

Sperm Bank, Inc
dba Fertility Center of California
www.spermbankcalifornia.com
Registration Form



PATIENT INFORMATION:

FCC ACCT _____

Name: _____ Date of Birth: ___/___/___
SSN: _____
Address: _____ City: _____
State: _____ Zip _____ Home Phone (____) ____-____
May we contact you by email for information, billing or lab results? Yes or No (please circle one)
Email Address: _____

Partners Name: _____ SSN: _____
Work Number (____) ____-____ Cell Number (____) ____-____
Email Address: _____ DOB: ___/___/___

Have you ever **tested positive** for HIV, Hepatitis B, Hepatitis C, HTLV-I or II, RPR? Yes No
if Yes specify: _____

Privacy Policy: FCC requires a personal identification number (PIN) for release of information about your account. Please clearly print your PIN number now that you will remember _____

To whom, other than yourself, may FCC release information about your account
_____ name _____ relationship

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: _____ Relationship _____ Home phone _____
Address: _____ Work phone _____
SSN# _____

Referring Physician

Name _____ Phone# _____ Fax# _____

PAYMENT POLICY

Payment is due at time of service unless previous arrangements are made. We accept cash, checks and certain credit cards. Our office follows the California Civil Code 1719 for all returned checks. The patient named above acknowledges that should collection become necessary, the patient agrees to be responsible for all collection costs and attorney fees to collect the amount for services rendered. Personal information such as Social Security Number (SSN) will only be used by our office to turn the account over to collection. The copy of the photo ID will only be used to verify and ensure that no one else can claim to be you to access your records. All information provided by you is used strictly by Fertility Center of California.

PATIENT SIGNATURE BELOW IS REQUIRED

Your signature below acknowledges acceptance of our payment and privacy policies and agreement to keep FCC updated with your current address and contact information. After the billing interval assigned above, FCC will make one attempt to contact the patient via the address above. If there is no response by the patient or estate (in the case of death), then if any and all cryopreserved reproductive materials shall become the property of FCC to be disposed of by FCC or their delegates as solely and unilaterally determined by FCC management.

I, _____ am in agreement with all of the terms and conditions as listed above without recourse.

_____ signature ___/___/___ date

If the patient above is a minor, a parent or guardian of the minor must sign below:

_____ signature parent or guardian if applicable



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 read it carefully.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information and to obtain your signature that you received this while on the day of service. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until further notice.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable federal law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you at your next visit or it can be viewed in our office.

You may request a copy of our Notice at any time.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health information is contained in a medical record that is the physical property for Fertility Center of California (FCC).

How We May Use or Disclose Your Health Information

For Treatment

We may use or disclose your health information to a physician, a group of physicians or medical practice, or other healthcare providers providing treatment to you for:

- The provision, coordination, or management of health care and related services by health care providers;
- Consultation between health care providers relating to a patient/customer;
- The referral of a patient for health care from one health care provider to another/or
- Appointment reminders

For Payment

We may use and disclose your health information to others for purposes of processing and receiving payment for treatment and services provided to you. This may include:

- Billing and collection activities and related data processing;
- Actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provisions of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;
- Medical necessity and appropriateness of care reviews, utilization review activities; and
- Disclosure to consumer reporting agencies of information relating to collection of payments

For Health Care Operations

We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of staff to:

- Evaluate the performance of our associates;
- Assess the quality of service, product and care in your case and similar cases;
- Learn how to improve our facilities and services;
- Conduct training programs or credentialing activities; and
- Determine how to continually improve the quality and effectiveness of the service and care we provide.

Appointments, Treatment and Quality Assurance

We may use your information to provide appointment reminders or recall notices (such as Voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits, products and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

To You, Your Family and Friends

We must disclose your health information to you, as described in the Your Health Information Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons Involved in Care

We may use of disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location or your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up a specimen, medical supplies, or other similar forms of health information.

Required by law

We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence;
- To assist law enforcement officials in their law enforcement duties; or
- To assist public health officials avert a serious threat to the health or safety of you or any other person.



Decedents

Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Government Functions

Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information. This does not refer to fertility or any testing involved in your fertility care.

Workers Compensation

Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Marketing Health Products or Services

We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

Your Authorization

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those describe in this Notice.

Your Health Information Rights

Access

You have the right to review or get copies of your health information, with limited exceptions. You may be asked to make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice setting forth the specific information to which you desire access. If you request an alternative format, provided that it is practicable for us to produce the information in such format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operation, where you have provided an authorization and certain other activities, for the last six years, but not for disclosures made prior to April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication

You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. You may obtain a form to request an amendment to your health information by using the contact information listed at the end of this Notice.

Electronic Notice

If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

If you have any questions or complaints, please contact: Mel Cohen, 6699 Alvarado Rd., Suite 2208, San Diego, California 92120. Phone 619-265-0102, email: info@spermbankcalifornia.com

Thank you for entrusting FCC with your reproductive health services.