University Reproductive Associates, P.C.
Patient Registration

Patient Information

Name____ Date of Birth _________________Age________
(Last) (First) (MI)

Address____ Home Phone (_____)__________________

City ___________________________________ State ___________ Zip _________ Cell Phone (_____)___________________

Social Security # ____________________________________ Drivers License # _______________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Partner/Spouse Name ____ Date of Birth _________________

Partner/Spouse Social Security # ____

Referring Physician ____

Emergency Contact ____ Phone (_____)_________________________

Relationship to patient ☐ Spouse ☐ Parent ☐ Other ____________________________

Employment Information:
Patient:
Employer____ Phone (_____)_____________________

Address ____

City____ State _____________ Zip Code _______________________________

Employed: ☐ Full Time ☐ Part Time ☐ Seasonal

Insurance Information:

Primary:

Insurance Carrier ____ Co-pay Amount _______________________

Policy Number ____ Group Number_____________________________

Guarantor: ☐ Self ☐ Other-Name ____

If other than self:
Social Security # ______________________________________ Date of Birth __________________________

Prescription Information:

Prescription Carrier ____ Co-pay Amount ____________________

Policy Number ____ Group Number ___________________________

Secondary Insurance:

Insurance Carrier ____ Co-pay Amount _________________________

Policy Number ____ Group Number________________________________

Guarantor: ☐ Self ☐ Other-Name ____

If other than self:
Social Security # ____________________________________ Date of Birth_________________________

Please Note: All patients are responsible for annual deductibles, co-pays and/or any co-insurance amounts as assigned by your insurance carrier. All self-pay patients are required to pay for services on the date rendered.

I hereby authorize my insurance benefits to be paid directly to University Reproductive Associates, P.C. for all services rendered. I also authorize the release of any medical information to my insurance carrier concerning my Illness. I understand that I am financially responsible for any fees, deductibles, co-payments and any non-covered services that may apply as directed by my insurance plan.

Patient/Guarantor ____**Date**_________________________

University Reproductive Associates

Patient Questionnaire Date: _______________

Please take a few minutes to answer these questions as completely as possible. Thank you

Name: ____ Occupation: ________________________

Partnerøs Name: ______________________________________ Occupation: _________________________

Doctor referred you here: ____

Medical/Surgical History:

Allergies: Denies Latex Contrast Dye Food ________________

Medications:____

Other:____

Explain Reaction:____

Do you have any medical conditions or problems? (if yes, please explain)

____

____

Have you had any surgery? (operation/year)

____

____

Do you take any medications, vitamins, or herbal supplements? (please list)

____

____

Do you smoke cigarettes? (packs per day x number of years) _______________________________

Do you drink alcohol? (number of drinks in an average week) _______________________________

Do you use any street drugs? (marijuana, cocaine, etc.) ___________________________________

Family History (Parents, Grandparents, Siblings, Aunts, Uncles, etc.)

Breast Cancer	no___	yes___	(who/age it occurred)__________________
Ovarian Cancer	no___	yes___	(who/age it occurred)__________________
Uterine Cancer	no___	yes___	(who/age it occurred)__________________
Colon Cancer	no___	yes___	(who/age it occurred)__________________
Birth Defects	no___	yes___	(who/age it occurred)__________________
Osteoporosis	no___	yes___	(who/age it occurred)__________________
Diabetes	no___	yes___	(who/age it occurred)__________________
High Blood Pressure	no___	yes___	(who/age it occurred)__________________

Other family diseases ____

____

MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

Have you been evaluated by a urologist? Yes No

Have you previously conceived with another woman? Yes: How many times? ___ No: Birth control used? Yes____ No____

Have you had a semen analysis? Yes No

Do you have difficulty with erections? Yes No

Do you have retrograde ejaculation of sperm into the bladder? Yes No

Have you had any of the following sexually transmitted diseases or pelvic infections?

Yes (check all the apply) No

Chlamydia ó date ____ Gonarrhea ó date _____ Herpes ó date ____ Genital warts/HPV ó date _____

Syphilis ó date _____ HIV/AIDS ó date _____ Hepatitis ó date ____ Other _____________________

Have you had a history of undescended testicles? Yes ó One side_____ Both _____ No

Do you have scrotal or testicular pain? Yes No

Did you have mumps after puberty? Yes No

Have you had prior injury to your testicles requiring hospitalization? Yes No

Have you been diagnosed with any of the following diseases?

Diabetes Mellitus ó Yes___ No___ Cancer ó Yes___ No___

Multiple Sclerosis ó Yes___ No___ Other neurologic problems - Yes___ No___

Prostatic infections ó Yes___ No__ Urinary infections ó Yes___ No____

High Blood Pressure ó Yes___ No___ If yes, any medications? _________________________

Have you had any fever in the last 3 months? Yes No

Have you had a vasectomy? Yes (date______) No

If yes, have you had a vasectomy reversal? Yes (date______) No

Have you had surgery for varicocele repair? Yes No

Have you had hernia surgery? Yes No

Did you undergo any bladder or penis surgery as a child? Yes No

Are you exposed to prolonged heat in the workplace? Yes No

Are you exposed to any radiation or harmful chemicals in the workplace? Yes No

Have you had chemotherapy for cancer? Yes No

Are you allergic to any medications? No Yes (Please list and describe reactions)_____________________________________

____

____

List your current medications: ____

List any current medical problem(s): ____

How many caffeinated beverages do you drink per day? _____ None

Do you smoke cigarettes? No Yes How many/day? ____ How many years? _____ Quit ó when? __________

Do you drink alcohol? No Yes

Beer - # per week ___ Wine - # per week ___ Liquor - # per week ___

Do you use marijuana, cocaine, or any other similar drug? No Yes (describe____) Do you use herbal medicines/vitamins or health food store supplements? No Yes (describe____________________________)

Are you aware of any radiation/toxic materials exposure? Yes No

Do you use hot tubs regularly? Yes No

Did your mother take DES during pregnancy to prevent miscarriage? Yes No Donøt know

Have any of your immediate family members had difficulty conceiving a child? Yes No

If yes, please describe ____

Physician Notes (for office use only)

____

____

____

Disorders in Your Family

		Relationship to You		
Cystic Fibrosis	Yes	__________________	No	Donøt Know
Tay-Sachs disease	Yes	__________________	No	Donøt Know
Canavan disease	Yes	__________________	No	Donøt Know

What is your Ancestry?

African ó American
American Indian/Native American
Ashkenazi Jewish
Cajun/French Canadian
Caucasian
Eastern European
Hispanic/Caribbean
Northern European
Southern European
Other (specify________________)

Revised 7/18/06

Bloom syndrome	Yes	__________________	No	Don't Know
Gaucher disease	Yes	__________________	No	Don't Know
Nieman-Pick disease	Yes	__________________	No	Don't Know
Fanconi Anemia	Yes	__________________	No	Don't Know
Familial Dysautonia	Yes	__________________	No	Don't Know
Muscular Dysautonia	Yes	__________________	No	Don't Know
Neurologic (brain/spine)	Yes	__________________	No	Don't Know
Neural Tube Defects	Yes	__________________	No	Don't Know
Bone/Skeletal Defects	Yes	__________________	No	Don't Know
Dwarfism	Yes	__________________	No	Don't Know
Developmental delay	Yes	__________________	No	Don't Know
Learning problems	Yes	__________________	No	Don't Know
Polycystic kidney disease	Yes	__________________	No	Don't Know
Heart defect from birth	Yes	__________________	No	Don't Know
Down syndrome	Yes	__________________	No	Don't Know
Other chromosome defects	Yes	__________________	No	Don't Know
Marfan syndrome	Yes	__________________	No	Don't Know
Hemophilia	Yes	__________________	No	Don't Know
Sickle Cell Anemia	Yes	__________________	No	Don't Know
Thalassemia	Yes	__________________	No	Don't Know
Galactosemia	Yes	__________________	No	Don't Know
Deafness/Blindness	Yes	_________________	No	Don't Know
Color Blindess	Yes	_________________	No	Don't Know
Hemochromatosis	Yes	_________________	No	Don't Know
None of the above	Other (Specify____			

SPOUSE/MALE PARTNER'S SIGNATURE ____ DATE________________

I Confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE____DATE_________________

Patient Name ______________________________________

1. **CONSENT TO CARE:** I wish to be treated by **University Reproductive Associates, P.C.** While I am a patient, I give permission to my doctor(s), the office employees, and all the persons caring for me to provide care in ways they judge are beneficial to me. I understand that this care may include tests, examinations and medical treatments. I understand that no guarantees have been made to me about the outcome of this care. **I understand that the University Reproductive Associates office is a teaching facility and that under the appropriate supervision medical students, residents and fellows may participate in my care and treatment.**

2. **RELEASE OF INFORMATION: University Reproductive Associates** may see, release to and/or confirm, all or part of any financial and medical information, **including information regarding psychological, psychiatric, HIV and related diagnoses, drug and/or** alcohol **related illness,** with any person, corporation or government agency that is or may be responsible to the office, the patient, and family member or employer for all or part of URA charges. I acknowledge that the Medical Center may require to release patient information, **including the highlighted above,** to federal and state agencies that monitor healthcare facilities, as well as any industries that produce and/or manufacture medical products. I acknowledge that URA may access patient information from my medical record for purpose of research. I acknowledge that I have been informed that I may be contracted to participate in a research study and that I have the right to agree or decline to participate.

3. **PATIENT RIGHTS: University Reproductive Associates has posted a copy of the New Jersey Bill of Rights** for my viewing, a copy will be given upon my request.

4. **PRE-CERTIFICATION REQUIREMENTS:** I understand if I do not comply with my insurance policy pre-certification requirements or if any service is not certified, that I may be responsible for any and all facility charges.

   Please check the appropriate box: (Pre-Certification)
   I acknowledge that the pre-certification requirements I am responsible for have all been met.

   Yes **No** **N/A**

5. **ASSIGNMENT OF BENEFITS:** I authorize my health insurance benefits to be paid directly to **UNIVERSITY REPRODUCTIVE ASSOCIATES, P.C.** Under the terms of my policy this payment may not exceed the balance due for services performed during this period of treatment.

6. **FINANCIAL AGREEMENT:** When billed I agree to make prompt payment to University Reproductive Associates for any and all charges not paid by insurance benefits. In addition, I agree, in order for University Reproductive Associates to service my account or to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of an automatic dialing device, as applicable.

7. **DEPOSIT REQUEST:** A deposit has been requested of me because I will be paying for all and/or part of URA bill.

8. **MEDICARE PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVM of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physiciansqservices to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

THE SERVICE YOU RECEIVE MAY NOT BE COVERED BY YOUR MEDICARE INSURANCE, IN THIS EVENT; YOU WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.

9. **OUTPATIENT SERVICE "MEDICAID":** I certify that service by this claim has been received and I request that payment for these services be made on my behalf. I assign the benefits payable for hospital services to the Hackensack Medical Center and the benefits payable for physiciansqservice to the physicians or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

I have read the information, any questions I had have been answered, and I understand its contents.

Patients objecting to any statement in the Consent Form may put a line through that statement and initial it. This action indicates that the patient is deleting this statement and that their signature does not indicate consent or acknowledge of that item. However, patients cannot delete paragraph number I which is the consent for treatment or items relating to their financial responsibility.

______________________________________ ______________________________________
Patient Date

______________________________________ ______________________________________
Guarantor (if other than Patient) Date

______________________________________ ______________________________________
Relationship of Guarantor to Patient, if applicable

University Reproductive Associates, P.C.

Patient Record of Disclosures

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 be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

In order to provide accurate medical treatment we will need to contact you with instructions. Please provide *two* telephone numbers where we can speak with you or leave a detailed message for you.

Home (____) ______________________________ **Work** (____) ________________________

Cell (____) ______________________________ **Other** (____) ________________________

____ ________________________________

Patient Signature **Date**

____ ____________________________

Print Name **Birth date**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Please list names and numbers of any immediate family member to which you are allowing us to discuss medical conditions with.

Name **Telephone #** **Relationship to Patient**

1.____

2.____

3.____

University Reproductive Associates, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (÷öPHIö) about you. You have the right to review our Notice and ask questions about our policy practices. As provided in out Notice, the terms of our Notice may change. If we change our Notice, you may obtain a copy by the methods described within the Notice.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

____

Name of Patient

____

Signature of Patient

____

Date

University Reproductive Associates, P.C.
Notice of Privacy Practices

Effective May 1, 2003

THE 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 the Privacy Office at (201) 288-6330.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to maintaining the confidentiality of medical information about you. We create a record of care and service you receive at this office. We need this record to treat you and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office, whether made by you personal doctor or by other personnel within our office.

This notice advises you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medial information about you; and
- follow the terms described in this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe the different ways that we may use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and provide example. Not every use or disclosure in a category will necessarily be listed below. However, all of the ways which we are permitted to use and disclose information will fall within one oft the categories.

Treatment . We may use medical information about you to provide you with medial treatment or services. We may disclose medical information about you to your doctors, nurses, technicians, medical students, or other office personnel who are involved in your medical care and treatment. Different departments of the office may also share medical information about you in order to coordinate the different things you need, such as prescription, lab works, and x-rays. We also may disclose medical information about you to people outside the office who may be involved in your medical care after you leave the office, as per your designation in the proceeding sections.

Infertility is generally the problem of a couple . a male and a female partner. During the evaluation and treatment of the couple for infertility, the health information of the male partner and of the female partner will be shared with each other. For example, the male and female partners may be interviewed together at the office visits. If one of the partners is not present, health information, including the results of tests, may be discussed and documented of the absent partners. Similarly, the male and female partners may be together at the time of physical examination, counseling, and embryo transfer. The health information of each partner will be shared with each other at these times.

If you are an infertility patient and success in having a child, you may provide us with a picture of your baby. The baby pictures may be displayed at the office where other patients and office staff may see them. These pictures will not be identified with your name, or any information that may identify you or your baby. You can specifically request that the picture of your baby not be displayed at the office.

Payment . We may use and disclose medical information about you so that the treatment and services which we provide to you at the office, hospital, ambulatory, surgery, center, nursing home or other site may

be billed to and payment may be collected from you and/or your insurance company or other responsible third party. We may also tell your health insurance plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

Health Care Operations . We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many office patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personal for review and education purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of specific patients.

Appointment Reminders . We may use and disclose medical information in connection with our efforts to remind you that you have an appointment or that you need to have a test usually ordered on a regular basis. For example, we may send you a reminder that you need to have your yearly breast examination, your yearly PAP test, or other tests that should be performed periodically. These reminders may be sent to you by mail, by telephone, by voice mail, or by e-mail once appropriate and reasonable steps are taken to protect the privacy of your health information.

Treatment Alternatives . We my use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. For example, we may use your information to determine whether you qualify for a nutritional counseling program, or whether you may take advantage of different types of support or counseling opportunities. We may refer you to a community support group or for individualized counseling.

Research . Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Other types of research may involve revision of the medical information of a group of patients followed over time to determine the success of a specific treatment. Health information may be stored in a data-base to examine the factors (for example, age, type, and dose of medication, etc.) that may have an effect on the success of the treatment. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with the patientsqneed for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the office. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the office.

Ambulatory Surgery Center, Outpatient Hospital Surgery, or Long term stay In-Hospital Registry . We include certain limited information about you in the registry while you are a patient at any of the locations indicated in the section. The information may include name, location in the specific center, your general condition and your religious affiliation. The registry information may only be released to people who ask for you by name and whom you have also indicated on your release of information form.

Individuals Involved in your care or payment for your care . We mat release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family and friend your condition and that you are in the hospital, ambulatory surgery center, or office. In addition, we may disclose medical information about you to an entity assisting in a disaster relief so that your family can be notified about your condition, status, and location.

As required by law . We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety . We may use and disclose medical information about you when necessary to prevent a serious of the public or another person. Any disclosure, however, would only be to someone able to prevent the treat.

SPECIAL SITUATIONS

Organ and Tissue Donations . If you are a sperm, ovum (egg), or embryo donor, or if you are a recipient of these cells, or tissues, your medical information may be released to proceed with treatments that involve these cells or tissues following accepted standards of care.

Military and Veterans . If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

If you are a member of the Armed Forces, we may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

Public Health Risks . We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or nay be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, domestic violence. We will make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities . We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor and health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes . If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a count or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if required by law or if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement . We may release medical information if requested by law enforcement officials acting pursuant to valid legal authority.

Coroners, Medical Examines, Funeral Directors . We may release medical information to a coroner or medical examiner for the purpose of identification of a deceased person or to determine a cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following medical information we obtain about you:

I. **Rights to Inspect and Copy**

You have the right to inspect and copy medical information that may be used to make decisions about your care.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of your entire chart, we may charges a fee as permitted by state law for the costs of copying ($1 per page), postage, and other supplies associated with your request. We will also charge a fee of $250 for any requested care plan and medical history summary reports.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

II. Right to Amend

If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the office.

The request and amendment, you request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny you request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny or request if you ask us to amend information that:

* was not created by us, unless the person or entity that created the information is no longer available
  to make the amendment;
* is not part of the medical information kept by or for the office;
* is not part of the information which you would be permitted to inspect and copy; or,
* is accurate and complete.

III. Right to an Accounting of Disclosures

You have the right to request an %Accounting of Disclosures.+ This is a list of the disclosures we made of the medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list, by mail, fax, or email. The first list you request within a 12 month period will be free. For additional lists, we may charge you a fee of $5 for the costs of providing the list. We will notify you of the cost involved and you may chose to withdraw or modify your request at the time before any costs are incurred.

IV. Right to 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.

We are not required to agree to your request. If we do agree, we all comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in the writing to the Privacy Officer. In the request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want to limits to apply.

V. Right to Request Confidential Communications

Many types of infertility treatments require daily communication between the doctor or the doctor$s office and you. The purpose of these communications is generally to give you instructions regarding your infertility treatment. This communication can take place through the telephone, cell phone, fax machine, voice mail systems, e-mail, and other

forms of verbal or written communications. The doctor or the doctor's office may communicate with you, with your partner, or with a family member or friend of your designation. You may be contacted at home, at your office, or at another specified location where you may be reached. You may thus be asked to provide us with a method and place where you can be reached during working hours (9:00 AM to 5:00 PM), when the office is open. You have a right to request that we communication with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, or by cell phone. To request confidential communication, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests that will provide adequate communication between you and the office.

VI. **Right to a Paper Copy of this Notice**

You have the right to a paper copy of this notice. A copy of this completed notice will be given to you at the time you complete the document.

CHANGES TO THIS NOTICE

We reserve the right to change or amend this notice. We reserve the right to make a revised or changed notice effective for medical information we already have about you as well as any information we received in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are seen at the office for treatment or health care services as an outpatient, you may request a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department or Health and Human Services. To file a complaint with the office, contact:

Privacy Officer
c/o University Reproductive Associates, P.C.
214 Terrace Avenue
Hasbrouck Height, NJ 07604

All complaints must be 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 you 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. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the provided to you.