



Welcome to Tennessee Reproductive Medicine. We appreciate the opportunity to serve you and promise to deliver exceptional care in a compassionate environment. Enclosed are several forms to facilitate your initial visit. Please complete and return these forms at least two (2) business days prior to your scheduled appointment. Completion and return of these forms allow us to update our records prior to your visit.

If you have additional records from a referring physician, please have these records forwarded as well.

**On your first visit:**

- Please arrive 10 minutes prior to your scheduled visit
- Please bring all insurance documentation
- Plan to be at the clinic for approximately 1 to 1 ½ hours
- Your physician will review your history and discuss evaluation options; treatment plans may be discussed or may be presented at subsequent visits.

**For follow-up visits, please arrive 10 minutes prior to all scheduled visits.**

**Payment Policy**

We accept various insurance plans. Please check with our schedulers when making your appointment regarding other specific companies. Please be aware that many insurance companies do not provide coverage for fertility investigations and/or treatments; therefore, we strongly encourage you to contact your insurance provider prior to your visit to understand your benefits. Payment (Co-Pays, Deductibles, Co-Insurances, etc.) for each visit is expected in full at time of the visit.

For various lab services (i.e. semen analysis, sperm preps, and other lab tests), Tennessee Reproductive Laboratory, Inc. does not participate with any third party payers and is therefore a ***non-contracted laboratory***. All fees for such tests are due prior to or at time of testing. If a patient is interested in filing their claims directly, then please notify our staff for the appropriate forms. Tennessee Reproductive Laboratory does not file any claims with third party payers.

**Cancellation Policy**

We understand that scheduling needs change over time and would like to accommodate you whenever possible if an appointment must be changed. We kindly request at least a 24-hour notice to reschedule appointments. If no notice is given and an appointment is not kept, a \$50 cancellation charge will be applied.

**For directions or more information, please call 423-876-2229 or visit [www.trmbaby.com](http://www.trmbaby.com).**

Patient ID: \_\_\_\_\_



TENNESSEE  
REPRODUCTIVE  
MEDICINE

Dr. Murray \_\_\_\_ Dr. Scotchie \_\_\_\_

**DEMOGRAPHIC INFORMATION**

Name: \_\_\_\_\_ Name you prefer to be called: \_\_\_\_\_

Marital Status: Married/ Single/Divorced/Separated/Widowed

Partner or spouse name (First, MI, Last) \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

| Phones:      | Order to be called | May we leave a message? |
|--------------|--------------------|-------------------------|
| Home _____   | 1 – 2 – 3          | ..... Yes / No          |
| Mobile _____ | 1– 2 – 3           | ..... Yes / No          |
| Work _____   | 1 – 2 – 3          | ..... Yes / No          |

Email: \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_\_ SSN: \_\_\_\_\_

Ethnicity/Race (please circle): Caucasian / African American / Hispanic / Asian / Mediterranean (Greek/Italian/other)

French Canadian / Eastern European / Other : / Other : \_\_\_\_\_

Local Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

**Referral Information**

How did you hear about us? (check all that apply:)

Referring Physician: \_\_\_\_\_  
Referring Physician Phone: \_\_\_\_\_ Referring Physician Fax: \_\_\_\_\_

Internet, when searching for \_\_\_\_\_

Radio advertisement     Billboard     Print ad     Women’s Expo/Taste of Home Show

Friend: \_\_\_\_\_     Other: \_\_\_\_\_

Patient ID: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder Sex: Male / Female

**Is the contact information for the policy holder the same as the patient contact information? Yes / No**  
**If No, please complete the information for the policy holder.**

Policy Holder Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Please list the order of the preferred method of contact: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

May we leave messages at all of the numbers above? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, list the number at which we may leave a message: \_\_\_\_\_

Email: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_\_ SSN: \_\_\_\_\_

Do you have secondary insurance? Yes / No



Patient ID: \_\_\_\_\_

**Gynecologic History:**

Age at 1<sup>st</sup> menstrual period \_\_\_\_\_ Number of days in cycle \_\_\_\_\_ Days of flow \_\_\_\_\_

Regular? Yes / No

Intermenstrual bleeding? Yes / No

Painful periods? Yes / No

(If yes, rate on a scale of 1-2-3-4-5-6-7-8-9-10)

Minimal  $\xrightarrow{\hspace{2cm}}$  Severe

If yes, number of days per month: \_\_\_\_\_

Do you miss work on account of cramps? Y/N

Pain between periods? Yes / No

(If yes, rate on a scale of 1-2-3-4-5-6-7-8-9-10)

Minimal  $\xrightarrow{\hspace{2cm}}$  Severe

If yes, number of days per month: \_\_\_\_\_

Painful Intercourse? Yes / No

(If yes, rate on a scale of 1-2-3-4-5-6-7-8-9-10)

Minimal  $\xrightarrow{\hspace{2cm}}$  Severe

How often does pain with intercourse occur?  Rare  Occasionally  With every attempt

Does pain prevent intercourse?  Yes  No

How often on average does patient have intercourse? \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_

Any prior abnormal pap smears? Yes / No

How was it treated? \_\_\_\_\_

Date of last abnormal pap? \_\_\_\_\_

Date of last breast exam: \_\_\_\_\_ Have you ever had any breast masses? Yes / No

Date of last mammogram? \_\_\_\_\_ Findings: \_\_\_\_\_

Have you ever used contraception? Yes / No

If yes, please list method and dates of use: \_\_\_\_\_

Have you ever had a gynecologic infection other than yeast or bacterial vaginosis? Yes/ No

If yes, please list infection, date and treatment: \_\_\_\_\_

Have you ever had gynecologic surgery? Yes / No

If yes, please list each surgery below

| <b>Procedure</b> | <b>Date</b> | <b>Findings</b> |
|------------------|-------------|-----------------|
| 1. _____         | _____       | _____           |
| 2. _____         | _____       | _____           |
| 3. _____         | _____       | _____           |

**Fertility History:**

Have you ever seen another fertility specialist?      Yes / No

If “yes”, physician name and phone number: \_\_\_\_\_

Please list prior infertility diagnoses: \_\_\_\_\_

Have you or your partner undergone any of the following evaluations?

| Test                    | Date  | Results |
|-------------------------|-------|---------|
| Ovulation Predictor Kit | _____ | _____   |
| Prolactin               | _____ | _____   |
| Thyroid                 | _____ | _____   |
| Day 3 FSH, Estradiol    | _____ | _____   |
| Progesterone            | _____ | _____   |
| Hysterosalpingogram     | _____ | _____   |
| Semen Analysis          | _____ | _____   |
| Other                   | _____ | _____   |

Have you undergone any of the following treatments?

| Treatment                     | Dose  | Number of cycles | Dates |
|-------------------------------|-------|------------------|-------|
| Clomid/Timed Intercourse      | _____ | _____            | _____ |
| Clomid/Insemination           | _____ | _____            | _____ |
| Injectables/Timed intercourse | _____ | _____            | _____ |
| Injectables/Insemination      | _____ | _____            | _____ |
| IVF                           | _____ | _____            | _____ |
| Other                         | _____ | _____            | _____ |

Have you had any of the following tests done for Recurrent Pregnancy Loss?

- |   |  |
|---|--|
| <input type="checkbox"/> Female karyotype             | <input type="checkbox"/> Male karyotype                                |
| <input type="checkbox"/> HSG/Hysteroscopy             | <input type="checkbox"/> Ureaplasma or mycoplasma culture or treatment |
| <input type="checkbox"/> Anticardiolipin antibodies   | <input type="checkbox"/> Lupus Anticoagulant                           |
| <input type="checkbox"/> Antiphospholipid antibodies  | <input type="checkbox"/> MTHFR Mutation                                |
| <input type="checkbox"/> Factor V Leiden              | <input type="checkbox"/> Prothrombin Mutation                          |
| <input type="checkbox"/> Protein C Deficiency         | <input type="checkbox"/> Protein S Deficiency                          |
| <input type="checkbox"/> Antithrombin III Deficiency  | <input type="checkbox"/> Activated Protein C Resistance                |
| <input type="checkbox"/> Other or Unknown Names _____ |  |

**Medical & Other Surgical History:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Please list any medical conditions:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Have you had chicken pox? Yes \_\_\_ No \_\_\_

**Please list all prior surgeries (other than gynecological procedures listed previously):**

| Procedure & Date | Physician | Findings |
|------------------|-----------|----------|
| 1. _____         | _____     | _____    |
| 2. _____         | _____     | _____    |
| 3. _____         | _____     | _____    |
| 4. _____         | _____     | _____    |

**Allergies (list all reactions and offending drug or agent):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Medications (Please include dosages):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Environmental & Family History:**

Do you smoke? Yes / No      If yes, number of cigarettes per day: \_\_\_\_\_ Years \_\_\_\_\_

Did you smoke in the past? Yes/No      If yes, please list start date \_\_\_\_\_ and stop date (or year)\_\_\_\_\_.

How many alcoholic beverages do you consume per week? \_\_\_\_\_

Do you use illicit drugs? Yes / No.      If yes, list drug and frequency: \_\_\_\_\_

Have you ever been in an abusive (physically, mentally, or emotionally) relationship? Yes / No

Occupation: \_\_\_\_\_

**Is there a family history of any of the following conditions?**

| Condition   | Affected Person | Condition  | Affected Person |
|---|-----------------|--|-----------------|
| <input type="checkbox"/> Down Syndrome            | _____           | <input type="checkbox"/> Spina bifida (open spine) | _____           |
| <input type="checkbox"/> Heart defect             | _____           | <input type="checkbox"/> Mental retardation        | _____           |
| <input type="checkbox"/> Premature menopause      | _____           | <input type="checkbox"/> Breast Cancer             | _____           |
| <input type="checkbox"/> Ovarian Cancer           | _____           | <input type="checkbox"/> Other birth defects       | _____           |
| <input type="checkbox"/> Autism                   | _____           | <input type="checkbox"/> Learning disability/ADHD  | _____           |
| <input type="checkbox"/> Sickle Cell Anemia       | _____           | <input type="checkbox"/> Cystic Fibrosis           | _____           |
| <input type="checkbox"/> Other inherited disorder | _____           |  |                 |

Ethnicity/Race (please circle): Caucasian / African American / Hispanic / Asian / Mediterranean (Greek/Italian/other)/French Canadian / Eastern European / Other : / Other : \_\_\_\_\_

Do you have any of the following ancestry in your family?

- Ashkenazi Jewish       French Canadian

Have you or your partner been screened for the Cystic Fibrosis carrier mutation? Yes / No  
If yes, results: \_\_\_\_\_

**Review of systems:**

Please circle any of the following symptoms you have experienced within the last 3 months

- General:**            Fevers, fatigue, weight changes, weakness, eating disorders
- Skin:**                Rash, ulcers, change in mole size, acne, hair growth
- Eyes:**                Change in vision, eye pain, blurry vision
- Breast:**              Pain, discharge, lump, skin changes
- Respiratory:**        Cough, shortness of breath, wheezing, coughing blood, chest pain, asthma
- Cardiovascular:**    Irregular heart beat, chest pain, palpitations, difficulty breathing when walking, difficulty breathing when laying down, leg swelling
- GI:**                    Abdominal pain, nausea, vomiting, diarrhea, constipation, blood in stools, heartburn
- GU:**                    Painful urination, blood in urine, incontinence
- Musculoskeletal:**   Painful joints or muscles, back pain, hip pain
- ENT:**                  Sore throat, difficulty hearing, sinus problems
- Nervous system:**    Headaches, dizziness, fainting, seizures, difficulty walking
- Psychology:**         Depression, anxiety, bipolar disorder, crying
- Endocrine:**          Unwanted hair growth (on face, abdomen, chest or back), acne, hair loss, loss of breast size, excessive sweating, hot flashes, vaginal dryness, constant thirst, frequent urination, skin tags, darkening of skin around neck or in folds of skin

**Medical History (Partner/Husband History, if applicable):**

Partner or spouse name (First, MI, Last) \_\_\_\_\_ Age \_\_\_\_\_

Have you previously been married? Yes \_\_\_ No \_\_\_

Have you previously fathered any pregnancies? Yes \_\_\_ No \_\_\_

If yes, were the pregnancies with current partner/wife \_\_\_\_\_ former partner/wife \_\_\_\_\_

If Yes, please list the following:

Date of pregnancy: \_\_\_\_\_ Type of pregnancy (live birth, miscarriage, ectopic, elective abortion)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Male risk factors for infertility: If any responses are Yes, please explain in space.**

Prior abnormal semen analysis? Y / N \_\_\_\_\_

Prior testicular torsion? Y / N \_\_\_\_\_

Prior testicular/pelvic trauma? Y / N \_\_\_\_\_

Prior Head trauma? Y / N \_\_\_\_\_

Low libido?(sex drive) Y / N \_\_\_\_\_

Varicocele? Y / N \_\_\_\_\_

Prior Vasectomy reversal? Y / N \_\_\_\_\_

History of Mumps after puberty? Y / N \_\_\_\_\_

Frequent hot tub or sauna use? Y / N \_\_\_\_\_

Any past or current anabolic steroid or creatine use? Y / N \_\_\_\_\_

Prior radiation or cancer treatment? Y / N \_\_\_\_\_

Recent fever? Y / N \_\_\_\_\_

History of tobacco abuse? Y / N \_\_\_\_\_

Major medical illness? Y / N \_\_\_\_\_

**Please list all prior surgeries:**

| Procedure & Date | Physician | Findings |
|------------------|-----------|----------|
| 1. _____         | _____     | _____    |
| 2. _____         | _____     | _____    |
| 3. _____         | _____     | _____    |
| 4. _____         | _____     | _____    |

Have you had any prior sexually transmitted infections? Yes \_\_\_ No \_\_\_

If "Yes", list infection: \_\_\_\_\_ Date \_\_\_\_\_

Was treatment received? Yes \_\_\_ No \_\_\_

**Medical History (Partner/Husband History, if applicable – Continued):**

**Allergies (list all reactions and offending drug or agent):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Medications (Please include dosages):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

How many alcoholic beverages do you have per week? \_\_\_\_\_

Do you smoke? Yes / No      If yes, number of cigarettes/day? \_\_\_\_\_ Years \_\_\_\_\_

Do you use any illicit drugs? Yes / No

Occupation: \_\_\_\_\_

Is there a family history of any of the following conditions?

| Condition   | Affected Person | Condition  | Affected Person |
|---|-----------------|--|-----------------|
| <input type="checkbox"/> Down Syndrome            | _____           | <input type="checkbox"/> Spina bifida (open spine) | _____           |
| <input type="checkbox"/> Heart defect             | _____           | <input type="checkbox"/> Mental retardation        | _____           |
| <input type="checkbox"/> Autism                   | _____           | <input type="checkbox"/> Other birth defects       | _____           |
| <input type="checkbox"/> Cystic Fibrosis          | _____           | <input type="checkbox"/> Learning disability/ADHD  | _____           |
| <input type="checkbox"/> Other inherited disorder | _____           | <input type="checkbox"/> Sickle Cell Anemia        | _____           |

Ethnicity/Race (please circle): Caucasian / African American / Hispanic / Asian / Mediterranean (Greek/Italian/other)/French Canadian / Eastern European / Other : / Other : \_\_\_\_\_

Do you have any of the following ancestry in your family?

- Ashkenazi Jewish       French Canadian

Patient ID: \_\_\_\_\_

## MALE DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_ Name you prefer to be called: \_\_\_\_\_

Marital Status: Married/ Single/Divorced/Separated/Widowed

Partner or spouse name (First, MI, Last) \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

| Phones:      | Order to be called | May we leave a message? |
|--------------|--------------------|-------------------------|
| Home _____   | 1 – 2 – 3          | ..... Yes / No          |
| Mobile _____ | 1– 2 – 3           | ..... Yes / No          |
| Work _____   | 1 – 2 – 3          | ..... Yes / No          |

Email: \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_\_ SSN: \_\_\_\_\_

Ethnicity/Race (please circle): Caucasian / African American / Hispanic / Asian / Mediterranean (Greek/Italian/other)

French Canadian / Eastern European / Other : / Other : \_\_\_\_\_

Local Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

## Referral Information

How did you hear about us? (check all that apply:)

Referring Physician: \_\_\_\_\_  
Referring Physician Phone: \_\_\_\_\_ Referring Physician Fax: \_\_\_\_\_

Internet, when searching for \_\_\_\_\_

Radio advertisement     Billboard     Print ad     Women's Expo/Taste of Home Show

Friend: \_\_\_\_\_     Other: \_\_\_\_\_

Patient ID: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**MALE INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder Sex: Male / Female

**Is the contact information for the policy holder the same as the patient contact information? Yes / No**  
**If No, please complete the information for the policy holder.**

Policy Holder Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Please list the order of the preferred method of contact: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

May we leave messages at all of the numbers above? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, list the number at which we may leave a message: \_\_\_\_\_

Email: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_\_ SSN: \_\_\_\_\_

Do you have secondary insurance? Yes / No

Patient ID: \_\_\_\_\_

**CONSENT FOR EMAIL COMMUNICATION**

I agree that I have been offered various forms of communication with Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) including telephone, fax, mail and email. I request that email may be used to communicate health information including future lab results. I understand that email accounts are not always secure and may not be able to protect the privacy of my health information. While TRM and TRL may be able to confirm the security of TRM's and TRL's email accounts, we cannot confirm the security of personal patient email accounts. Therefore, by signing this agreement, I relinquish TRM and TRL from any and all liabilities related to personal health information conveyed in email format if this is my chosen mode of contact for receiving lab results.

Please note that only short correspondence of evaluation results will be communicated via email. Physician consults cannot be conducted via email.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient ID: \_\_\_\_\_

**CONSENTS FOR FEMALE PATIENT**

Printed Patient Name: \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT**

I authorize Drs. Ringland Murray and Jessica Scotchie and their staff of Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) to conduct evaluations and render treatment for conditions related to fertility, reproductive endocrinology, gynecology and any associated disorders which may affect one of the prior conditions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION, TREATMENT INSTRUCTIONS AND PRESCRIPTIONS**

I authorize Drs. Ringland Murray and Jessica Scotchie and their staff of Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) to release information pertaining to my care to the phone numbers listed in my new patient information packet, pharmacy, referring physician, reference laboratories and insurance companies. I agree to update Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) of any changes in my contact information, insurance company and pharmacy. I understand that I have the right to withdraw this consent for the release of information at any time. Such withdrawal must be in writing. No information can be released after consent has been withdrawn.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"**

I have received a copy of Tennessee Reproductive Medicine, PLLC's Notice of Privacy Practices as required by HIPAA Privacy Regulations developed October 2002.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NEW PATIENT PACKET AND FINANCIAL RESPONSIBILITY**

I am aware that every effort has been made to verify my insurance coverage for services provided by Tennessee Reproductive Medicine (TRM). I understand that services rendered may not be covered by my health insurance or other health benefit program and I will be financially responsible for those services performed by Tennessee Reproductive Medicine (TRM) not covered by my health insurance. I also understand that Tennessee Reproductive Laboratories (TRL), which performs semen analyses, laboratory evaluation during treatment cycles and all laboratory management during assisted reproductive technology treatments, does not participate with any third party payers and is therefore a non-contracted laboratory. I agree to be financially responsible for any and all services rendered by Tennessee Reproductive Laboratories (TRL) prior to initiating treatment. I understand that payment for all services is expected in full at each visit. I acknowledge receipt and understanding of the New Patient Packet and all information included therein, and I accept responsibility for the terms and conditions related to financial responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENTS FOR HUSBAND/MALE PARTNER**

Printed Female Patient Name: \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT**

I authorize Drs. Ringland Murray and Jessica Scotchie and their staff of Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) to conduct evaluations and render treatment for conditions related to fertility, reproductive endocrinology, gynecology and any associated disorders which may affect one of the prior conditions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION, TREATMENT INSTRUCTIONS AND PRESCRIPTIONS**

I authorize Drs. Ringland Murray and Jessica Scotchie and their staff of Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) to release information pertaining to my care to the phone numbers listed in my new patient information packet, pharmacy, referring physician, reference laboratories and insurance companies. I agree to update Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) of any changes in my contact information, insurance company and pharmacy. I understand that I have the right to withdraw this consent for the release of information at any time. Such withdrawal must be in writing. No information can be released after consent has been withdrawn.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"**

I have received a copy of Tennessee Reproductive Medicine, PLLC's Notice of Privacy Practices as required by HIPAA Privacy Regulations developed October 2002.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NEW PATIENT PACKET AND FINANCIAL RESPONSIBILITY**

I am aware that every effort has been made to verify my insurance coverage for services provided by Tennessee Reproductive Medicine (TRM). I understand that services rendered may not be covered by my health insurance or other health benefit program and I will be financially responsible for those services performed by Tennessee Reproductive Medicine (TRM) not covered by my health insurance. I also understand that Tennessee Reproductive Laboratories (TRL), which performs semen analyses, laboratory evaluation during treatment cycles and all laboratory management during assisted reproductive technology treatments, does not participate with any third party payers and is therefore a non-contracted laboratory. I agree to be financially responsible for any and all services rendered by Tennessee Reproductive Laboratories (TRL) prior to initiating treatment. I understand that payment for all services is expected in full at each visit. I acknowledge receipt and understanding of the New Patient Packet and all information included therein, and I accept responsibility for the terms and conditions related to financial responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_