FLORIDA FERTILITY INSTITUTE/TUBAL REVERSAL EXPERTS
PATIENT INFORMATION FORM

The information requested on this form is an important part of your medical record. **Completion of a preliminary health questionnaire does not establish a physician-patient relationship with Florida Fertility Institute/Tubal Reversal Experts.**

Full Legal Name____ Date of Birth______________________

Address____ Social Security #_________________________

____ Race______________ Marital Status_________
City State Zip

Home #_________________ Cell #_________________ Work #_________________ Partner_________________________

Email____ Employer____

Please provide an ENLARGED copy of your DRIVER'S LICENSE or other PHOTO ID with your completed paperwork.

TUBAL REVERSAL PATIENTS SHOULD ESTABLISH WITH A **HIGH-RISK OBGYN** FOR THEIR CONTINUED CARE.
It is important you are seen at the first sign of pregnancy.

☐ I DO NOT HAVE A HIGH-RISK OBGYN at this time.
*A copy of your operative report will be mailed to you 2-3 weeks after surgery to provide to the specialist you establish with.

☐ I HAVE ESTABLSIHED with a HIGH-RISK OBGYN and am providing their contact information below.

Name of High-Risk OBGYN ____

Address____
City State Zip

Phone#__________________________________ Fax #________________________________

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

____

May be contacted: ☐ in the event of an emergency ONLY ☐ at any time / Initials___________ Date________________

Statement of Acceptance: I, the undersigned, acknowledge and accept financial responsibility for any and all charges associated with my surgery, including, but not limited to, consultation, any preliminary testing, surgical fees and/or cancellation fees. I have read and consented to the practice's Financial Policies, am aware that $500 of my surgery fees are non-refundable and that my surgery WILL BE CANCELLED if I fail to pay in full, at the time of scheduling. As a HIPPA compliant medical facility, Notice of Privacy Practices have been made available to me. I understand that video and/or audio recording is strictly prohibited and that is my responsibility to keep the practice informed of any changes to my personal information.

Signature____ Date____________________________

FINANCIAL POLICIES

Tubal Reversal Reanastamosis, more commonly known as "tubal reversal" is considered an elective procedure. You have been determined eligible for a tubal reversal based on the physician's review of the history and/or records provided. While our goal is for you to have a successful surgery, as with any surgery, there are no guarantees.

Quotes

- Quotes are valid for 60 days and Promotional quotes are only valid during the term of the promotion.

Guarantees

- The success of surgery can only be truly determined at the time of surgery itself. Therefore; there are no guarantees, refunds or warranties written or implied.

Fees

- **Consult Fees** are due at the time of service unless consult is on day of surgery, then fees are due at the time of surgery scheduling.
- **Surgical Fees** are due at the time of surgery scheduling. Patients scheduled at **Countryside** will receive a reduction in surgical fees of $1,000 which they will pay to Countryside the day of their procedure.

Payment Methods

- Credit/Debit card (2% fee added), Cash or Cashier's Check/Money Order payable to 'Florida Fertility Institute.'
- This is a Self-Pay procedure, not covered or reimbursed by insurance.

Finance Companies

- Loans funded to us, the provider, must be reduced by $900 which the patient is responsible for paying.

Changes to Surgery

- **Cancellation of Surgery**:
  Cancellation of surgery results in forfeiture of a percentage of fees as follows:

  Merchant card fees are non-refundable.

Days Between Surgery & Cancellation Date	Percentage of Funds Retained by FFI	Percentage of Funds Refunded to Patient
31 Days or More	30%	70%
22 – 30 Days	50%	50%
15 – 21 Days	70%	30%
7 – 14 Days	90%	10%
6 Days or Less	98%	2%

- **Rescheduling of Surgery**:
  Requests 60 days or more from the surgery date will result in a $750 fee due at the time of rescheduling.
  Requests 59 days or less from the surgery date will result in a cancellation of surgery.

- All refunds must be processed by the means originally paid and can take 4-6 weeks to fully process.

Statement of Acceptance

By signing below, I attest that I have read, acknowledge and accept all of the aforementioned policies. I understand that all charges/balances incurred are my financial responsibility inclusive of fees for medical services rendered, all legal fees potentially associated with my account and any associated fees as herein described. I understand that this is a self-pay procedure. I am aware that I may not submit to insurance for this procedure as it has been discounted to a self-pay rate, is a global fee and encompasses services from multiple providers; therefore, any submission on my part may be a misrepresentation of actual, true charges.

_____/_____/_______   ________________________________   ________________________________

Date   Patient Name (Printed)   Patient Signature

SURGERY CONSENT FORM

Patient Name: ___________________________________

1) I authorize and direct Mark Sanchez, M.D. and/or Yissa Fonticiella, M.D. and their associates to perform the following surgery on me: *Exploratory Laparotomy Micro Tubal Reanastomosis* and to perform any other surgical procedure that medical judgement may dictate advisable for me for future conception or necessary to perform my Micro Tubal Reanastomosis. *Examples may include* lysis of adhesions or removal of endometriosis via laparoscopy. In these instances, the patient may be responsible for additional fees to the surgery center, anesthesia and pathology which are separate entities from Florida Fertility Institute.

2) The nature of the operation has been fully explained to me as well as the risks, benefits, complications and alternatives. No warranty or guarantee has been made as to the result.

3) I understand that Dr. Sanchez and/or Dr. Fonticiella may use resident physicians to assist in the surgery and that following the surgery the resident physician will be responsible for my in-hospital care (if necessary) and report my progress to my surgeon.

4) I understand that the Dr. Sanchez and/or Dr. Fonticiella and their associates or assistants will be occupied solely with performing the surgical operation, and the person or persons performing services involving pathology and radiology, are not the agents, servants or employees of Dr. Sanchez and/or Dr. Fonticiella, but are independent contractors.

5) I understand my surgery is scheduled at ___________________________________ on ____________________ and that I must be accompanied by a friend/family member over 18 years old with proper identification in order to be released from the surgery center.

I acknowledge acceptance of this agreement by my signature below:

______/______/______ ___________________________________
Date Print Name

______/______/______ ___________________________________
Date Patient Signature

MICROSURGICAL TUBAL RECONSTRUCTION VIA LAPAROTOMY CONSENT FORM

Dr. Mark Sanchez and/or Dr. Yissa Fonticiella has determined that you are infertile or sterile and the reason for this condition may be because your fallopian tubes are not open. The fallopian tubes are the tubes in the female pelvis, which allow the egg produced by your ovaries to reach your uterus or womb. If these tubes are closed, it is unlikely that the sperm could come into contact with the egg resulting in pregnancy. You and your physician are considering an operation on your fallopian tubes to try and make them open in an attempt to make you fertile. This operation will not help you physically. It is only preformed on those women who have an overwhelming desire to become pregnant. Furthermore, as in any operation there exists the possibility of complications developing. **It is possible that this operation will not help, it is even possible that you will be worse after the operation.** Your physician can make no guarantee as to the results or benefits that may be obtained from this operation.

Fallopian tube reconstruction is performed via mini laparotomy, requiring a surgical cut in the lower abdomen. Following such incision the physician may find that the fallopian tubes are too damaged to repair and no reconstruction can be performed. Complications from microsurgical tubal anastomosis are infrequent but can occur. Some possible complications of this operation include bleeding, infection, generalized disease and inflammation of the lining of the abdomen, abnormal or “ectopic” pregnancy, hernia or “rupture” developing at the site of the surgical cut in the abdomen, damage to the nerves going to the legs, causing weakness, numbness, and pain in the thighs, legs, and feet, damage to the intestines, blocked bowels, pneumonia, blood clots in the legs and lungs, stroke and heart attacks. These complications can result in prolonged illness, the need for blood transfusions, poor healing, scarring and the need for further surgical operations.

An ectopic pregnancy is a pregnancy that develops in the fallopian tubes instead of in the uterus or womb. Approximately 10% of women who have pregnancies following pelvic microsurgery have the pregnancy occur in the fallopian tube. This type of pregnancy may require further surgery and always results in termination of the pregnancy without live birth. Some of the other possible complications of fallopian tube reconstruction can cause prolonged illness, scarring, poor healing wounds, and permanent deformity. Very rarely, some of the complications of fallopian tube reconstruction can even cause death. The purpose of this form is to ensure that your decision to have surgery is made with full knowledge of the risks of this kind of operation.

I CERTIFY: I have read or had read to me the contents of this form; I understand the risks, complications and alternatives involved in this operation. I have had the opportunity to ask any questions which I had, and all my questions have been answered. I understand the procedure(s) and the potential risks and complications associated with the procedure(s) and that alternative procedure(s) may be available. I sign this consent freely and voluntarily and by my signature below, consent to the procedure(s) discussed herein.

DATE: ______/_______/_______ SIGNED: ___________________________________

Patient Signature

I have consulted with and explained the contents of this consent form to the person above.

DATE: ______/_______/_______ SIGNED: ___________________________________

Physician Signature

FLORIDA FERTILITY INSTITUTE
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)

By ____ Date ____________________
Healthcare Provider or Authorized Representative

WAIVERS OF LIABILITY

Tubal Reversal Reanastamosis, more commonly known as, “tubal reversal” is considered an elective procedure. You have been determined eligible for a tubal reversal based on the physician’s review of the history and/or records provided. While our goal is for you to have a successful surgery, as with any surgery, there are no guarantees. Ultimately, the success of surgery can only be known at the time of surgery itself.

What defines a successful surgery?
A tubal reversal is considered successful when one or both tubes are successfully repaired AND when one or both tubes are determined “patent” open at the conclusion of surgery.

There is a possibility the tubes can close during the healing process. It is important to follow your post-operative guidelines to allow for appropriate healing. Our nurse is available by phone for any questions or concerns you might have.

It is important you establish with a high-risk OBGYN for your continued care as you should be seen at the first sign of pregnancy.

MALE FERTILITY: Our practice recommends semen analysis testing to evaluate any potential male fertility factor that may hinder or prevent successful conception.

ADVANCED MATERNAL AGE FACTORS: Our practice recommends specialized blood work called an (AMH – Anti-Mullerian Hormone) for women of advanced maternal age. Statistically, by around the age of 42 there is typically less than a 5% chance of successful conception due to changes in hormone levels and ovarian reserve (egg quality and quantity).

CONSENT: By signing below I am consenting to allow Dr. Mark Sanchez and/or Dr. Yissa Fonticiella to proceed with the tubal reversal surgery. I understand that there are no guarantees or warrantees, written or implied. I understand the potential risks and complications and outcomes of this operation. I understand that this is an elective procedure and that alternative procedure(s) may be available. By signing I revoke any rights relative to recourse from surgical outcomes as they relate to these factors. All of my questions regarding the procedure have been addressed to my satisfaction. I am signing this waiver/consent of my own free will.

_______________________________________   _______/_______/_______

Patient Name (Printed)   Date

____

Patient Signature

PREOPERATIVE INSTRUCTIONS

You have been scheduled to undergo surgery at: ____

Your procedure is called: Exploratory Laparotomy with Micro-Surgical Tubal Anastomosis

The date of your surgery is: ______________________

The hospital will call you regarding your time of arrival.

REMEMBER: Your pre-operative labs must be completed seven (7) days before your scheduled surgery date. The pre-operative labs do not have to be done fasting. The nurse will only phone regarding your lab results if they are not within normal limits.

It is very important that you do not eat or drink anything after midnight the day prior to your surgery. This includes: food, water, beverages, candy and chewing gum. Please be advised that your surgery may be cancelled if you eat or drink past midnight.

It is very important that you do not take any aspirin, diet pills, herbal supplements or vitamins, or any over-the-counter pain reliever other than Tylenol two weeks prior to your surgery. Please check with your primary care physician for instructions on what medications are okay before surgery. Please be advised that your surgery may be cancelled if any of the above listed medications are taken.

Be advised that a urine drug screen may be included in your pre-operative laboratory evaluation and your surgery may be cancelled if there is a positive test.

If you have any questions about any of these instructions or about your surgery, please contact the office at (727) 796-7705 and ask to speak with the nurse.

____ ____________________________

Patient Name (Print) Date

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Patient Signature