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

PATIENT INFORMATION

NAME _____ DATE ___/___/___

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

ADDRESS _____

EMAIL _____

CELL _____ HOME _____ WORK _____

EMPLOYER _____ EMPLOYER PHONE _____

PRIMARY CARE PHYSICIAN _____

PHONE _____ ADDRESS _____

RACE (optional) _____

REFERRING INFORMATION

PHYSICIAN / SPECIALTY _____ PHONE _____

☐ 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 _____

REFERRING PHYSICIAN / SPECIALTY _____

PHONE _____ ADDRESS _____

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 _____

POLICY HOLDER NAME _____

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

ADDRESS _____ PHONE _____

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 _____

POLICY HOLDER NAME _____

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

ADDRESS _____ PHONE _____

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 acknowledge payment 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 ___/___/___

BLUE CARE NETWORK, M-PREMIERE CARE, HAP (if out of local network), and insurance that requires 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.

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

CONFIDENTIAL COMMUNICATIONS

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

I/we authorize the practice to leave a message on my work voicemail. YES / NO

I/we authorize the practice to leave 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 ____/____/____

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 _____

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 and Progenity. 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.

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 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 balances must be paid in full BEFORE starting another procedure or scheduling a consultation appointment.
- NO SHOW APPOINTMENT – There will be a fee of $65 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 or 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 YOUR MEDICAL INFORMATION 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, 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 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.

Uses and Disclosures of Protected Health Information (PHI)
Your protected health information 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 be 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 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 you 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 reliance on the use or disclosure indicated in the authorization.

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 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 at 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 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

IVF Michigan, P.C./Toledo Fertility Center LLC/Arbor Park Reproductive Laboratory

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

Patient Name: _____ Date of Birth: _____

(Print Name)

Social Security Number:_____ Phone: _____

I authorize _____ to release my medical information, including:

(Name of Facility)

Phone: _____ Fax: _____

_____ 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 released 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., Suite 350, Bloomfield Hills, MI 48304 | Phone: (248) 952-9600 Fax: (248) 952-9650

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,

_____ _____

SIGNATURE OF REQUESTOR DATE

POLICY AND PROCEDURE TO RELEASE MEDICAL RECORDS

• You must sign a medical release form to obtain a copy of your medical record.

• Processing your record request could take up to 10 business days. Embryology reports take an additional 2-5 business days to process.

• The first set of copies will be processed at no charge. We highly suggest you get this copy for your records to avoid potential fees in the future.

• Each additional set of copies will be charged at the current rate approved by th State of Michigan as follows: the initial charge is $24.48 plus $1.22 per page up to 20 pages. Pages 21-50 will be $.61 cents per page. Pages 51 and up will be $.24 cents per page. There will be an additional fee for records in long term storage which will equal the charge to us for delivery from the storage facility. The final charge will be the cost of mailing the records to you/facility/doctor.

• Only medical records of treatment performed in our office will be released to you. If you have additional records from another physician in your patient chart, you will need to contact their office to obtain copies of those records.

• If you have a spouse or partner with records or test results in your chart, they also will need to sign the record release in order to have them released.

• If the records are being copied and released to you, the record request must be signed in the presence of and IVF/TFC/Arbor Park staff member, or it must be notarized. If being released to a physician's office, just your signature is required.

• IVF Michigan and Toledo Fertility Center require confirmation of identity before records can be released. This can be done in person, when picking up records, or email. Email address must match the one given at the time of registration. Emails requesting records must have valid driver's license, state ID, passport, or visa attached along with IVF Michigan authorization for release of medical records form.

• Records requested for personal use will be released only to the address on file or picked up at your treating office.

_____ **DATE** ____/____/____

Patient signature