

FACT SHEET: Copper IUD



How does the copper IUD help me?

- The copper IUD is a hormone-free option.
- If you don't like the copper IUD or you decide to get pregnant, your health care provider can remove the copper IUD at any time.
- The copper IUD is safe and effective birth control which protects from pregnancy for 10 years. The copper IUD has no effect on your ability to get pregnant in the future after you have it removed.

How does the copper IUD work?

- The copper IUD is a small, soft, flexible T-shaped device primarily composed of plastic and copper. A health care provider inserts the copper IUD in your uterus.
- The copper IUD works for 10 years.
- The copper IUD works by the interaction of copper ions with the uterine environment. The copper ions interfere with egg fertilization, sperm movement, and are toxic to the sperms themselves. Without live sperm, you cannot get pregnant.
- No method of birth control is 100% effective. The copper IUD is over 99% effective.

Can I feel the IUD?

- Many women like to check their IUD's string after each period.
- To check, insert a finger into your vagina and feel for the cervix (it feels like the tip of your nose.) You should feel the string near your cervix. Do NOT pull on the string. If you cannot feel the string, contact your healthcare provider.
- The IUD should not hurt or cause discomfort once placed in the uterus.
- Your partner won't usually be able to feel the IUD string.

What the IUD will NOT do:

Protect you from sexually transmitted infection, heartbreak, or having inappropriate postings put up about you on twitter™ and facebook™. It is YOUR responsibility to make appropriate sexual decisions and to recognize and avoid unhealthy relationships.

If you choose to touch naked people...
USE CONDOMS EVERYTIME
you have any kind of sexual contact

Will it make me gain weight?

- The copper IUD has no hormones, so it has no effect on your weight. Most young women begin using birth control at a time when they would be gaining a small amount of weight anyway. Seniors are bigger than freshman—they're supposed to be; a woman's weight typically doesn't stabilize until her early 20's.

Does the copper IUD have risks?

- The copper IUD is very safe. If you have any of the following symptoms within the first 3 weeks after insertion, see your health care provider: Fever (>101°F), chills or strong pain in your belly.
- If you have any of the following symptoms at any time while you have the IUD in you, see your health care provider: feeling pregnant (breast pain, nausea), positive home pregnancy test.

What happens after the IUD is inserted?

- You must wait 24 hours after the IUD is inserted before you can use tampons, take a bath or have sex.
- The first follow-up will be in 4 weeks.

When does the IUD start protecting against pregnancy?

- The copper IUD works right after it is placed in you.
- GTW recommends condoms for on-going for disease protection.

What happens to my periods?

- You may have slightly heavier periods and cramps as long as the IUD is inside you. Take Aleve, 2 tablets every 12 hours for 3-5 days to decrease cramps and bleeding, if it happens.
- If bleeding is extremely heavy or associated with fever or severe abdominal pain, contact your doctor's office.

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When is the IUD inserted?

- Your physician will recommend when to schedule the insertion procedure based on your menstrual cycle and the kind of birth control you are currently using. Do not stop your current birth control until advised by your physician.
- GTW recommends condoms for birth control backup for the first 7 days and on-going for disease protection.
- Minors (patients under 18 years of age) must be accompanied by a parent or legal guardian for the insertion procedure.

How is the IUD inserted?

- About 1 hour prior to insertion, it is recommended to take an over the counter anti-inflammatory (such as 600-800 mg of ibuprofen) to help minimize cramping and discomfort of insertion.
- The actual insertion takes a few minutes. However, plan on about a 30-45 minute appointment for paperwork, preparation time, etc.
- A pelvic exam will be performed to feel the size and position of your uterus. A speculum will be placed in the vagina to visualize the cervix. A sterile instrument will be used to measure the depth of your uterus. The IUD will then be inserted through your cervix to the top of your uterus. You may experience cramping and a pinching sensation while the IUD is being inserted. But usually this entire insertion takes only a few minutes.

What happens after the IUD is inserted?

- You must wait 24 hours after the IUD is inserted before you can use tampons, take a bath or have sex.
- A follow-up appointment will be required in 4 weeks.

What is the cost for the IUD? How do I schedule the procedure?

- GTW will submit the benefits verification request to Contemporary Women's Care to verify your coverage and schedule the IUD insertion procedure.
- Contemporary Women's Care will submit the request to your insurance. Your insurance company will contact you with the insurance coverage verification and costs. You will need to let insurance know if you wish to proceed with the IUD.
- Contemporary Women's Care will then contact you to schedule your insertion procedure with Mary Ann Franken, MD at:

Contemporary Women's Care
4323 N Josey Lane, Suite 306
Carrollton, TX 75010
Phone 972-939-7011

www.ContemporaryWomensCare.net

- Complete the attached New Patient paperwork and bring to your appointment at Contemporary Women's Care.
- Continue your current form of birth control until the insertion procedure.

How is the IUD removed?

- Removal of the IUD requires a pelvic exam. A speculum will be placed in the vagina to visualize the cervix. Once the strings are identified, they will be grasped with a sterile instrument and slowly pulled out, removing the IUD. You may experience discomfort or a cramping sensation. But usually the removal takes just a few seconds.

IUD Post-Procedure Information and Follow-up

The First 24 Hours

Today may go back to school or work after your visit. You must wait 24 hours before you can use tampons, take a bath, or have vaginal sex.

Contraception

Copper IUD (Paraguard™)

It begins working **NOW** to prevent pregnancy

It can stay inside you for 10 years. Removal date is 10 years from today.

Progestin IUD (Mirena®)

It begins working in **7 days** to prevent pregnancy. For 7 days after your IUD is inserted, use condoms and continue your pills/patch/ring as backup.

It can stay inside you for **5 years**. Removal date is 5 years from today

Progestin IUD (Skyla®)

It begins working in **7 days** to prevent pregnancy. For 7 days after your IUD is inserted, use condoms and continue your pills/patch/ring as backup.

It can stay inside you for **3 years**. Removal date is 3 years from today

Your menstrual cycle

Copper IUD (Paraguard™)

- You may have slightly more cramping or bleeding with your periods as long as you have the IUD in you.

Progestin IUD (Mirena® or Skyla®)

- You may have irregular cramping and bleeding with your periods, or spotting between your periods. This is normal. The cramping and bleeding can last for 3-6 months with the Mirena and Skyla IUDs. After 6 months, the irregular cramping or bleeding should get better. Many women will stop having their periods with Mirena. Most women will continue to have a light period with Skyla.

Monthly IUD Check

Your IUD may come out by itself in the first 3 months. If you can feel the strings, the IUD is in the right place. If your IUD comes out, you can become pregnant immediately.

To check, insert a finger into your vagina and feel for the cervix (it feels like the tip of your nose.) You should feel the string near your cervix. Do NOT pull on the string. If you cannot feel the string, contact your healthcare provider.

Call your medical provider (972-733-6565) if there are concerns or issues

The IUD is very safe. If you have any of the following symptoms within the first 3 weeks after insertion, see your health care provider: Fever (>101°F), chills or strong pain in your belly.

If you have any of the following symptoms at any time while you have the IUD in you, see your health care provider: feeling pregnant (breast pain, nausea), positive home pregnancy test.

CONTEMPORARY WOMEN'S CARE, P.A.
JULIE THOMAS, M.D. * NEDRA RICE, M.D. * SHAHEEN JACOB, M.D.
CHRISTA RODRIGUEZ, WHNP-C
4323 North Josey Lane Plaza I, Suite 306 Carrollton, TX 75010
972-939-7011

PATIENT INFORMATION FORM

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET/P.O. BOX CITY STATE ZIP

DATE OF BIRTH: _____ / _____ / _____ SSN: _____
MONTH DAY YEAR AGE

PLEASE INDICATE PREFERRED NUMBERS TO CONTACT YOU, INCLUDING LOCATION (i.e. Home, Work, Cell):

1. _____
2. _____
3. _____

EMERGENCY CONTACT NAME: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

MARITAL STATUS: (circle one) SINGLE - MARRIED - WIDOWED - SEPARATED - DIVORCED

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIP PHONE NUMBER

RESPONSIBLE PARTY

NAME: _____
FIRST MIDDLE LAST

PRIMARY CONTACT NUMBER: _____ ALTERNATE NUMBER: _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

POLICY HOLDERS NAME: _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____ / _____ / _____ SSN: _____
MONTH DAY YEAR AGE

EMPLOYER: _____ ADDRESS: _____ PHONE: _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME: _____

I have reviewed the above information. It is correct and current as of this date.

Patient Signature

Date

Patient Signature

Date

Patient Signature

Date

PATIENT INFORMATION FORM

I. I hereby give consent to Contemporary Women's Care, P.A. to provide whatever treatment the assigned physician may deem necessary.

I certify that the insurance and personal information I have provided to Contemporary Women's Care, P.A. is accurate.

II. I understand I am responsible for payment of charges and that payment is due at the time of service. I hereby assign insurance benefits to be paid directly to Contemporary Women's Care, P.A. for professional physician fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by my insurance policy. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits within 90 days of any and all appeals or requests for information. Any amounts which are 90 days past due will be eligible to be turned over to a collection agency unless previous arrangements have been made. Collection agency fees are recognized to be my (the patient's) responsibility. There will be a \$35.00 charge for any returned check.

III. OBSTETRICAL CARE: All patient fees for obstetrical care is required to be paid by the end of the 5th month of pregnancy. If financial obligations are not paid on time the practice reserves the right to discharge me from their care.

PATIENT SIGNATURE: _____ DATE: _____

MEDICAL RECORDS RELEASE AND INSURANCE ASSIGNMENTS

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THIS ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.

V. RELEASE OF INFORMATION: I authorize any physician examining and/or treating me to release to any third party (such as an insurance company) any medical information and records concerning diagnosis and treatment when requested for use in determining claim for payment. I authorize Contemporary Women's Care to be my personal representative which allows CWC to submit any and all appeals when my insurance company denies me benefits to which I am entitled, submit any and all requests for benefit information from my insurance company and initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits.

PATIENT SIGNATURE: _____ DATE: _____

VI. PHYSICIAN INSURANCE ASSIGNMENT: I authorize payment directly to any physician examining or treating me for surgical and/or medical benefits. Any services for which assignment is not accepted are acknowledged to be my full and complete financial responsibility.

PATIENT SIGNATURE: _____ DATE: _____



Contemporary Women's Care

HOW MAY WE CONTACT YOU FOR TEST RESULTS?

Please provide us with your contact phone numbers:

Home _____

Cell _____

Work _____

Other _____

May we leave a detailed message on your answering machine regarding test results? _____ Yes _____ No

Are we allowed to speak with anyone else regarding your results? _____ Yes _____ No

Please provide the names and phone numbers of anyone you allow to receive information relating to your test results. Results WILL NOT be given unless you write their name and number below.

Name Phone Number Relation

Name Phone Number Relation

Name Phone Number Relation

Signature

Date

Contemporary Women's Care P.A.

Medical History

Name: _____ Date of Birth: _____

Obstetrical History: Please list all pregnancies including miscarriages and abortions.

Date	Route (Vag or C/S)	Sex	Delivery - # Weeks Before/After Due Date	Wt.	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Date	Weeks	Miscarriage or Abortion	D & C Required	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Gynecological History:

First day of last period: _____ Age at first period: _____ Length of period: _____

How many days from start of one period to start of next period? _____

Flow: Light _____ Medium _____ Heavy _____

Do you pass clots of blood? Yes _____ No _____ If yes, how large? _____

Cramps? No _____ Mild _____ Moderate _____ Severe _____

Relieved by medication? Yes _____ No _____

What method are you currently using to prevent pregnancy? _____

Have you ever had: No _____ Yes _____ When _____

- Gonorrhea _____
- Chlamydia _____
- Syphilis _____
- Genital Warts _____
- Trichomonas _____
- Herpes _____
- Hepatitis B _____
- HIV _____

Date of last Pap: _____ Results: _____

Have you ever had an abnormal pap? Yes _____ No _____ Unsure _____

If yes, when? _____ Results _____ Treatment Required _____

Date of last Mammogram: _____ Results: _____

Previous Medical History:

Do you have:	No	Yes	Date of Diagnosis	Treatment
Hypertension	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Hypothyroidism (Low)	_____	_____	_____	_____
Hyperthyroidism (High)	_____	_____	_____	_____
Seizures	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
High Triglycerides	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____
Other Cancer	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Surgical History: Please list each surgery you have had.

Date	Type	Reason	Surgeon	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Hospitalizations – Other than surgeries and deliveries:

Date	Reason	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medications that you are taking regularly: Please include over the counter meds, vitamins, herbs, and supplements.

Medication	Dose	Reason	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any allergies to medications:

Medication	Reaction
_____	_____
_____	_____
_____	_____

Family History: Please list family members with medical problems.

	Illnesses	Living/Deceased	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you have any family history of breast, ovarian, or colon cancer?
 No _____ Yes _____ If yes, please list above.

Marital Status: _____ Occupation: _____

Persons living with you: _____

Do you have an exercise program? No _____ Yes _____ Type _____ Times/week _____

Do you follow a specific diet? No _____ Yes _____ Type _____

Is your diet high _____ medium _____ low _____ in fat?

How many servings of dairy do you eat per day? _____ (8 oz milk, 1 oz cheese, 6 oz yogurt)

Do you smoke now? No _____ Yes _____ PPD _____ For _____ years

Have you smoked in the past? No _____ Yes _____ PPD _____ For _____ years

When did you stop? _____

How many alcoholic drinks do you have each day? _____ Week _____ Month _____

Do you use: Marijuana _____ Cocaine _____ Heroin _____ Methamphetamines _____ IV Drugs _____

Other _____

Do you wear your seatbelts? Yes _____ No _____

Do you have smoke detectors in your home? Yes _____ No _____

Do you have carbon monoxide detectors in you home? Yes _____ No _____

Do you perform monthly self breast exams? Yes _____ No _____

Have you been immunized for Hepatitis B? Yes _____ No _____

Have you had chicken pox? Yes _____ No _____

Date of last Tetanus booster: _____

CONTEMPORARY WOMEN'S CARE
4323 N. JOSEY LANE, SUITE 306
CARROLLTON, TX 75010
PHONE: 972-939-7011 FAX: 972-939-2951

FINANCIAL POLICY STATEMENT

IMPORTANT INFORMATION!

PLEASE READ!

In order to reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policy. If you have questions, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience we accept cash, check, Master Card, Visa, Discover and American Express. Your insurance policy is a contract between you and your insurance company, the doctor is not involved.

We will bill contracted insurance plans directly. Any co-payment and/or co-insurance or deductible is payable at the time of service. Past due accounts will result in the account being sent to our collection agency. Any patients sent to collections will be dismissed from the practice until the balance is paid in full. No services will be rendered by this office (appointments or prescription refills) until the balance is paid in full.

For surgery patients, our office requires a \$150 deposit prior to your surgery date if your plan has a co-insurance or deductible due. Follow-up care is provided as part of the global surgery fee if it is routine. Care or complications not related to the surgery will be billed separately.

The global obstetrical fee for pregnant patients includes only routine care. Problems unrelated to the pregnancy or additional visits due to high-risk problems or other complications will be billed separately. Lab work, sonograms, and fetal non-stress tests are not part of the global obstetrical fee and are billed separately. Insurance companies require us to bill the global OB fee at the time you deliver.

We will complete the first insurance disability or medical leave form for you at no charge. **There will be a \$5.00 - \$10.00 charge for the completion of subsequent forms based on the complexity of the form and the time involved in its completion. Please allow at least 2 business days for the completion of these forms.**

I have read and understand this financial policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice.

Signature of Patient

Date

Name of Patient (please print)

PATIENT WAIVER

IMPORTANT INFORMATION!

PLEASE READ!

To Our Patients:

Many insurance companies today do not cover preventive services (annual physicals, immunizations, screening tests, etc.) or treatment/counseling for infertility or pre-pregnancy counseling.

We do our best to verify your coverage prior to your visit, **but we cannot guarantee payment of benefits by your insurance plan.** This is a contract between you and your insurance company and your responsibility to know the terms of your plan.

Some (but not all) of the services that may not be covered by insurance are:

Immunizations: Hepatitis B, Influenza, MMR, Pneumovax, Tetanus, Gardasil (HPV vaccine)

Injections: Depo Provera, Depo Lupron, Rhogam

Screening Tests: Cholesterol, Diabetes, Thyroid

Triple Screen Test: AFP, Estriol, HCG (Obstetrics)

Office Visits: Infertility, Annual Well Woman Exams, Pre-Pregnancy Counseling, Weight Loss Treatment, Depression

Other: Implanon, Mirena IUD, Paraguard IUD

An annual well woman exam is **preventive** in nature and consists of a physical exam, Pap test and refills of prescriptions for birth control pills or hormone replacement therapy. **Well woman means precisely that – there are no problems to treat or discuss.** Insurance companies are also very particular that your annual exam must be scheduled exactly one year from the date of your previous exam. **If you schedule your exam too early, it is very likely the insurance will deny payment and you will be responsible for the charges.**

If there is a problem/concern to discuss or treat, then this is not considered a well woman exam and will be billed either as a new or established problem office visit. We are required by insurance company guidelines to submit our bill to your insurance company using accurate information about the type of service you received. **Please do not ask us to change the coding of your visit as this is insurance fraud!**

I understand that I am responsible for full payment to Contemporary Women's Care for any services that may not be covered by my insurance plan.

Patient Signature

Date

(Rev. 5/10)



Women's Health
ACCESS SOLUTIONS

Patient Authorization Form

PARAGARD® (intrauterine copper contraceptive)

Fax: (855) 215-5315

Phone (888) 275-8596

Fax (855) 215-5315

www.TWHAccessSolutions.com

Biologics, Inc. C/O TWH Access Solutions

120 Weston Oaks Court

Cary, NC 27513

In accordance with the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("HIPAA"), this Authorization authorizes my healthcare provider, health plan, and my pharmacy to disclose my health and personal information to Teva Women's Health, Inc. and its agent, Biologics, Inc. (and its affiliates, and their respective representatives, and agents (collectively, "Biologics")) in furtherance of the below stated authorized purposes. This Authorization also authorizes Biologics to call me for an appointment reminder before my placement date. The Teva Women's Health Access Solutions program is the "Access Solutions Program" operated by Biologics on behalf of Teva Women's Health, Inc.

Authorized Purposes

I understand that the Access Solutions program and Biologics will receive my health and personal information for the following purposes: (1) to conduct benefit verification determining insurance reimbursement and coverage of PARAGARD®; (2) if my physician selects that the PARAGARD® unit is shipped by a specialty pharmacy, to contact me to discuss any relevant copay, to bill the insurance company, to bill the applicable copay and to ship the unit to my healthcare provider and (3) to contact me by telephone to remind me about appointments and in furtherance of conducting benefits investigations.

By signing the following form, I understand:

1. Once my healthcare provider gives Biologics and the Access Solutions program information about me based on this Authorization, my medical and health information may be subject to redisclosure and no longer protected by federal privacy regulations.

I further understand and agree that Biologics and the Access Solutions program may retain my medical and health information as disclosed under this Authorization after this authorization expires for purposes related to the appointment reminder call data.

I also understand that in the event of an audit, and for purposes of such an audit, some information may also be disclosed to Teva Women's Health, Inc., the manufacturer of PARAGARD®, or its affiliates after this Authorization has expired, so long as the audit is for a period of time when this Authorization was in effect.

2. I may refuse to sign this Authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my healthcare provider; or to seek payment; or my eligibility for benefits.

3. I may revoke my authorization at any time by providing a written notice of same to my healthcare provider that refers to (or with a copy of) this Authorization form, or to Biologics/the Access Solutions program at the address listed at the top of this Authorization. However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my healthcare provider to Biologics and any use of such information by Biologics in reliance of this authorization. I understand that I have the right to receive a copy of this Authorization.

4. This Authorization shall expire one year after I have signed it, or upon revocation, whichever is earlier.

Signature of Patient or Personal Representative

Dated

Name of Patient or Personal Representative

(If Applicable) Description of Personal Representative's Authority to Sign for Patient

