REGISTRATION FORM

PATIENT

SOCIAL SECURITY NO.					
NAME (LAST, FIRST, MIDDLE INITIAL)		NICKNAME			
ADDRESS					
CITY/STATE/ZIP					
HOME PHONE	CELL PHONE	WORK PHONE			
DATE OF BIRTH	AGE	SEX	MARRIED	DIVORCED	SINGLE

PATIENT'S EMPLOYMENT

COMPANY NAME	YOUR OCCUPATION
ADDRESS	
CITY/STATE/ZIP	

PRIMARY INSURANCE

INSURANCE COMPANY NAME	
P.O. BOX/ADDRESS	
CITY/STATE/ZIP	
PHONE NUMBER	POLICYHOLDERS NAME
POLICY I.D. NUMBER	GROUP NO

REFERRING PHYSICIAN

NAME
ADDRESS
CITY/STATE/ZIP
PHONE

EMERGENCY CONTACT

NAME	PHONE

RELATIONSHIP

SPOUSE/PARTNER (if applicable)

SOCIAL SECURITY NO.					
NAME (LAST, FIRST, MIDDLE INITIAL)		NICKNAME			
ADDRESS					
CITY/STATE/ZIP					
HOME PHONE	CELL PHONE	WORK PHONE			
DATE OF BIRTH	AGE	SEX	MARRIED	DIVORCED	SINGLE

SPOUSE/PARTNER EMPLOYMENT

COMPANY NAME	YOUR OCCUPATION
ADDRESS	
CITY/STATE/ZIP	

SECONDARY INSURANCE

INSURANCE COMPANY NAME	
P.O. BOX/ADDRESS	
CITY/STATE/ZIP	
PHONE NUMBER	POLICYHOLDERS NAME
POLICY I.D. NUMBER	GROUP NO

OTHER FORM OF REFERRAL

FRIEND	
INTERNET	YELLOW PAGES
INSURANCE DIRECTORY	
OTHER	

Acknowledgment that information is true and correct.

Submitted by: _____ DATE: _____

ALL INFORMATION IS REQUIRED BEFORE 1ST APPOINTMENT

Reproductive Solutions, LLC.Financial Disclosure and Agreement

Please review carefully and retain for your records

THIS FINANCIAL DISCLOSURE AND AGREEMENT PERTAINS TO ALL SERVICES PROVIDED AT REPRODUCTIVE SOLUTIONS, LLC, d.b.a. ADVANCED REPRODUCTIVE CARE (ARC).

INSURANCE AND BILLING

During the course of your evaluation and treatment, physicians and other medical professionals may be involved in your care. It is common to be billed for physician and advanced practitioner services, anesthesia services, pathology services (if a biopsy was taken) and facility fees. Some entities may bill separately for services provided. You are free to utilize the health care facility or provider of your choice, subject to the terms of your physician's affiliation or restrictions which may exist under your health insurance coverage. Patients should check with their health insurance provider if they have any questions or concerns about their coverage.

PROOF OF INSURANCE COVERAGE

Copies of insurance cards are required for proof of coverage and submission of claim to insurance. If more than one insurance policy exists, proof of coverage is required for both insurance policies. Payment in full will be required the same day service is provided when proof of insurance has NOT been provided, unless otherwise arranged with our office.

CHANGE OF INSURANCE COVERAGE

It is patient responsibility to notify the physician office of any changes to insurance coverage PRIOR to any scheduled visits. Any balance deemed patient responsibility by the insurance carrier, including payment denials resulting from failure to update insurance information, are the responsibility of the patient.

VERIFICATION OF INSURANCE BENEFITS

The physician's office will attempt to verify Insurance benefits to determine the level of coverage and financial responsibility for services requested. Information obtained from insurance and/or any verbal/ written correspondence received is NOT a guarantee of payment. Any information obtained from insurance is used for the sole purpose of helping patients navigate the potential out of pocket costs associated with their care, to the best of our ability. It is patient responsibility to be aware and understand his/her insurance plan(s), limitations of coverage and benefits and to determine and/or inquire of prior authorization requirements that need to be completed prior to each scheduled visit.

BILLING

Patient authorizes payment of medical benefits to the medical service provider. Claims will be submitted to insurance on file with our office. Services provided that are not covered by the patient's insurance policy will be deemed "self-pay" and will be billed directly to the patient.

FINANCIAL RESPONSIBILITY

PATENT RESPONSIBILITY and NON PAYMENT

Payment for any amount deemed patient responsibility is due prior to or at the time of service. Patient responsibility for co-pays, co-insurance, non-covered services or other categories deemed patient responsibility may be determined through the benefit verification process, prior to a patient receiving an account statement. These payments will be due prior to or at the time of service.

Failure to pay an account balance past 90 days may result in the account being referred to a collection agency and/or suspension of the patient account for care that is not identified as a medical emergency. Continued failure to reconcile an outstanding balance may result in dismissal from the practice.

Patients are required to pay co-payments and/or co-insurance. The physician's office is contractually obligated to collect on this category of financial responsibility and these fees cannot be waived by our office.

PAYMENT OPTIONS

Credit or debit is the preferred form of payment, however, cash or check will be accepted, if necessary.

PERSONAL CHECKS and NON-SUFFICIENT FUNDS

In the event a check is returned due to non-sufficient funds (NSF), the physician office works directly with a third-party check collection agency in an attempt to electronically debit the amount of the check plus processing fees with equitable taxes. It is the discretion of Reproductive Solutions, LLC to terminate any attempts to collect by the third-party check collection agency and assess a $35.00 service fee to the face value of the returned check and decline personal checks as a form of payment. Any fee incurred by Reproductive Solutions, LLC is transferable to the patient. Additional charges may also be incurred from your banking institution in addition to any fees assessed by Reproductive Solutions, LLC.

FEES

Reproductive Solutions, LLC reserves all rights to make any and all necessary changes to its established fees at any given time without advanced notification.

COST ESTIMATES

Cost estimates are only an estimate of fees for the period of time and services requested. Fees are subject to change without prior notice. It is patient/consumer responsibility to request an up-to-date cost estimate, if the timing or scope of services change. Some out-of-pocket expenses for services provided may not be able to be determined until after services or course of treatment has been completed.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

NOTICE OF PRIVACY PRACTICES

Our organization is dedicated to maintaining the privacy of your individually identifiable health information. This Notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. The terms of this Notice apply to all records containing your health information that are created or retained by our organization. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. We are permitted to use or disclose your health information, even without your permission, for the following purposes:

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, such as pharmacists who are filling your prescriptions, and to authorized family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Healthcare operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to assess the care and outcomes of your case and others like it.

NOTE: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you for fundraising purposes, but you have the right to opt out of receiving such communications.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information, without your permission, for the following purposes:

Required by Law: We may be required to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public health activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and special government functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers' compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business associates: We may disclose your health information to business associates or third parties that we have contracted with to perform agreed upon services.

We do not engage in selling your health information, however if we do, we will obtain your written authorization before we are permitted to sell your health information. In all other situations, including marketing activities, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the privacy officer for exercising these rights.

Request restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to restrict disclosures of your health information to your health plan for payment and health care operations purposes (and not for treatment) if the disclosure pertains to a health care item or service for which you paid out-of-pocket in full. If requesting a restriction for a health care item or service for which you paid out-of-pocket in full, we will honor your request, unless the disclosure is necessary for your treatment or is required by law. For all other restriction requests, we are not required to agree to such restrictions.

Confidential communication: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using post-cards to remind you of appointments.

Inspect and obtain copies: In most cases, you have the right to look at or get a copy of your health information. An administrative fee may apply. We have the right to deny your request.

Amend information: If you believe that information in your record is incorrect, or, important information is missing, you have the right to request that we correct the existing information or add the missing information. Amendment requests must be made in writing.

Accounting or disclosures: You may request a list of instances where we have d is closed health information about you for reasons other than treatment payment, or health care options.

Breach notification: We are required to notify you in the event of a breach of your unsecured protected health information, and will do so accordingly.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the notice currently in effect.

Changes in Privacy Practices

We may change our Privacy Practices at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the Privacy Officer listed below.

Complaints

If you are concerned that we have violated your privacy rights, or, you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Advanced Reproductive Center
ATTN: Privacy Officer
435 N. Mulford Road, Suite 9
Rockford, IL 61107
815-229-1700

I hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Intended Parent Name (1):
Signature:

Intended Parent Name (2):
Signature:

If not signed, reason why:

Staff Witness: _____ Date: _____

Advanced REPRODUCTIVE CENTER

CONSENT FOR VERBAL RELEASE OF INFORMATION

1. Please provide your email address and preferred phone contact information.

   Home: _____ Cell: _____ Work: _____

   Email: _____

2. Which phone number is best to use during the day (7am-5pm)? ◯ Home ◯ Cell ◯ Work

3. Representatives of Advanced Reproductive Center may leave detailed messages regarding appointments or send practice notifications using the information provided.

4. Check box if we may leave detailed lab/test results on your voicemail* ☐ Home ☐ Cell ☐ Work

   * Answering machines and voicemail must have an identifying message to confirm these are your numbers – for example, "You have reached Jane Doe."

   * Please list any persons with whom we MAY share details regarding your health care. Indicate below whether this may include sensitive health information (SHI) such as reproductive health information, HIV and other STD information and results, and/or genetic testing. For couples, list both intended parents if you wish information to be shared.

Name	Relationship	Release SHI?
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No

- I understand that this consent is valid until it is revoked by me. I understand that I may remove this content at any time by giving written notice of my desire to do so, to the physician or practice. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.
- I understand my consent to the individual(s) who receives my medical/financial information is separate and distinct from Advanced Reproductive Center's use and disclosure of information described and permitted under the Notice of Privacy Practices, which has been provided to me.

Signature: _____ Date: _____

Printed Name: _____
(patient, parent or guardian)

Advanced Reproductive Center employs a number of different resources for the purpose of contacting you to deliver important information. Your privacy is important to us and we will not share or sell your information to any third-party vendor except when required for legal or debt collection purposes. Listed below are examples of some of the reasons we may need to reach you using the information we collect at the time of registration (for new patients) or have on file (for established patients), which may include your email address, home or mobile telephone number.

Patient Portal Access: You will receive an email with instructions to set up your patient portal account.

Practice Announcements: These may include new physician or provider announcements or provider retirement/relocation notifications.

Appointment Reminders: These may include information regarding a scheduled or missed appointment via email, home phone, mobile phone or text messaging.

Patient Education: These may include video applications intended to provide necessary information regarding a scheduled procedure. We may also send information regarding new treatments or clinical research trials, notification of educational seminars on specific health topics or other relevant information.

Customer Service Improvements: We are always evaluating applications to improve our service to you, as applications become available, you may receive a notification or registration invitation.

Collection Activity: If your account becomes delinquent, Advanced Reproductive Center may employ the services of a collection agency to recover any outstanding balance on your account. You may request the removal of your mobile number for this purpose by providing written notification to Advanced Reproductive Center, ATTN: Billing Manager, 435 N Mulford Road, Suite 9, Rockford, IL 61107.

Intended Parent Name (1): _____

Signature _____ Date: _____

Intended Parent Name (2): _____

Signature _____ Date: _____