BUFFALO INFERTILITY & IVF ASSOCIATES

4510 MAIN STREET · SNYDER, NEW YORK · 14226 · OFFICE 716-839-3057 · FAX 716-839-1477

PATIENT PERSONAL INFORMATION – ALL INFORMATION IS STRICTLY CONFIDENTIAL

Date: _____

Referred by: _____

Patient Name: _____

Date of Birth: _____ Age: _____

Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Preferred contact number(s) (please rank order of preference) — OK to leave voicemail with medical results?

__ Cell Phone: _____ □ Yes □ No

__ Home Phone: _____ □ Yes □ No

__ Work Phone: _____ □ Yes □ No

Spouse/Partner's Name: _____

Date of Birth: _____ Age: _____

Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Preferred contact number(s) (please rank order of preference) — OK to leave voicemail with medical results?

__ Cell Phone: _____ □ Yes □ No

__ Home Phone: _____ □ Yes □ No

__ Work Phone: _____ □ Yes □ No

In case of Emergency, please notify:

Name: _____

Phone #: _____

Relationship: _____

PREFERRED PHARMACY

Name _____

Phone # _____

INSURANCE INFORMATION – PRIMARY (SELF)

Plan Name: _____

Policy Number: _____

Group Number: _____

Effective Date of Insurance: _____

SECONDARY INSURANCE / ADDITIONAL COVERAGE (SPOUSE)

Does patient have other health insurance? □ Yes □ No

If yes, name of policy holder: _____

Plan Name: _____

Policy Number: _____

Group Number: _____

Effective Date of Insurance: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____, and assign directly to Infertility & IVF Medical Associates of WNY all medical benefits. If any, otherwise payable to us for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance, including 33 1/3% collection costs and 50% attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of this signature on all submissions.

Signature of Insured: _____ Date: _____

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made directly to Infertility & IVF Medical Associates of WNY for any services rendered to me. I authorize any medical information about me to be released to the Health Care Administration and its agents and to any other health insurance or on approved claim forms or electronically submitted claims. I understand my signature requests payments to be made. In Medicare assigned cases, Infertility & IVF Medical Associates of WNY agrees to accept Medicare charge determination and I am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary's Signature: _____ Date: _____

MEDICAL HISTORY Do you have, or have you had, any of the following:

	Current	Past	Never		Current	Past	Never		Current	Past	Never
Serious Head Injury	□	□	□	Abdominal Pain	□	□	□	Thyroid Disease	□	□	□
Headaches	□	□	□	Indigestion	□	□	□	Diabetes	□	□	□
Fainting Spells	□	□	□	Nausea / Vomiting	□	□	□	Endocrine Disorder	□	□	□
Dizziness	□	□	□	Change in Bowel Habits	□	□	□	Night Sweats	□	□	□
Convulsions / Epilepsy	□	□	□	Diarrhea	□	□	□	Fevers or Chills	□	□	□
Ringing in Ears	□	□	□	Constipation	□	□	□	Hot Flushes	□	□	□
Deafness	□	□	□	Hemorrhoids	□	□	□	Vaginal Dryness	□	□	□
Glaucoma	□	□	□	Anal Fissures	□	□	□	Weight Change	□	□	□
Eye Pain	□	□	□	Bloody Stools	□	□	□	Poor Appetite	□	□	□
Disturbance of Vision	□	□	□	Peptic Ulcers	□	□	□	Excessive Weakness	□	□	□
Nosebleeds	□	□	□	Appendicitis	□	□	□	Excessive Sweating	□	□	□
Hoarseness	□	□	□	Gall Bladder Disease	□	□	□	Unwanted Hair Growth	□	□	□
Sores in Mouth	□	□	□	Jaundice / Hepatitis	□	□	□	Unwanted Hair Loss	□	□	□
Dentures	□	□	□	Mononucleosis	□	□	□				
Difficulty Swallowing	□	□	□	Hernia	□	□	□	Anemia	□	□	□
								Blood Transfusion	□	□	□
Sinusitis	□	□	□	Bladder Infection	□	□	□	Bleeding Disorder	□	□	□
Asthma	□	□	□	Kidney Infection	□	□	□	Blood Disease	□	□	□
Chronic Cough	□	□	□	Kidney Stones	□	□	□				
Pneumonia	□	□	□	Kidney Disease	□	□	□	Cancer	□	□	□
Chest Pain	□	□	□	Blood in Urine	□	□	□	Lump(s) in Breast(s)	□	□	□
Shortness of Breath	□	□	□	Pus in Urine	□	□	□	Lump(s) in Neck	□	□	□
Tuberculosis	□	□	□	Sugar in Urine	□	□	□	Lump(s) in armpit/groin	□	□	□
COPD	□	□	□	Up to Urinate at Night	□	□	□	Leg Cramps	□	□	□
				Urgent Urination	□	□	□	Pain / Swelling of Feet	□	□	□
High Blood Pressure	□	□	□					Varicose Veins	□	□	□
High Cholesterol	□	□	□	Anxiety	□	□	□	Skin Sores	□	□	□
Rapid / Irreg Heartbeat	□	□	□	Depression	□	□	□				
Heart Palpitations	□	□	□	Nervousness	□	□	□	Measles (Rubeola)	□	□	□
Heart Murmur	□	□	□	Excessive Worry	□	□	□	Rubella	□	□	□
Heart Disease	□	□	□	Nightmares	□	□	□	Mumps	□	□	□
Rheumatic Fever	□	□	□	Thoughts of Suicide	□	□	□	Chicken Pox	□	□	□

MEDICATIONS Please list all medications, including prescription, over the counter, vitamins and herbs

□ I do not take any medications

	Medication	Dose	How Often		Medication	Dose	How Often
1	_____	_____	_____	6	_____	_____	_____
2	_____	_____	_____	7	_____	_____	_____
3	_____	_____	_____	8	_____	_____	_____
4	_____	_____	_____	9	_____	_____	_____
5	_____	_____	_____	10	_____	_____	_____

CONTRACEPTIVE USE

□ I have never used contraceptives

	Type	Start Date	End Date	Reason Discontinued
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____

ALLERGIES Please list all allergies to medications, foods, or latex

☐ **I have no known allergies**

	Allergic to	Reaction		Allergic to	Reaction
1			4		
2			5		
3			6		

SURGICAL HISTORY Please list all previous surgical procedures

☐ **I have never had surgery**

	MM/YYYY	Surgical Procedure	Hospital	Surgeon	Complications
1					
2					
3					
4					
5					

FAMILY HISTORY Have your parents, grandparents, siblings, or children been diagnosed or treated for the following:

	Yes	No	If Yes, Relation		Yes	No	If Yes, Relation		Yes	No	If Yes, Relation
Cancer	☐	☐		Heart Disease	☐	☐		Thyroid Disease	☐	☐	
Breast	☐	☐		High Blood Pressure	☐	☐		Diabetes	☐	☐	
Ovarian	☐	☐		High Cholesterol	☐	☐		Endocrine Disorder	☐	☐	
Infertility	☐	☐		Kidney Disease	☐	☐		Blood Disease	☐	☐	
Recurrent Miscarriages	☐	☐		Kidney Stones	☐	☐		Muscular Disorders	☐	☐	
Early Menopause	☐	☐		Epilepsy	☐	☐		Neurologic Disorders	☐	☐	
Endometriosis	☐	☐		Anxiety / Depression	☐	☐		Glaucoma	☐	☐	
Fibroids	☐	☐		Mental Illness	☐	☐		Lung Disease	☐	☐	
PCOS	☐	☐		Suicide	☐	☐		Tuberculosis	☐	☐	

SOCIAL HISTORY

	Yes	No	
Do you smoke?	☐	☐	If Yes, how much?
Do you use alcohol?	☐	☐	If Yes, how much?
Do you use recreational drugs? (ex. marijuana, cocaine, heroin, etc)	☐	☐	If Yes, please describe
Do you use caffeine? (ex. coffee, tea, soda,etc)	☐	☐	If Yes, please describe
Do you exercise?	☐	☐	If Yes, please describe

OBSTETRICAL HISTORY Please list all previous pregnancies

☐ **I have never been pregnant**

#	MM/YYYY	Duration of Pregnancy (# weeks, miscarriage, full term)	If Delivered, Method of Delivery (Vaginal, C-section)	If Miscarriage, was a procedure required (D&C)?	If Live Birth, Sex, Weight		Complications
1							
2							
3							
4							
5							
6							

GYNECOLOGIC HISTORY

			Comments
Do you menstruate?	□ Yes	□ No	
Date that your last period began:	_____		
Date that your previous period began:	_____		
At what age did you have your first period?	_____		
My periods are:	□ Regular	□ Irregular	
Average number of days between periods:	_____		
Average number of days that you have bleeding:	_____		Menstrual flow is: □ Scant □ Moderate □ Heavy □ Excessive
Do you pass clots with your periods?	□ Yes	□ No	
Do you have pain with your periods?	□ Yes	□ No	
Do you have pain during/after intercourse?	□ Yes	□ No	
Have you ever missed school or work due to pain or excessive bleeding?	□ Yes	□ No	
Do you have bleeding/spotting between menstrual periods?	□ Yes	□ No	
Do you have bleeding/spotting after intercourse?	□ Yes	□ No	
Have you ever used contraception?	□ Yes	□ No	What kind(s)? _____
Have you ever been diagnosed with:			
Polycystic Ovary Syndrome (PCOS)	□ Yes	□ No	
Endometriosis	□ Yes	□ No	
Uterine Fibroid(s)	□ Yes	□ No	
Endometrial Polyp(s)	□ Yes	□ No	
Ovarian Cyst(s)	□ Yes	□ No	
Sexually Transmitted Infection	□ Yes	□ No	
Pelvic Inflammatory Disease (PID)	□ Yes	□ No	
Have you ever had an abnormal Pap smear?	□ Yes	□ No	Date of last Pap smear: _____

SEXUAL HISTORY

	Yes	No	
Are you sexually active?	□	□	
Is your partner male?	□	□	
Have you used over the counter ovulation kits to time intercourse?	□	□	
Do you use lubricants during intercourse?	□	□	If Yes, what types _____

SYSTEMIC REVIEW

WEIGHT _____ MAXIMUM WEIGHT _____ MINIMUM WEIGHT _____

HEIGHT _____

Do / have you participated in any significant dietary changes over the past 3 years? _____

Do/ have you participated in any exercise programs over the past 3 years? _____

If so please document exercise Type _____ Hours per week_____

Type _____ Hours per week _____

*The effect of being overweight on fertility therapies have been well documented.

*Please speak with your physician regarding weight loss attempts and ideal weight range for your height

*Obesity does not usually cause infertility but it may have a significant impact on treatment responses & may have multiple negative effects on both you & fetus

ETHNICITY * Data will be used for genetic testing recommendation purposes

□ Caucasian □ Hispanic □ Asian □ African American □ Other _____

Do you or anyone in either family have?

□ Neural tube defects /spina bifidal /anencephaly	□ Cystic fibrosis	□ Tay- Sachs disease	□ Chromosomal disorder
	□ Muscular dystrophy	□ Sickle Cell disease or trait	□ Genetic / inherited disorder
□ Thalassemia	□ Huntington chorea	□ Hemophilia	□ Baby with birth defects
□ Down Syndrome	□ Mental retardation/ fragile X	□Hormonal disorder	□ Infertility
□ Hydrocephalus	□ Epilepsy or seizures	□ Kidney Disease	□ Mental illness
□ Stillbirth	□ Phenylketonuria	□ Neurofibromatosis	□ Myotonic dystrophy
□ 3 or more miscarriages	□ Diabetes		
□ **Any birth defects?**	□ **Any inherited disorders?**		

Please explain a "Yes" answer to any of the above _____

_____

_____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on you ethnicity. Are you:

African American □ Yes □ No Ashkenazi Jewish □ Yes □ No

Mediterranean / Asian / French Canadian □ Yes □ No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

HISTORY OF FERTILITY THERAPY (Fill out if applicable)

Have you been treated for infertility previously? □ YES □ NO

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Please check all that apply:

□ Clomid (Serophene)	□ hCG Profasi	□ Antibiotics
□ Gonal F	□ Progesterone	□ baby Aspirin
□ Follistim	□ Lupron	□ Heparin
□ Repronex	□ Microdose Lupron	□ Steroids
□ Pergonal	□ Antagon	□ Oral Contraceptives
□ Fertinex	□ Parlodel	□ Other ……

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

□ Hysterosalpingogram	When _____/_____/_____	Results ……
□ Sonohysterogram	When _____/_____/_____	Results ……
□ Laparoscopy, Hysteroscopy	When _____/_____/_____	Results ……
□ Thyroid tests	When _____/_____/_____	Results ……
□ Chromosomes	When _____/_____/_____	Results ……
□ Genetic Screening	When _____/_____/_____	Results ……

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? □ YES □ NO

If yes, □ partner □ donor sperm #IUI's _____ #IVF cycle _____

PRESENT COMPLAINT Please state briefly what you would like to address during your visit

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Patient's Signature Date

I confirm that I have reviewed the above information

_____ _____

Physician's Signature Date

BUFFALO INFERTILITY & IVF ASSOCIATES
4510 MAIN STREET · SNYDER, NEW YORK · 14226 · OFFICE 716-839-3057 · FAX 716-839-1477

PATIENT PERSONAL INFORMATION – ALL INFORMATION IS STRICTLY CONFIDENTIAL

MALE HISTORY FORM

Date: _____

Name: _____ Date of Birth: _____ Age: ____

MEDICAL HISTORY Do you have, or have you had, any of the following:

	Current	Past	Never		Current	Past	Never		Current	Past	Never
Cancer	□	□	□	Tuberculosis	□	□	□	Serious injury / accident	□	□	□
Diabetes	□	□	□	Hepatitis / liver disorder	□	□	□	Blood transfusion	□	□	□
Hypertension	□	□	□	Gall bladder problems	□	□	□	Psychiatric disorder	□	□	□
High Cholesterol	□	□	□	Ulcers	□	□	□	Seizures	□	□	□
Heart Disease	□	□	□	Colitis / enteritis	□	□	□	Stroke	□	□	□
Rheumatic Fever	□	□	□	Kidney Disorder	□	□	□	Blood clots	□	□	□
Scarlet Fever	□	□	□	Rubella	□	□	□	Anemia	□	□	□
Mitral valve prolapse	□	□	□	Multiple sclerosis	□	□	□	Bleeding disorder	□	□	□
Asthma	□	□	□	Mumps	□	□	□	Thyroid disorder	□	□	□
Pneumonia	□	□	□	Prostatic infections	□	□	□	Recent immunization	□	□	□
Bronchitis	□	□	□	Urinary infections	□	□	□				

Any Medical problem not listed above (please list type, dates, treatments)

1. _____
2. _____

MEDICATIONS Please list all medications, including prescription, over the counter, vitamins and herbs

☐ **I do not take any medications**

	Medication	Dose	How Often		Medication	Dose	How Often
1	_____	_____	_____	4	_____	_____	_____
2	_____	_____	_____	5	_____	_____	_____
3	_____	_____	_____	6	_____	_____	_____

ALLERGIES Please list all allergies to medications, foods, or latex

☐ **I have no known allergies**

	Allergic to	Reaction		Allergic to	Reaction
1	_____	_____	4	_____	_____
2	_____	_____	5	_____	_____
3	_____	_____	6	_____	_____

SURGICAL HISTORY Please list all previous surgical procedures

☐ **I have never had surgery**

	MM/YYYY	Surgical Procedure	Hospital	Surgeon	Complications
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____

FAMILY HISTORY Have your parents, grandparents, siblings, or children been diagnosed or treated for the following:

	Yes	No	If Yes, Relation		Yes	No	If Yes, Relation		Yes	No	If Yes, Relation
Cancer	□	□	_____	Heart Disease	□	□	_____	Thyroid Disease	□	□	_____
Breast	□	□	_____	High Blood Pressure	□	□	_____	Diabetes	□	□	_____
Ovarian	□	□	_____	High Cholesterol	□	□	_____	Endocrine Disorder	□	□	_____
Infertility	□	□	_____	Kidney Disease	□	□	_____	Blood Disease	□	□	_____
Recurrent Miscarriages	□	□	_____	Kidney Stones	□	□	_____	Muscular Disorders	□	□	_____
Early Menopause	□	□	_____	Epilepsy	□	□	_____	Neurologic Disorders	□	□	_____
Endometriosis	□	□	_____	Anxiety / Depression	□	□	_____	Glaucoma	□	□	_____
Fibroids	□	□	_____	Mental Illness	□	□	_____	Lung Disease	□	□	_____
PCOS	□	□	_____	Suicide	□	□	_____	Tuberculosis	□	□	_____

SOCIAL HISTORY

	Yes	No	
Do you smoke?	□	□	If Yes, how much? _____
Do you use alcohol?	□	□	If Yes, how much? _____
Do you use recreational drugs? (ex. marijuana, cocaine, heroin, etc)	□	□	If Yes, please describe _____
Do you use caffeine? (ex. coffee, tea, soda,etc)	□	□	If Yes, please describe _____
Do you exercise?	□	□	If Yes, please describe _____

PREGNANCY HISTORY (that you have been responsible for)

☐ **I have never initiated a pregnancy**

Date MM/YY	Miscarriage?	Elective Abortion?	Months to Conceive?	Infertility Treatment?	Weight and Sex?	Complications?
1.						
2.						
3.						

HISTORY OF FERTILITY THERAPY (Fill out if applicable)

Have you been treated for infertility previously? □ YES □ NO

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What medications have you taken for infertility? _____

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

□ Semen Analysis When _____/_____/_____ Results ……

□ Chromosomes When _____/_____/_____ Results ……

□ Genetic screening When _____/_____/_____ Results ……

□ Other _____ When _____/_____/_____ Results ……

UROLOGIC HISTORY (if applicable)

Have you been evaluated by an urologist? □ Yes □ No

Are you able to ejaculate inside your partner's vagina? □ Yes □ No

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

Have you had any of the following sexually transmitted disease or severe testicular pain?

□ Yes (check all that apply) □ No

□ Chlamydia – date _____ □ Gonorrhea – date _____ □ Herpes – date _____ □ Genital Warts / HPV – date _____

□ Syphilis – date _____ □ HIV/AIDS – date _____ □ Hepatitis – date _____ □ Other

Have you had a history of undescended testicles? □ Yes One side _____ Both _____ □ No

Have you ever had torsion / twisting of the testicles? □ Yes □ No

Did you have mumps after puberty? □ Yes □ No

Have you had injury to your testicles requiring an ER visit or hospitalization? □ Yes □ No

Have you had a fever (>101'F) in the past 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 varicocele surgery? □ Yes □ No

Have you had hernia surgery? □ Yes □ No

Have you had other surgery to the scrotum or groin area? □ Yes □ No

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

Are you exposed to harmful chemicals or fumes in the workplace? □ Yes □ No

Do you use hot tubs regularly? □ Yes □ No

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

ETHNICITY * Data will be used for genetic testing recommendation purposes

□ Caucasian □ Hispanic □ Asian □ African American □ Other _____

Do you or anyone in either family have?

□ Neural tube defects /spina bifidal /anencephaly	□ Cystic fibrosis	□ Tay- Sachs disease	□ Chromosomal disorder
	□ Muscular dystrophy	□ Sickle Cell disease or trait	□ Genetic / inherited disorder
□ Thalassemia	□ Huntington chorea	□ Hemophilia	□ Baby with birth defects
□ Down Syndrome	□ Mental retardation/ fragile X	□Hormonal disorder	□ Infertility
□ Hydrocephalus	□ Epilepsy or seizures	□ Kidney Disease	□ Mental illness
□ Stillbirth	□ Phenylketonuria	□ Neurofibromatosis	□ Myotonic dystrophy
□ 3 or more miscarriages	□ Diabetes		
□ **Any birth defects?**	□ **Any inherited disorders?**		

Please explain a "Yes" answer to any of the above _____

_____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on you ethnicity. Are you:

African American □ Yes □ No Ashkenazi Jewish □ Yes □ No

Mediterranean / Asian / French Canadian □ Yes □ No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

_____ _____

Partner's Signature Date

I confirm that I have reviewed the above information

_____ _____

Physician's Signature Date

KRYSTENE B. DIPAOLA, M.D.
ADAM M. GRIFFIN, M.D.
MICHAEL W. SULLIVAN, M.D.

Notice of Privacy Practices

PURPOSE:
This notice describes how your medical information may be used, disclosed and how you can have access to this information. Please review carefully.

This notice takes effect January 1, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION
   The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY
   Law requires us to:
   - Keep your medical information private
   - Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
   - Follow the terms of the notice that is now in effect

   We have the right to:
   - Change the privacy practices and the terms of this notice at any time, provided that the changes are permitted by law
   - Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep , including information previously created or received before the changes

   Notice of change to privacy practices:
   - Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. For each kind of use or disclosure, we will explain that we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you.

We may also share medical information about you to your other health care providers to assist them in treating you.

We may disclose your medical information for payment purposes.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activates required by the Food and Drug Administration. We may also, when we

are authorized by law to do so, notify a person who may been exposed to a communicable disease or otherwise be a risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Health Oversight Activities: We may disclose information to an agency providing health oversight for activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reported by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have the right to:

1. Look at or get copies of your medical information. You may request that we provide copied in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $.75 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use of disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. You request that we communicate your medical information to you by different means or at different locations must be made in writing to contact the person listed at the end of this notice.
5. Request that we change medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed.

If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at eh end of this notice.

We may leave messages at the phone numbers & addresses that are on file, as provided by you. It is your responsibility to notify us of any changes.

QUESTIONS AND COMPLAINTS

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Judith Winters, Office Manager

(716)839-3057

If you think that we may have violated your privacy rights, contact the person above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S. Department of health and Human Services. We will not retaliate in any way if you choose to file a complaint.

KRYSTENE B. DIPAOLA, M.D.
ADAM M. GRIFFIN, M.D.
MICHAEL W. SULLIVAN, M.D.

Buffalo
INFERTILITY & IVF ASSOCIATES

Notice of Privacy Practices

Buffalo Infertility & IVF Associates may leave messages at the phone numbers listed below & use the address that is on file.

It is the patient's responsibility to notify Buffalo IVF & Infertility of any changes.

Phone numbers:

Home: _____

Cell: _____

Work: _____

Other: _____

E-Mail:

_____

Acknowledgement Form

I have had the opportunity to review the Notice of Privacy Practices that is posted on BuffaloIVF.com or have requested a copy to review.

Name: _____ Date of Birth: _____

Signature: _____

Date: _____

KRYSTENE B. DIPAOLA, M.D.
ADAM M. GRIFFIN, M.D.
MICHAEL W. SULLIVAN, M.D.

Buffalo
INFERTILITY & IVF ASSOCIATES

Thank you so much for choosing Buffalo IVF for your care!

We're curious how did you hear about us?

Please select all that apply:

- ☐ Referred from a physician's office
  If yes, which office _____
- ☐ Referred by a friend, relative or acquaintance
  If yes, relationship _____
  In person, phone, email or social media _____
- ☐ Referred by social media
  If yes, Facebook, Instagram, Other _____
- ☐ Online Search
  If yes, did you search…?
  Buffalo IVF specifically _____
  One of our doctors specifically _____
  Services/Care that was needed _____
- ☐ Online Reviews
  If yes, Please identify which site _____

Your input helps us deliver a better experience to all of our patients. In a few sentences, could you please describe how you made your decision to come to Buffalo IVF…

_____
_____
_____

Thank you for your time!