created under the patient's legal name. Please ask any member of our staff if you would like more information on this policy. Please bring a copy of a government issued photo ID to your consultation.

Patient Information

Last Name*_____ First Name*_____ M.I._____

Nickname (if applicable)_____ Address_____ City_____ State:_____ Zip Code:_____

Social Security #_____--_____--_____ Home # (_____) _____

Date of Birth_____ (MM) / _____ (DD) / _____ (YYYY) Age_____ Work # (_____) _____

Marital Status_____ Cell # (_____) _____

Dr. scheduled to see_____ E-Mail_____

Referred By_____ In Case of Emergency (other than spouse/ partner)

Telephone (_____)_____ Name_____

Present Gynecologist_____ Relationship to Patient_____

Address_____ Address_____

Telephone (_____)_____ Fax (_____)_____ Telephone (_____)_____Cell/Work (_____)_____

Employer_____ Occupation_____

NOTE: Please complete this section even if you bring your insurance card to the appointment. Please also bring a copy of partner's insurance card, if different than patient's.

Patient Insurance

Primary Insurance_____ Subscriber's Name_____

Address_____ Employer_____

City_____ State_____ Zip_____ I.D #_____ Group #_____

Telephone (_____)_____ Relationship to subscriber_____

Patient Name, as it appears on insurance card _____

Spouse/Partner

Please Select:
☐ Spouse
☐ Partner

Please Select:
☐ Male
☐ Female

Date_____ (MM) / _____ (DD) / _____ (YYYY) Social Security #_____--_____--_____

Last Name*_____ First Name*_____ M.I._____

Address_____ City_____ State_____ Zip Code_____

Telephone (_____)_____ E-mail_____ Occupation_____

Employer_____ Employer's Address_____ State_____ Zip Code_____

Primary Insurance_____ Subscriber's Name_____

Address_____ Employer_____

City_____ I.D #_____ Group #_____

Telephone (_____)_____ Relationship to subscriber_____

Partner Name, as it appears on insurance card _____

I authorize the undersigned physicians to release any information in the course of my examination or treatment. I further authorize any benefits due for services rendered to be paid directly to Reproductive Medicine Associates of NY, LLP, Alan B. Copperman, MD; Lawrence Grunfeld, MD; Tanmoy Mukherjee, MD; Benjamin Sandler, MD; Jeffrey Klein, MD; Eric Flisser, MD; Rashmi Kudesia, MD; Daniel Stein, MD, Matthew Lederman, MD; Beth McAvey, MD; Joseph Davis, D.O; Kimberley Thornton, M.D.; or Natan Bar-Chama, MD. I also understand that payment for services rendered is always due at time of service. I acknowledge that I have received and reviewed the RMA of NY Treatment Disclosure.

Patient Signature_____ Date_____ (MM) / _____ (DD) / _____ (YYYY)

Partner Signature_____ Date_____ (MM) / _____ (DD) / _____ (YYYY)

RMA of New York

Last Name: _____

First Name: _____

DOB: _____

Patient Intake Form

In order for us to provide the best care possible, please fill out this form in careful detail. If you have any questions, feel free to ask the front desk or your physician.

Personal Information:

Today's Date: _____

Reason for your visit: _____

Referring Physician:

Last name: _____ First name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____

Present employment:

Title: _____ Location: _____ Number of years employed: _____

Brief description:

Medical History: Please list any medical conditions that you have/have had

Surgical History: Please list any surgeries you have had, along with the date(s) of the surgeries

Surgery: _____ Date: ____ (MM) / ____ (DD) / ____ (YYYY)

Surgery: _____ Date: ____ (MM) / ____ (DD) / ____ (YYYY)

Surgery: _____ Date: ____ (MM) / ____ (DD) / ____ (YYYY)

Surgery: _____ Date: ____ (MM) / ____ (DD) / ____ (YYYY)

Medications: Please list all medications you take

Natan Bar-Chama, M.D.
Reproductive Medicine Associates of New York
Center for Male Reproductive Health
635 Madison Avenue, 10th Floor ·New York, NY 10022
www.rmany.com | 212.756.5777

Section reviewed by physician

RMA of New York

Last Name: _____

First Name: _____

DOB: _____

Patient Intake Form

Known Drug Allergies:

Drug: _____ Type of reaction : _____

Drug: _____ Type of reaction : _____

Drug: _____ Type of reaction : _____

Drug: _____ Type of reaction : _____

Male Medical History: Do you or have you ever had (check all that apply)

- ☐ Anemia
- ☐ Blood in Semen
- ☐ Chlamydia
- ☐ Colitis
- ☐ Cystic Fibrosis
- ☐ Difficulty Smelling
- ☐ Diabetes
- ☐ Family History of Cystic Fibrosis
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Infected Epididymis
- ☐ Infection of the Penis
- ☐ Infection of the Prostate
- ☐ Infection of the Testicles
- ☐ Mumps as an Adult
- ☐ Neurological Problems
- ☐ Nongonococcal Urethritis
- ☐ Pain in Scrotum/Testicles
- ☐ Sexually Transmitted Disease
- ☐ Surgery
- ☐ Syphilis Testis Injury
- ☐ Testis Tumor
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicocele
- ☐ Visual Disturbances

Female Partner's Information and Medical History:

Last name: _____ First name: _____

DOB: _____ (MM) / _____ (DD) / _____ (YYYY) Age: _____

Occupation: _____ Referring physician: _____

Are you married to your partner? ☐ Yes ☐ No If yes, for how long? _____

Pregnancies:

Number of months you have been attempting to achieve pregnancy with your partner: _____ months

Have you achieved a pregnancy with this partner in the past? ☐ Yes ☐ No

If yes, please provide the date(s) & outcome(s) of pregnancies: _____

Has your partner had any pregnancies previously with another partner? ☐ Yes ☐ No

If yes, please provide the date(s) & outcome(s) of pregnancies: _____

Has your partner had any of the following illnesses?

- ☐ Gonorrhea
- ☐ Non-Specific Urethritis
- ☐ Pelvic Inflammatory Disease
- ☐ Herpes
- ☐ Venereal Disease

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First Name: _____

DOB: _____

Patient Intake Form

Is your partner's menstrual cycle regular? ☐ Yes ☐ No

The following have been used to determine when your partner ovulates:

☐ EBT ☐ Hysterosalpingogram ☐ Progesterone Level

☐ FSH level ☐ Laparoscopy ☐ Urine HCG

☐ Endometrial Biopsy ☐ Postcoital Test

Family History:

Is there a family history of infertility? ☐ Yes ☐ No

If yes, list all members, their relationships to you, and known diagnoses:

_____

Is there a history of hormonal disorders in your family? ☐ Yes ☐ No

If yes, list all members, their relationships to you, and type of disorder:

_____

History of Fertility Therapy:

Have you been treated for infertility before? ☐ Yes ☐ No

If yes, who was your physician? _____

What cause of fertility was diagnosed? _____

What drugs have you taken for infertility? (check all that apply)

☐ Clomiphene Citrate (Clomid) ☐ Tamoxifen ☐ Other – specify: _____

☐ Fertinex ☐ Testolactone

☐ HCG ☐ Testosterone or Male Hormone

Have you ever had a vasectomy? ☐ Yes ☐ No If yes, when? _____

Have you and your partner ever tried in vitro fertilization (IVF)? ☐ Yes ☐ No

Have you and your partner ever tried micromanipulation (ICSI)? ☐ Yes ☐ No

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First Name: _____

DOB: _____

Patient Intake Form

Which of the following tests, if any, have you had performed? (check all that apply)

- ☐ Acrosome Reaction Assay — Date: _____ Results: _____
- ☐ Chlamydia Test — Date: _____ Results: _____
- ☐ Chromosome Test — Date: _____ Results: _____
- ☐ Hormonal Test — Date: _____ Results: _____
- ☐ Mycoplasma Test — Date: _____ Results: _____
- ☐ Semen Analysis — Date: _____ Results: _____
- ☐ Testicular Biopsy — Date: _____ Results: _____
- ☐ X-ray/Ultrasound of Testes — Date: _____ Results: _____
- ☐ Y-Deletion Test — Date: _____ Results: _____
- ☐ Other _____ — Date: _____ Results: _____

History of Fertility Therapy:

Are you circumcised? ☐ Yes ☐ No

Do you have difficulty getting an erection? ☐ Yes ☐ Most of the time ☐ Sometimes ☐ No

Do you have difficulty maintaining an erection? ☐ Yes ☐ Most of the time ☐ Sometimes ☐ No

Do you have any discharge from the penis? ☐ Yes ☐ Most of the time ☐ Sometimes ☐ No

Have you noticed a change in your sex drive recently? ☐ Yes ☐ No

Do you use lubricants for sexual intercourse? ☐ Yes ☐ Most of the time ☐ Sometimes ☐ No

Do you have trouble with ejaculations? ☐ Yes ☐ Most of the time ☐ Sometimes ☐ No

If yes or most of the time, do you have: ☐ Premature ejaculations ☐ Retrograde ejaculations

Is intercourse ever painful for your partner? ☐ Yes ☐ No

If yes, please explain: _____

At what age did you begin to grow a beard? _____

Rate your level of sexual desire on a scale of 1-10, 10 being highest: _____

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

How many times do you and your partner have intercourse around ovulation? _____

How do you and your partner determine the ovulation period? _____

What methods of contraception, if any, have you and your partner ever used? _____

Risk Factors:

Are you or have you ever been exposed to any of the following?

☐ Heat ☐ Toxic Fumes ☐ Chemicals ☐ Radiation ☐ Other: _____

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RMA of New York

Last Name: _____

First Name: _____

DOB: _____

Patient Intake Form

Weight: _____ lbs. Height: _____ ft. _____ in

Have you lost greater than 20lbs. of weight in the past year? ☐ Yes ☐ No

Do you follow a particular food diet or have any special dietary habits? ☐ Yes ☐ No

If yes, please specify: _____

List the forms and frequency of your regular exercise routine:

Exercise type: _____ Hrs/week: _____

Do you frequently use a sauna or steam bath? ☐ Yes ☐ No

Have you ever undergone sterilization? ☐ Yes ☐ No

Were both of your testicles descended at birth? ☐ Yes ☐ No

Have you had a high fever during the past 3-4 months? ☐ Yes ☐ No

Have you ever had surgery in the pelvic or scrotal area? ☐ Yes ☐ No

If yes, please specify: _____

Have you ever been treated for cancer? ☐ Yes ☐ No

If yes, please specify: _____

Do you use or have you ever used any of the following?

Alcohol ☐ Yes ☐ No If yes, how many glasses per week? _____

Cigarettes ☐ Yes ☐ No If yes, how many packs per day? _____ for how many years? _____

Illicit or recreational drugs ☐ Yes ☐ No

If you feel uncomfortable documenting usage, please be sure to discuss specifics with your urologist during your consultation.

Please list any additional comments you have:

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Section reviewed by physician

Reproductive Medicine Associates of New York Treatment Disclosure

Welcome to Reproductive Medicine Associates of New York, LLP (RMA of New York). We are pleased that you have chosen to seek consultation or care with our highly committed team of physicians, clinical staff and support staff. RMA of New York is a partnership founded in 2001 by physicians Alan Copperman, M.D.; Lawrence Grunfeld, M.D.; Tanmoy Mukherjee, M.D.; and Benjamin Sandler, M.D. RMA of New York has expanded significantly over the years and is proud to offer patient care through physicians at locations in Midtown & Downtown Manhattan, Westchester, Long Island, Brooklyn and Mexico City, Mexico.

RMA of New York physician staff is board certified and/or board eligible in their field of specialty. Curriculum vitae for the physician team is available on our website at www.rmany.com and by choosing "Our Team." RMA of New York is established as a group practice whereby all physicians of the same specialty will perform patient examinations and procedures for any patient. While your RMA of New York physician will always try to perform your examination or procedure, operating as a group practice allows RMA of New York to be staffed 364 days per year and provide each patient with the care that is timed to maximize the opportunity for success. If your treatment includes a procedure performed at RMA of New York that requires anesthesia, an anesthesiologist who is Board Certified and licensed in the State of New York will be used.

Many treatment plans at RMA of New York can require frequent monitoring and interaction with both the physicians and the highly experienced nursing staff. All nursing staff is licensed as Registered Nurses (RN) or Licensed Practical Nurses (LPN) and is also licensed in the State of New York. The Nurse Practitioner staff is also licensed in the State of New York.

New York law requires a physician to provide each patient or prospective patient with the name, practice name, mailing address and telephone number of any health care professional scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in the physician's office for the patient or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with such health care professional. A comprehensive list is available by request at our front desk, on our website **http://rmany.com/financing-options/** or by calling our office at 212-756-5777.

The entire RMA of New York team is committed to delivering on our mission of combining medical excellence with compassionate, individualized care. If you have any feedback or concerns regarding your experience at RMA of New York, you may speak to any one of our staff members or supervisors.

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