IVF MICHIGAN / TOLEDO FERTILITY / ARBOR PARK LAB
PATIENT INFORMATION FORM

PATIENT INFORMATION

TODAY'S DATE ___/___/___ RACE (optional) _____

NAME _____

DATE OF BIRTH ___/___/___ SOCIAL SECURITY NUMBER _____

ADDRESS _____

EMAIL _____

CELL _____ HOME _____ WORK _____

EMPLOYER _____ EMPLOYER PHONE _____

PRIMARY CARE PHYSICIAN _____

PHONE _____ ADDRESS _____

REFERRING INFORMATION

PHYSICIAN / SPECIALTY _____ PHONE _____

☐ SELF ☐ FRIEND / FORMER PATIENT _____

RADIO STATION_____ INSURANCE _____

INTERNET_____ OTHER _____

OB/GYN_____ PHONE _____
(If other than referring)

ADDRESS _____

PREFERRED PHARMACY _____ PHONE _____

DRUG ALLERGIES_____

EMERGENCY CONTACT _____ PHONE_____
(If different than partner / spouse)

PARTNER / SPOUSE INFORMATION

NAME _____

DATE OF BIRTH ___/___/___ SOCIAL SECURITY NUMBER _____

ADDRESS _____

CELL _____ HOME _____ WORK _____

EMPLOYER _____ EMPLOYER PHONE _____

PRIMARY CARE PHYSICIAN _____

PHONE _____ ADDRESS _____

REFERRIGN PHYSICIAN / SPECIALTY _____

PHONE _____ ADDRESS _____

IVF STAFF USE BELOW

PATIENT NAME _____

DATE OF BIRTH ___/___/___ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

POLICY HOLDER: ☐ SELF ☐ PARTNER ☐ OTHER

*If other we need the name, social security number and the address of that person.

POLICY / ID NUMBER _____ GROUP _____ CO-PAY_____

SECONDARY INSURANCE _____

POLICY HOLDER: SELF PARTNER OTHER

*If other we need the name, social security number and the address of that person.

POLICY / ID NUMBER _____ GROUP _____ CO-PAY_____

BLUE CARE NETWORK, M-PREMIERE CARE, HAP (if out of local network), and insurance that require prior authorization or referral.

It is the patient's responsibility to keep their referral updated each time they are seen in our office. If a referral is not obtained for the patient visit date, the patient will be responsible for payment. I have read the above information and fully understand my responsibility regarding my referrals to IVF Michigan/Toledo Fertility Center/Arbor Park Lab.

I AUTHORIZE THE STAFF OF IVF MICHIGAN, P.C./TFC AND ARBOR PARK REPRODUCTIVE LAB TO FURNISH MY INSURANCE CARRIER ANY INFORMATION REQUESTED CONCERNING MY TREATMENT, OR INFORMATION ACQUIRED DURING THE COURSE OF MY TREATMENT. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIANS OF IVF MICHIGAN, P.C./ARBOR PARK REPRODUCTIVE LAB FOR CHARGES NOT COVERED BY THIS AUTHORIZATION, OR UNTIL SUCH TIME BENEFITS ARE PAID.
NO INSURANCE: I understand payment in full is due at the time of service.

SIGNATURE _____

DATE ___/___/___

CONFIDENTIAL COMMUNICATIONS*

I/we authorize the practice of leaving a message on my home answering machine. YES / NO

I/we authorize the practice of leaving a message on my work voicemail. YES / NO

I/we authorize the practice of leaving a message on my cell voicemail. YES / NO

I/we authorize the practice to email information to myself or my partner. YES / NO

NAME _____

DATE OF BIRTH ___/___/___

I authorize the release of my protected health information and treatment as well as all billing information associated with my account in person, by phone, fax, or by email to:

NAME _____

CELL _____ **HOME** _____ **WORK** _____

EMAIL _____

*If changes occur in the confidential communications, it is the patient's responsibility to notify staff and fill out a new communication form.

SIGNATURE _____

DATE ___/___/___

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*NOTICE REGARDING HIV/HEPATITIS B&C TESTING AFTER OCCUPATIONAL EXPOSURE OF IVF MICHIGAN PERSONNEL

Occasionally, personnel at IVF Michigan/TFC/Arbor Park Lab may experience accidental exposure to your blood or body fluids during your care. This exposure may place the caregiver at risk of infection. Therefore, in accordance with the Michigan Public Health Code if a health care professional or facility employee of IVF Michigan sustains a percutaneous mucous membrane or open wound exposure to your blood or other body fluids, a blood test will be performed on you to determine your HIV/Hepatitis B&C status. The cost of the test will be charged to you or your insurance company.

The performance and results of this test are confidential. This information will not be released without your written consent except to those individuals or organizations that have been given access by law who are also required to keep your records confidential. **INITIAL** ____

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*ANNUAL EXAM

I understand that I will continue all routine gynecologic and primary medical care including, but not limited to: breast evaluation and Pap smear screening by my primary care physician, internist or gynecologist and not IVF Michigan, P.C. physicians. **INITIAL** ____

*The physicians of IVF Michigan, P.C. and the Toledo Fertility Center have a financial interest in Arbor Park Reproductive Lab, Counsyl and Verinata. In addition, IVF Michigan, P.C. billing department bills for services performed by these companies on behalf of IVF Michigan, P.C. patients. If patients do not wish to use the providers listed above, they may inquire about other options.

*CONSENT TO DELIVER SPECIMEN (HUSBAND / PARTNER)

I, _____ *(Husband / Partner),*
hereby authorize my *(Wife / Partner)* _____
to transport and deliver any semen samples that may be needed for testing and/or for use for procedures to IVF/TFC/Arbor Park Reproductive Laboratory for the duration of my treatment.

_____ **DATE** ___/___/___
Signature of male partner

_____ **DATE** ___/___/___
Signature of female partner

YEARLY UPDATE

I acknowledge that I have had no changes in my insurance or demographics since the initial date of this document

INITIAL ____ **DATE** ___/___/___ **INITIAL** ____ **DATE** ___/___/___

INITIAL ____ **DATE** ___/___/___ **INITIAL** ____ **DATE** ___/___/___

IVF MICHIGAN, P.C./TOLEDO FERTILITY CENTER, LLC FINANCIAL POLICY RESPONSIBLE PARTY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete and sign our patient information sheet and insurance forms prior to seeing a physician.

- Full payment is due at the time of service if we do not participate with your insurance company
- Co-pays are due at the time of service if we do participate with your insurance company
- We will accept cash, checks, debit cards or major credit cards (Visa, MasterCard, Discover and American Express)
- Payment for procedures and balances of $550 or more must be paid with a major credit card, debit card, cashier's check or money order.
- All prior balance must be paid in full BEFORE starting another procedure or scheduling a consultation appointment
- NO SHOW APPOINTMENT – There will be a fee of $60 charged to all accounts who fail to give at least 24 hours' notice

REGARDING INSURANCE

We will accept assignment of insurance benefits if we participate with your insurance. If your insurance company does not pay for our services, you understand that you are fully responsible for any amount owed, including co-pays and deductibles. You are responsible to provide us with your current insurance information, failure to do so will result in balances being transferred to you from insurance. In cases where authorization or referral is needed we will make every effort to obtain authorization and referral as indicated by your insurance benefits. Authorization is not a guarantee of payment any balances as a result of denial will be your responsibility. We encourage you to know your benefit and be aware of any rules you need to follow, authorizations and referrals you will need.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. You are ultimately responsible for payment regardless of any insurance company's arbitrary determination and customary rates or denied charges.

HMOs

You are required by your insurance company to obtain any insurance referral for your visits. You will be responsible for obtaining this referral and updating it as you progress through your treatment with us. If you arrive to your appointment(s) and we do not show that we have a current referral on file for your visit that day, you will be required to sign a waiver upon arrival. This waiver states that you understand that you are responsible for charges for that visit if your insurance company does not pay your claim due to unauthorized services rendered.

By signing this financial policy, I/we agree to be financially responsible for all fees associated with the procedure.

NAME (Print) _____ **DATE OF BIRTH** ___/___/___

_____ **DATE** ___/___/___

Signature

NAME (Print) _____ **DATE OF BIRTH** ___/___/___

_____ **DATE** ___/___/___

Signature of husband / partner

_____ **DATE** ___/___/___

Signature of witness

IVF MICHIGAN, P.C./TOLEDO FERTILITY CENTER, LLC / ARBOR PARK LABORATORY, INC.

Notice of Privacy Practices

PATIENT NAME _____ **DATE** ___/___/___

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services with IVF Michigan, P.C., Arbor Park Reproductive Laboratory and Toledo Fertility Center, LLC.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information (PHI)
Your protected health information (PHI) may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information (PHI) to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information (PHI), as necessary, to any health agency that provides care to you, such as a referring physician. This is to ensure the physician has the necessary information to diagnose and/or treat you.

Payment
Your protected health information (PHI) will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay/surgical procedure that may require that your relevant protected health information (Pm) he disclosed to the health plan to obtain approval for the hospital admission/surgical procedure.

Health Care Operations

We may use or disclose, as needed, your protected health information (PHI) in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information (Pill) to medical school students that see patients in our office. In addition, we may use the sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information (PHI), as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information (PHI) in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health Human Services to investigate or determine our compliance with the requirements of Section 164-500.

S.A.R.T. Results

IVF Michigan, P.C./Arbor Park Reproductive Laboratory/Toledo Fertility Center, L.L.C. is able to disclose any statistics to S.A.R.T. (Society of Assisted Reproductive Technology) regarding your pregnancies or nonpregnancies resulting from any procedure done with our corporation.

Photographs of Your Children/Family

If you send or bring in a photograph of yon and/or your family as a result of treatment received through IVF Michigan, P.C., Arbor Park Reproductive Lab and/or Toledo Fertility Center, L.L.C., we have the right to display that photograph unless you consent otherwise.

Other Permitted and Required Uses and Disclosures

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in

Your Rights

Following is a statement of your rights with respect to your protected health information (PHI).

You have the right to inspect and copy your protected health information (PHI).

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information (PHI) that is subject to law that prohibits access to protected health information (PHI).

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information (PHI) for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit the use and disclosure of your protected health information (PHI), your protected health information (PHI) will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information (PHI). If we deny your request for amendment, yon have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information (PHI).

We reserve the right to change the terms of this notice and will inform you, by mail, of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before April 14, 2003.

Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information (PHI). If you have any objection(s) to this form, please ask to speak with Michelle Blau, 248-952-9600.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

NAME (Print) _____

_____ **DATE** ___/___/___

Signature

_____ **DATE** ___/___/___

Signature of witness

HEALTH ASSESSMENT

The American College of Obstetricians and Gynecologists has suggested that a thorough health assessment prior to pregnancy is key to a successful and healthy pregnancy outcome. We heartily endorse the notion that infertility therapy goes hand-in-hand with a healthy couple and a healthy lifestyle. Cessation of smoking, minimizing alcohol intake, regular exercise, and stress management are equally important and will improve the effectiveness of ANY fertility therapy.

Recommended Pre-pregnancy Blood Testing for pre-existing health concerns may include:

RUBELLA (German Measles)
_____ I have been tested for Rubella
_____ I wish to be tested for Rubella and immunized if NOT immune
_____ I do NOT wish to be tested

V ARICELLA (Chicken Pox and Shingles)
_____ I have been tested for Varicella
_____ I wish to be tested for Varicella and immunized if NOT immune
_____ I do NOT wish to be tested

HEPATITIS B/C
_____ I do wish to be tested
_____ I do NOT wish to be tested

SYPHILIS
_____ I do wish to be tested
_____ I do NOT wish to be tested

ANY OTHER SCREENING TESTING _____

PRE-NATAL VITAMINS (Folic Acid and Iron)
_____ I do wish to begin vitamins
_____ I do NOT wish to begin vitamins

NAME (Print) _____ **DATE OF BIRTH** ___/___/___

_____ **DATE** ___/___/___
Signature

DECLINE TESTING

I acknowledge we have been offered testing by IVF Michigan, P.C./Toledo Fertility Center, LLC, in conjunction. I decline to undergo antenatal genetic testing. My signature below is an indication of my decision.

_____ **DATE** ___/___/___

Signature

AUTHORIZATION FOR MEDICAL RECORDS RELEASE TO IVF Michigan, P.C./Toledo Fertility Center LLC/Arbor Park Reproductive Laboratory

37000 Woodward Ave. Ste. 350, Bloomfield Hills, MI 48304
Phone: (248) 952-9600 Fax: (248) 952-9650

NAME _____ **DATE OF BIRTH** ___/___/___

SOCIAL SECURITY NUMBER _____ **PHONE** _____

_____ Office Notes _____ Operative Notes: _____
(Please specify date of service)

_____ Laboratory Results _____ Release All Records

This release also specifically allows for the release of the following information (this information will not be release unless the appropriate box is initialed):

Any record of treatment for Drug and/or Alcohol dependency or abuse
Any record of Mental Health Treatment
Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

Release all records, as indicated above, except the following: _____
_____

Release these records to:

IVF Michigan, P.C./Toledo Fertility Center, LLC/Arbor Park Reproductive Laboratory
37000 Woodward Ave. Ste. 350, Bloomfield Hills, MI 48304

This information is to be released for the following purpose(s) only and may not be used for any other purpose or released to any other person(s) without my written consent:

____ Continuation of Care

____ Personal Use

____ Other:

_____

This release is effective for six months from the date of execution, however, it may be revoked by me at any time by providing notice in writing to the above named party. I am entitled to a copy of this Authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits,

_____ **DATE** ___/___/___

Signature of requestor