New Patient Checklist

We recommend that you complete this checklist before your visit with us!

1. **Confirm your appointment** (date and time) with us a few days before the visit.

2. **Complete both registration forms, yours and your partner's, along with the genetic screening questionnaire, prior to your visit.** Also please read, sign and return the copy of our "Office Financial Policy" and our "Notice of Privacy Practices. This will save time during your initial registration. You will be given copies of these signed agreement at check in.

3. Check and clarify **directions** to our office via maps, our web site (www.infertilitydocs.com), or a phone call to our office. Please allow for extra travel time during peak traffic hours. Also please remember that the physicians' schedules are generally full. Therefore, if you are late for your appointment with the physician, we may have to reschedule your visit.

4. Make sure that you have a **referral,** if needed. If you are not sure, please call the member services number on your insurance identification card to find out about rules that your insurance company needs you to follow. Remember, we do not make the rules, your insurance company does, and we all must follow them.

5. We recommend that you bring your **medical records** related to any prior infertility tests to your first visit. Please remember to copy them *before* your appointment. Unfortunately, our busy staff cannot provide copy services to patients.

6. Remember to bring both your **original insurance ID card** and a photo ID issued by a local, state, or federal government agency (e.g. a driver's license; passport; military ID, etc.). We will photocopy them during your initial registration. This is a federal law passed to prevent identity theft and it applies to both our female patients and their partners.

7. We ask that **cell phones** be shut off during your consultation with the doctor.

PATIENT INFORMATION SHEET

LAST NAME	**FIRST**	**MI**
ADDRESS	**CITY, STATE, ZIP**	
E-MAIL ADDRESS	**Are you a student?** ☐ Yes ☐ No ☐ Full time ☐ Part time	

HOME PHONE	**OTHER PHONE**	BIRTH DATE	**SEX** ☐ Female ☐ Male

SOCIAL SECURITY NUMBER	**MARTIAL STATUS** ☐ Married ☐ Single ☐ Other- Please Specify	
SPOUSE / PARTNER'S LAST NAME	**SPOUSE / PARTNER'S FIRST NAME**	**MI**

SPOUSE OR PARTNER ADDRESS *IF DIFFERENT FROM ABOVE*	**CITY, STATE, ZIP**	
YOUR EMPLOYER'S NAME (School Name if applicable)	WORK PHONE	**EMPLOYMENT STATUS** ☐ FULL ☐ PART TIME
EMPLOYER'S ADDRESS (School address if applicable)	**CITY, STATE, ZIP**	

REFERRING PHYSICIAN (We will correspond with your referring physician)

NAME: **PHONE:**

IF A DOCTOR DID NOT REFER YOU, HOW DID YOU HEAR ABOUT US?

☐ Referred By My Insurance Company ☐ Friend ☐ Google ☐ Social Media (Facebook/Twitter) ☐ Other Internet/Website
☐ Yellow Pages ☐ Newspaper, List Name ☐ Other, Please Specify

PRIMARY INSURANCE

COMPANY NAME:	**PHONE NUMBER:**	
ADDRESS	**CITY, STATE, ZIP**	
SUBSCRIBER NAME & RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD	ID NUMBER	**GROUP NUMBER**

SECONDARY INSURANCE

COMPANY NAME:	**PHONE NUMBER:**	
ADDRESS	**CITY, STATE, ZIP**	
SUBSCRIBER NAME & RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD	ID NUMBER	**GROUP NUMBER**

PRESCRIPTION PLAN

COMPANY NAME	**PHONE NUMBER**	
ADDRESS	**CITY, STATE, ZIP**	
SUBSCRIBER NAME & RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD	ID NUMBER	**GROUP NUMBER**

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

PATIENT SIGNATURE:____ **DATE:**____________

HUSBAND/PARTNER INFORMATION SHEET

LAST NAME		FIRST	MI
ADDRESS		CITY, STATE, ZIP	
E-MAIL ADDRESS		Are you a student? ☐ Yes ☐ No ☐ Full time ☐ Part time	
HOME PHONE	OTHER PHONE	BIRTH DATE	SEX ☐ Female ☐ Male
SOCIAL SECURITY NUMBER		MARTIAL STATUS ☐ Married ☐ Single ☐ Other- Please Specify	
SPOUSE / PARTNER'S LAST NAME		SPOUSE / PARTNER'S FIRST NAME	MI
SPOUSE OR PARTNER ADDRESS *IF DIFFERENT FROM ABOVE*		CITY, STATE, ZIP	
YOUR EMPLOYER'S NAME (School Name if applicable)		WORK PHONE	EMPLOYMENT STATUS ☐ FULL ☐ PART TIME
EMPLOYER'S ADDRESS (School address if applicable)		CITY, STATE, ZIP	

REFERRING PHYSICIAN (We will correspond with your referring physician)

NAME: **PHONE:**

IF A DOCTOR DID NOT REFER YOU, HOW DID YOU HEAR ABOUT US?

☐ Referred By My Insurance Company ☐ Friend ☐ Google ☐ Social Media (Facebook/Twitter) ☐ Other Internet/Website
☐ Yellow Pages ☐ Newspaper, List Name ☐ Other, Please Specify

PRIMARY INSURANCE

COMPANY NAME:		PHONE NUMBER:
ADDRESS		CITY, STATE, ZIP
SUBSCRIBER NAME & RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD	ID NUMBER	GROUP NUMBER

SECONDARY INSURANCE

COMPANY NAME:		PHONE NUMBER:
ADDRESS		CITY, STATE, ZIP
SUBSCRIBER NAME & RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD	ID NUMBER	GROUP NUMBER

PRESCRIPTION PLAN

COMPANY NAME		PHONE NUMBER
ADDRESS		CITY, STATE, ZIP
SUBSCRIBER NAME & RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD	ID NUMBER	GROUP NUMBER

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

PATIENT SIGNATURE:____ **DATE:**_______________

CENTER FOR
ADVANCED REPRODUCTIVE MEDICINE
& FERTILITY

Credit Card Authorization Form

In accordance with our **Office Financial Policy** and **Office Policy on Insurance Coverage**, a credit card authorization form is required to be on file to settle patient balances on the day they occur.

Patient Name:____

Name Imprinted on Credit Card:__________________________________

Billing Address of Credit Card:
Street # and Street Name:______________________________________

City:________________________________ State:______________

Zip Code:______________

______VISA ______Mastercard ______Discover _____American Express

(Note: Advanced authorizations are not accepted for Debit Cards.)

Credit Card #:____

3 or 4 Digit Security Code (on back of card)___________________________

Credit Card Expiration Date:__________/__________
Month Year

I hereby authorize **The Center for Advanced Reproductive Medicine and Fertility** to charge the above credit card for any patient balance due. I understand that I will be telephoned should the amount to be charged exceed $500.00, or should the date of service to which the charge is related be greater than 1 year prior. I confirm that the above is a Credit Card and is not a Debit Card. This authorization will remain valid for 1 year from the date of the signature.

Signature:__________________________________Date:__________

Four Ethel Road
Suite 405A
Edison, New Jersey 08817
Telephone: (732) 339-9300

123 North Union Street
Suite 102
Cranford, New Jersey 07016
Telephone: (908)998-3660

114 Stanhope Street
Forrestal Village
Princeton, New Jersey 08540
Telephone: (609)-297-4070

FAX: (732) 339-9400
www.InfertilityDocs.com

CENTER FOR
ADVANCED REPRODUCTIVE MEDICINE
& FERTILITY

Telephone Contact Consent

Our staff may need to contact you by phone or leave a telephone message on an answering machine/voice mail regarding testing or treatment. Protecting the privacy of your personal medical information is always our goal. In this regard, please indicate below the **contact number** that you wish for calls from our clinical staff regarding your care. (We *highly* recommend home phones with landlines and attached answering machines are your choice. This way, you can access messages from anywhere. Voice mail messages are sometimes unreliable and can get lost.)

Contact number: (______) ______-______________.
(An answering machine or voice mail must be available on this line!)

(Optional) Other people with whom medical information regarding my care can be shared:

1. ______________________________
2. ______________________________
3. ______________________________

______________________ ______________________ ____________
Print Name Signature Date

GENETIC SCREENING QUESTIONAIRE

Name____ **Date**__________________

Medical Record __________________________ **Telephone #**______________________

1. Are you 35 years of age or older? Yes___No___

2. Do you, your partner or anyone in either of your families have any of the following disorders:
   - Down syndrome Yes___No___
   - Other chromosome abnormalities (translocations, trisomies, deletions) Yes___No___
   - Neural tube defects [spina bifida (open spine), anencephaly (open skull)] Yes___No___
   - Huntington's disease/chorea Yes___No___
   - Hemophilia/bleeding disorders Yes___No___
   - Muscular dystrophy Yes___No___
   - Cystic fibrosis Yes___No___

   If yes, indicate the relationship of the affected individual to you and your partner. __________

3. Were you or your partner born with a congenital birth defect? Yes___No___
   If yes, who is affected and what type of birth defect is present? __________

4. Have you or your partner had any children, born dead or alive with any birth defect not listed in question 2? Yes___No___
   If yes, what was the defect and who was affected? __________

5. Do you or your partner have any relatives with mental retardation? Yes___No___
   If yes, indicate the relationship of the affected person to you or your partner. __________
   Indicate the cause, if known: __________

6. Do you, your partner, or anyone in your families have a birth defect, familial disorder, or a chromosome abnormality not listed above? Yes___No___
   If yes, indicate the condition and the relationship of the affected individual and you and your partner: __________

7. Have you or your partner had a stillborn child or two or more first trimester pregnancy losses? Yes___No___
   Have either your or your partner had a chromosome analysis performed? Yes___No___
   If yes, please indicate who, where it was performed, and the results: __________

8. Are either you or your partner of Jewish ancestry? Yes___No___
   If yes, have either of you been screened for Tay Sachs disease? (please indicate who was tested and the results) __________

9. Are either you or your partner of African American ancestry? Yes___No___
   If yes, have either of your been screened for sickle cell trait?(please indicate who was tested and the results) __________

10. Are either you or your partner of Italian, Greek, Mediterranean, or Asian ancestry? Yes___No___
    If yes, have either of you been screened for thalassemia?(please indicate who was tested and the results) __________

11. Have you been taking vitamins or folic acid during the last 6 months? Yes___No___
    If yes, indicate the name and the length of time you have been taking the vitamin: __________

12. Excluding iron and vitamins, have you taken any medications or recreational drugs during the last 6 months? (include nonprescription drugs) Yes___No___
    If yes, indicate the name, dosage and the length of time you have been taking the medication: __________

Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I (we) hereby acknowledge that I (we) have been presented with a copy of **The Center for Advanced Reproductive Medicine & Fertility's** Notice of Privacy Practices.

____

Print Female Name | Signature | Date

____

Print Male Name | Signature | Date

____

Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Renee Kurland (Practice Administrator) or Dr. Gregory Corsan.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the

highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Dr. Gregory Corsan

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Dr. Gregory Corsan

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Dr. Gregory Corsan

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Dr. Gregory Corsan. ***We are not required to agree to your request.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to Dr. Gregory Corsan. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Gregory Corsan. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

CENTER FOR

ADVANCED REPRODUCTIVE MEDICINE

& FERTILITY

Office Policy on Insurance Coverage

To help you better understand, and to assist you in obtaining insurance benefits for your care here, please review the following:

Insurance coverage for infertility and reproductive medicine is not as straightforward as in most other areas of medicine. For example:

- Many times there is coverage for diagnostic testing to determine why you are infertile, but no coverage for the treatment recommended by your doctor.
- Many times whether your insurance pays for a claim often depends on why the service was performed. For example, a series of ultrasound studies done to determine whether an ovarian cyst is shrinking may be paid for by your insurer. However, a similar series of ultrasound studies done to track your response to fertility medications may not be covered.
- At times the information given to us regarding infertility benefits from your insurance carrier is incorrect or incomplete, despite our best efforts to get accurate information from them.

We are anxious to help you receive your maximum allowable benefits so we have developed this approach:

Determination of Insurance Benefits

Once you become a patient at **The Center for Advanced Reproductive Medicine & Fertility** we will call your insurance carrier to obtain information regarding coverage for infertility diagnosis and treatment using our **Insurance Verification Form**. We will provide you with a copy of this form when completed. When you receive it, please review it very carefully. If you think you have different coverage than we determine, or a different level of benefits, please call your insurance carrier to clarify this. At the same time, please ask them where you can find your "written benefit information". Once you have a copy of it, please send it to us by mail, email (reneek@infertilitydocs.com) or by FAX at 732-339-9400.

Unfortunately, this 'verification' of benefits that we perform on your behalf does not obligate insurers to pay for your care. Insurance companies protect themselves by stating that verification of your insurance coverage by them is:

- Not a guarantee of payment, and is
- Not a guarantee of what is actually covered

Because of this disclaimer, even when they have indicated that a service is covered, and even if we have received precertification or preauthorization, there is no obligation for them to pay your claims. The insurer continues by stating, "A final determination will be made on receipt of the claim." There are many reasons why a claim may not be paid:

- The service you received is not covered by your plan
- The reason for the service or diagnosis is not covered by your plan
- The appropriate deductibles and copay amounts have not been met
- There is a "pre-existing condition" exclusion

- The service was provided after the contract ended

The **NJ Family Building Act** requires many insurers to cover infertility treatment in NJ. However, patients seeking infertility treatment must first meet clinical criteria in order to use the benefits. Here are the requirements:

- If a patient is less than 35 years of age, they must have a 2 year documented history of infertility.
- If a patient is 35 years or older, they must have a 1 year documented history of infertility.
- The infertility must not be a result of a voluntary sterilization procedure, i.e. tubal ligation or vasectomy.
- You have used all reasonable, less expensive, and medically appropriate means of treatment and they have failed before moving to a more expensive and medically appropriate treatment. (IUI before IVF if both are treatment options).
- If you (male) are not able to impregnate another person (female).
- If you (female) are not able to carry a pregnancy to a live birth.
- If you (female) are less than 46 years of age.
- If you have not yet completed four egg retrievals per lifetime that were covered or paid for by any insurance plan. Self-pay IVF cycles do not count toward the lifetime maximum of 4 egg retrievals.

Not all NJ residents have this benefit. Additionally, many NJ residents are covered by plans administered in either NY or PA. These insurance plans must follow the law in the specific state where they are purchased.

Some NJ residents have self-funded or self-insured plans, e.g., The Carpenter's Union. Plumbers Union, etc. Another example of a self-funded plan may be a very large employer with several thousand employees located in multiple states and even other countries, i.e. Merck, Pfizer, Johnson & Johnson, Solaris Health System, to name a few. These employers, because of their size and the way they provide health insurance for their employees are legally obligated to follow Federal Guidelines, the ERISA Act. This federal law does not provide any provision for covering the diagnosis or treatment of infertility. Therefore these types of employers do not legally have to provide coverage for infertility treatment, however, many do.

Settling of Balances

Once we confirm through our Insurance Verification Form that you have coverage, we will be happy to file a claim with your insurance carrier. We will collect any copayment due at the time of the service. There will also be times when we will collect any patient co-insurance amount before the treatment begins, i.e. a cycle of in-vitro fertilization (IVF). If after processing your claim, your insurance carrier leaves a "Patient Responsibility" amount, it now becomes due by you. Patient due balances may be paid in several ways.

- For your convenience, these balances can be paid by the credit card authorization that we have on file for you or when you come into the office.
- For balances not paid in this manner, you will receive a bill in the mail.

Any unpaid balances **must** be paid by the time of your next visit to our office Failure to pay the balance due at this time will result in a $25.00 administrative fee added to your balance. You may be asked to reschedule your appointment or procedures for a time when you will be prepared to pay.

Patient Account Representative

We understand that infertility is a challenging problem and managing your insurance benefits can be difficult. We are here to help you understand your insurance benefits and answer any questions you may have. Our **Patient Account Representatives** can explain the patient due balances that your insurance carrier may leave, or a denied or appealed claim and its status. These personnel are well trained and can help you navigate this insurance maze. Please feel free to call upon them if you encounter any difficulties along the way.

Thank you.

I have read, understand and agree to the Office Policy on Patient Insurance Coverage and a copy has been provided to me:

____

Signature of Patient Date

____

Signature of Spouse/Partner Date

____

Signature of CARMF Representative Date

CENTER FOR

ADVANCED REPRODUCTIVE MEDICINE

& FERTILITY

Office Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the finest medical care at the lowest possible cost. The following is our **Office Financial Policy** which we require you to read and sign prior to your initial consult with the doctor.

All patients, both female and male, must complete a **Patient Information Sheet** before seeing the doctor. Federal law requires us to ask you to provide us with a photo ID issued by a local, state, or federal government agency (e.g. a driver's license; passport; military ID, etc.) and an original insurance identification card in order to prevent identity theft. Please bring the appropriate items with you at the time of your visit. Failure to do so may require your initial appointment to be rescheduled.

Unfortunately, not all patients with health insurance will have coverage for the costs involved with infertility consultation, testing and treatment. **It is primarily your responsibility to determine the insurance coverage available under your insurance plan for services performed here,** including your initial office visit. We recommend that you contact your insurer well in advance of your first visit to discuss your benefits. Once you become a patient here we will call your insurance carrier to obtain information regarding coverage for infertility care using our **Insurance Verification Form** and will provide you with a copy of the information we receive.

If your insurance company requires a written referral, it must be presented at the time of the initial visit. We will collect your co-payment at the time of each visit and bill your insurance company for the service provided. If you are uninsured, or, we are not participating providers in your plan, or, if infertility is not a covered benefit, FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME THAT SERVICES ARE RENDERED. WE ACCEPT CASH, CREDIT CARDS, (Visa, MasterCard, Discover and American Express), DEBIT CARDS, AND CHECKS.

Very few insurance companies cover all medical costs. In order to keep our fees low, we require that all co-payments as well as any patient due balances and/or co-insurance amounts be paid at the time of service. Please stop by our front desk with each visit to confirm that you are current with all payments. When your co-pay, co-insurance or patient responsibility balance for that day's visit or service is not paid at the time of service delivery, we will assess a $25.00 administrative billing fee and bill you for the unpaid amount. In addition, you may be asked to reschedule your appointment or procedure(s) for a time when you will be prepared to pay.

Because of the very busy lives of our patients, it is often difficult to reach out to patients and ask them to come in to the office to settle unpaid balances as they arise. There are instances when charges become a patient responsibility and this may even occur on days when there is no office visit scheduled. Therefore, we require a **credit card authorization** be on file so that your balances can be settled as they occur. Our patients like this strategy for convenience. An authorization form will be supplied to you and your spouse/partner for your signatures.

Returned checks are subject to a fee of $30.00. After having a check returned for non-payment, all future payments must be made by cash, credit card, bank check or money order. Balances older than 30 days are subject to additional collection fees and interest of 1.5% per month.

Failure to cancel your appointment with our physicians at least 36 hours prior to your appointment will result in a $50 "no show" charge billed to you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. If you have any questions, please feel free to talk to our Practice Administrator, Renee Kurland. We will make every effort to clarify any items or issues you may have.

Patient's Attestation:

I have read, understand and agree to this Financial Policy. I have been given a copy:

____ ____________

Signature of Female Patient — Date

____ ____________

Signature of Male Patient — Date