INFORMATION ON ZIKA VIRUS

Zika virus disease is spread to people primarily through the bite of an infected *Aedes* species mosquito. The most common symptoms of Zika are fever, rash, joint pain and conjunctivitis (red eyes). The illness is usually mild, with symptoms lasting for a few days to a week after being bitten by an infected mosquito. People usually do not become ill enough to visit a doctor. For this reason, many people might not realize they have been infected. Zika virus may also cause Guillain Barre Syndrome in infected individuals, involving tingling in the extremities and progression to muscle weakness and occasionally paralysis.

Zika virus infection during pregnancy can cause a serious birth defect called microcephaly, as well as other severe fetal brain defects. Microcephaly is a condition in which a baby is born with a much smaller head than normal because the brain has not developed properly during pregnancy. The baby may suffer from a number of physical and cognitive problems, ranging from mild to severe, including a decreased ability to learn and function. Understanding of the Zika virus and its effect on infected pregnant women and their babies is still evolving. The Centers for Disease Control (CDC) is the primary source for the most current information.

In May, 2015 a world health alert was issued regarding the first confirmed Zika virus infection in Brazil. Local transmission has been reported in many countries and territories since the first alert. The CDC lists the countries and territories reporting active Zika transmission. Please see http://www.cdc.gov/zika/geo/index.html and the CDC Traveler's Health site http://wwwnc.cdc.gov/travel/) for the most updated travel information notices. Currently, the majority of these regions are in Central and South America. However, specific areas where Zika is spreading are often difficult to determine and are likely to change over time.

Zika can also be transmitted sexually through semen from infected males to their partners. All reported cases of sexual transmission occurred shortly before onset or shortly after resolution of a symptomatic illness consistent with Zika virus disease. It is not known whether infected men who never develop symptoms can transmit Zika virus to their partners. Sexual transmission of Zika virus from infected women to their partners has not been reported yet. Sexual transmission of many infections, including those caused by other viruses, is reduced by consistent and correct use of latex condoms.

Testing for Zika virus is now available through the Quest and LabCorp laboratories. However, testing is not universally covered by insurance. To date, there are no vaccines to protect against Zika, and there is no specific treatment.

The CDC has provided guidance for pregnant women and women considering becoming pregnant. Please see http://www.cdc.gov/zika/specific-groups.html. The CDC has also issued guidelines for health-care providers in the United States caring for pregnant women and women of reproductive age. As more information becomes available about the Zika virus, these guidelines will be updated. In addition, the American Society of Reproductive Medicine (ASRM) has issued guidelines based on the CDC and Food and Drug Administration (FDA) published guidelines. Florida Fertility Institute follows these guidelines and strongly encourages you to continually monitor the CDC guidance as you attempt to become pregnant or are pregnant.

While there have been no reported cases of Zika virus transmission through assisted reproductive technology (ART), transmission through donated gametes (eggs and sperm) and embryos is theoretically possible. The FDA has issued guidelines for procedures using donated tissue, including protocols for sperm donation. Florida Fertility Institute follows the FDA's guidance for tissue donation.

Based on the information available regarding the risk to patients and the unborn child, the physicians at Florida Fertility Institute strongly advise you and your partner NOT to travel to areas with active Zika transmission while attempting pregnancy. Failure to comply with this notice may result in a delay of your treatment as a patient at Florida Fertility Institute.

If you or your partner have recently lived in or traveled to an area reporting local Zika transmission, or have had sex without a condom with a man infected with Zika, and are interested in attempting pregnancy, Florida Fertility Institute will recommend that you wait to attempt pregnancy according to the time frames currently suggested by the CDC and the American Society for Reproductive Medicine as outlined in the following table.

CDC's suggested time frame to wait before trying to get pregnant:

Possible exposure via recent travel or sex without a condom with a partner infected with Zika		
Women		**Men**
Wait at least 8 weeks after symptoms start or last possible exposure		Wait at least 6 months after symptoms start or last possible exposure
People living in or frequently traveling to areas with Zika		
	Women	**Men**
Positive Zika test	Wait at least 8 weeks after symptoms start	Wait at least 6 months after symptoms start
No testing performed or negative test	Talk with doctor or healthcare provider	Talk with doctor or healthcare provider

FLORIDA FERTILITY INSTITUTE
PATIENT INFORMATION FORM

We thank you for taking the time to complete all of the information requested on this form. It is an important part of your personal medical record and enables us to provide you with needed follow up care. **Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with Florida Fertility Institute.**

Patient information

Full legal name_____ Date of birth _____

Address_____ Social Security #_____

_____ Race _____
City State Zip

Home phone#_____ Cell phone #_____ Marital Status_____

Employer_____ Work phone#_____ Spouse/Partner_____

Email address_____

Insurance Information

Do you have health insurance? Y/N (if no, skip this section)

Name of Insurance company_____

Are you the main policy holder? Y/N (if yes, you may skip this section)

Name of policy holder_____ Date of birth_____

Employer_____ Social Security #_____

Home phone #_____ Work phone #_____

Patient's relationship to insured_____

Doctor Information

Name of primary care/family physician_____

Address_____
City State Zip

Phone#_____ Fax #_____

*Please be advised that if your insurance requires referrals to be seen by a specialist, you need to contact your primary care doctor to obtain the necessary authorization prior to your visit.

Please provide the following along with your paperwork:

***Driver's license or photo ID** ***Insurance card(s) if applicable**

Office Policies/Financial Policies

- Payment is due in full at the time of service. This includes payment in full for services rendered to uninsured patients as well as all applicable amounts (co-pays, deductibles, co-insurances, and/or payment in full for noncovered services) due by insured patients.
- We accept Visa, Mastercard, America Express, Discover, cash, money orders, cashier's and personal checks as forms of payment. Personal checks may only be written by patients of our practice. Patients will be assessed a 2% processing fee is payment is made by credit card.
- Checks cannot be accepted from patients who have previously written a returned check to our office. All returned checks are subject to a minimum service charge of $50.00. Non-payment on returned checks will result in prosecution through the State Attorney's Office.
- It is important for insured patients to understand that your coverage is an agreement between you and your insurer. It is also important to understand its provisions. Although an insurance verification will be done on your behalf, it is not a guarantee of coverage or payment by your insurance company. Patients are responsible for charges incurred by claims which are submitted to and denied by your insurance company. This includes, but is not limited to denials due to non-covered services, improper/lack of authorization, and untimely filing/terminated coverage because of failure by the patient to inform our office of any changes to insurance status.
- Your insurance may request medical information at any time to process claims and/or authorize payment of medical benefits to the provider rendering services.
- We make every effort to inform patients of any account balances by mail and/or by phone. This is done to help keep our patient's accounts and credit in good standing. We reserve the right to charge a late fee of $10.00 on all delinquent accounts over 30 days past due and an administrative fee based on a monthly periodic rate of 18% annual on the balance of all delinquent accounts.
- It is a patient's responsibility to keep us informed of any changes to your personal information. Please let us know as soon as possible if you've had a change of address, phone number, etc. This information allows us to contact you efficiently for any needed follow up, appointment information, or other information that you may need.
- Forms such as FMLA, etc. that are filled out for the patient will require at least one week to process. Request for medical records is $1.00 per page and requires 7-10 business days for processing.
- We are a HIPPA compliant medical facility. Notice of Privacy Practices is available on our website or upon request.
- We require a 24 hour notice to cancel scheduled appointments. All appointments that are not kept or not cancelled within 24 hours notice are subject to a $75.00 no show charge.
- Video and/or audio recording is prohibited. Failure to do so will result in discharge from the practice. The physician may, at his discretion, provide written consent for video and/or audio recording in the event of extenuating circumstances.
- I acknowledge that I have received information regarding the Zika virus.
- I understand and accept that I may be contacted by telephone, mail, text, or email for my healthcare as well as educational and/or promotional items.
  - □ I prefer to opt out of receiving information by text and email. (if applicable)

Statement of acceptance: I, the undersigned, acknowledge and accept all of the aforementioned policies. I also understand that all charges/ balances incurred by myself or my dependents are my financial responsibility. This includes all fees due for medical services rendered, balances remaining after insurance payment, and all fees to collect on me/my dependent(s) account. I also acknowledge that I have received or have been offered, either today or at a previous visit, a copy of the Florida Fertility Institute's privacy policies.

Signature: _____ Date: _____

Please list name(s) and contact information for any person(s) with whom we may discuss your general medical information.

_____

The above named may be contacted: □ in the event of an emergency ONLY □ at any time

Consent for Treatment and Agreement to Pay

1. CONSENT FOR ROUTINE DIAGNOSTIC PROCEDURE AND MEDICAL TREATMENT

I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my provider at FFI. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my provider. Further, I understand that should any medical personnel, physician, or other person be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Florida Fertility Institute PA.

2. AGREEMENT TO PAY

I acknowledge and agree that I am responsible for and will pay for all regular charges by the fees in effect on the dates of service rendered, for items or services and treatment provided to me, including any amount not paid by my insurance plan. I understand I can request additional information about charges for procedures, devices, and other items of services, or can obtain a non-binding estimate prior to services being rendered.

I understand that some items or services that FFI may provide to me may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services or items or services in excess of the limits in my member benefit agreement. I understand that I am personally responsible for any time or service determined by my third party payor (my insurance company) to be non-covered for any reason.

I understand that I am personally responsible for deductibles and co-insurance established by my member benefit agreement with my insurance carrier, including those required for in-network laboratory and other ancillary services or items.

I understand and agree that I have been advised that I may be billed by FFI and that this Assignment of Benefits and Agreement to pay applies to any and all FFI physician services. If a delinquent account balance is referred to collections, I understand that the applicable collection fee will be applied to my balance.

3. ASSIGNMENT OF BENEFITS

I hereby authorize and request all insurance carriers, health maintenance organizations or managed care organizations with whom I have coverage, to pay directly to Florida Fertility Institute PA, and any and all benefits due under the terms of my policy for items or services provided by FFI. If my health insurance will not allow direct payment to FFI, I agree to immediately forward to FFI all health insurance payments I receive for my care.

4. GUARANTOR AGREEMENT

By signing in the space below as Patient/Legal Representative or Guarantor, I hereby agree that all charges connected with this treatment or any other treatment rendered past or future, not covered by any insurance program, sponsorship or other third party coverage I may have are due and payable by me. I hereby acknowledge having been told that I may be billed by FFI and that this assignment and guarantor agreement shall be allowed to cover all and any accounts, including FFI physician accounts. If the delinquent account is referred for collections, I am aware that all applicable fees will be my cost.

PLEASE READ THIS ENTIRE AUTHORIZATION PRIOR TO SIGNING BELOW

By: _____ Date_____
Patient (Sign & Print Name)

By: _____ Date_____
Parent or Guardian if patient is a Minor (Sign & Print Name)

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

(For claims related to medical care and treatment)

1. **AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE & TREATMENT.** I agree that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned provider of medical services, including any partners, agents, or employees of the provider of medical services, shall be submitted to binding arbitration.

2. **AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT.** I further agree that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the past diagnosis, treatment, or care by a provider of medical services, or the provider's agents or employees, shall be submitted to binding arbitration.

3. **WAIVER OF RIGHT TO JURY TRIAL.** By entering into this Agreement, I am giving up my constitutional right to have any such dispute decided in a court of law before a jury, and instead I am accepting the use of binding arbitration.

4. **ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS.** l claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including myself, my estate, any spouse or heirs of mine, any biological or adoptive parent of mine and any children of mine, whether born or unborn, at the time of occurrence giving rise to the claim. In the case of any pregnancy, this would include my expected child or children. By signing this Agreement, I consent to participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5. **ARBITRATION PROCEDURES.** I agree and recognize that the provisions of Florida Statutes, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statutes, Chapter 766.106 or 766.207, I and/or other claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Accordingly, any demand for arbitration shall not be made until the conclusion of the pre-suit screening period under Florida Statutes, Chapter 766. Within (20) twenty days after a party of this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy, the parties to the dispute or controversy shall each have an absolute and unfettered right to appoint an arbitrator of its choice and shall give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. I agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

6. **ARBITRATION EXPENSES.** Expenses of the arbitration shall be shared equally by the parties to this Agreement.

7. **APPLICABLE LAW.** Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 et seq. The arbitration panel shall allow for reasonable discovery in accordance with the issues raised related to any claim based upon a reasonable schedule set by such arbitration panel, which shall at least include discovery related to: the disclosure of experts and witnesses; expert, witness and party depositions; and written discovery, including the power of each party to issue subpoenas. In conducting the arbitration under Florida Statutes, Section 682.01 et seq., all substantive provisions of the Florida law governing medical malpractice claims and damages related thereto, including but not limited to, Florida's Wrongful Death Act, the standard of care for medical providers, caps on damages under Florida Statutes 766.118, the applicable statute of limitations and repose as well as and the application of collateral sources and setoffs shall be applied. Venue for the arbitration shall be held in the county where the medical services, that are the subject of the arbitration, were rendered.

8. **EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION.** In the event that I refuse to go forward with arbitration, Florida Fertility Institute PA, its healthcare providers, employees or agents reserves the right to proceed with arbitration, the appointment of a arbitrator, and hearings to resolve the dispute, despite my refusal to participate or my absence. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this arbitration Agreement or contains an illegal aspect, precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

9. **SEVERABILITY.** If any provision of this 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.

10, **ACKNOWLEDGEMENTS BY PATIENT.** By signing this Agreement, I also acknowledge that I have been informed that:

a. **NO DURESS.** The Agreement may not be submitted to me for approval when my condition prevents me from making a rational decision whether or not to agree;

b. **AGREEMENT BASED UPON OWN FREE WILL.** The decision whether or not to sign the Agreement is solely a matter for my determination without any influence by the physician or hospital;

c. **BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL.** Binding arbitration means that I give up my right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision.

d. **READ AGREEMENT, AND UNDERSTOOD.** I have read and understand the above Agreement. I understand I have the right to have my questions about arbitration or this Agreement answered and I do not have any unanswered questions. I execute this Agreement of my own free will and not under any duress.

e. **SIGNATURE OF AGREEMENT.** This Agreement shall be effective upon my and/or the my representative's signature below. Upon such signature, this Agreement shall be deemed to he fully executed and binding upon all parties.

f. **BY SIGNING THIS AGREEMENT I AM WAIVING MY RIGHT TO A JURY TRIAL AND I AM AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO MY MEDICAL CARE AND TREATMENT.**

By _____ Date _____
Patient (Sign & Print Name)

By _____ Date _____
Parent or Guardian if patient is a Minor (Sign & Print Name)