



Patient Registration

Today's Date: _____

Ver 9/22/08

Patient's Name:		Spouse/Partner's Name:	
Birth date:	Age:	Birth date:	Age:
Social Security #		Social Security #	
Occupation: _____		Occupation: _____	
Employer: _____		Employer: _____	
Home Address: _____		<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
City/State/ Zip: _____		<input type="checkbox"/> Remarried <input type="checkbox"/> Single in a committed relationship	
Email address: _____			

Referral Source:

Physician Patient/Friend/Relative Other _____
 Radio: 96.9 (The Mix) 98.7 (The Peak) 107.3 (KMLE) 99.9 (KEZ) TV _____
 Internet: Google Yahoo Pregnancy Info Locate-A-Doc Fertility Doc Shop Fertility Life Lines Other _____
 Print: 101 North MD News Phoenix Mag Airpark News AZ Foothills Other _____

Contact List:	Call Order	OK to call	OK to leave detailed message
Home Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Work Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cell Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/Partner:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Responsible Party/Insurance Subscriber's Name:	Date of Birth:
Address:	Home Tel #:
City, State, Zip:	Work Tel #:

Primary Insured's Ins. Plan:	Secondary Ins. Plan:
Insurance Address:	Insurance Address:
City, State, Zip:	City, State, Zip:
Plan ID #: _____ Group #: _____	Plan ID #: _____ Group #: _____
Co-Pay:	Co-Pay:

Local Pharmacy Name:	Phone #:	Fax #:
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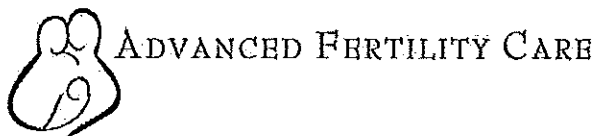
Under HIPPA Guidelines, I authorize you to discuss my protected health information for any purpose with the following person(s):

Name : _____ Relationship: _____ Phone Number: _____

I agree that the above information is correct as listed or changed as indicated. I authorize my insurance company to make payments directly to Advanced Fertility Care, PLLC (AFC). I further authorize AFC to release any information about my medical care to my insurance company. This includes diagnosis, treatment and other information contained within the medical record. I agree to pay for any medical services that are not covered under my insurance.

Date _____

Signature _____



Nathaniel Zonerach, MD, FACOG
Reproductive Endocrinology & Infertility

Consent To Treat

Medical Treatment: The patient consents to the treatment, services, office visits and procedures which may be performed in the office, which may include but are not limited to multiple visits, laboratory procedures, ultrasound evaluation, x-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered under the general or specific instructions of the responsible physician or other health care providers. The office may establish certain criteria which will automatically trigger the performance of specific tests which patient agrees may be performed without any further separate consent.

Legal Relationship between Healthcare Providers/Patients: The patient will be treated by his/her attending doctor, healthcare providers and be under his/her care and supervision.

I have read and understand this treatment agreement.

I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement.

Signature: _____

Printed Name: _____

Date: _____



AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments for professional services are due at the time services are provided. We accept cash, personal checks Visa, MasterCard, Discover Card and financing through one of the companies on our website.

Insurance

It is your responsibility to know what your insurance covers and does not cover. You are ultimately responsible for all charges not covered by your insurance. Some insurance plans limit the number of procedures they will cover within a treatment cycle, so there may be times when not all procedures done will be covered by your insurance.

If we have received all of your insurance information 24 hours prior to the day of the appointment and we are able to confirm eligibility, we will be happy to file claims on your behalf for covered services at AFC. The accuracy of all the information we receive is essential for proper claim filing. We will assist you in estimating your portion of the fee for services; however, we can not guarantee what your insurance company will pay on a claim. **Please understand that filing your claims is a courtesy our office provides to our patients, it does not guarantee payment to us.** We are providing our professional services you -- not the insurance company! Consequently, you are ultimately responsible for payment of our fees.

For example, if your insurance states that they will cover diagnostic testing only, this means that they will not pay for the mid cycle or follicular ultrasound of a treatment cycle. This particular type of ultrasound would be considered self pay.

BENEFITS ARE NOT DETERMINED BY OUR OFFICE

Benefits are not a guarantee of coverage or payment. Coverage is determined when the claim is actually received.

You may have noticed that sometimes your insurance reimburses you or the doctor at a lower rate than the doctor's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your doctor's fee has exceeded the usual, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most doctors in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit. Unfortunately, insurance companies imply that your doctor is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.



Once the physician has determined your treatment protocol, you will have a financial visit to discuss the upcoming treatment and identify charges for expected procedures. However, once treatment begins, unique patient situations sometimes require additional procedures. These additional procedures may not be announced to you as "additional" by our clinicians, as they are providing you with care based solely upon your individual needs. (These procedures for example may relate to extra ultrasounds and blood tests to monitor effects of medication during ovarian stimulation.)

All prices quoted to you are quoted under a fee for service arrangement. Under the fee for service arrangement, you will be charged for all of the services provided by AFC, and you will not be entitled to a refund in the event that, for any reason, the treatment is not successful.

This arrangement may not be modified by a verbal agreement.

You will be financially responsible for all services provided, even if such services were not anticipated when you began treatment and are not included in the financial visit. Charges that are patient responsibility and remain unpaid after 30 days are subject to an administrative fee of \$15.00 per billing cycle.

I agree to be responsible for all charges incurred by me and to pay my account. If my account is sent to an attorney or collection agency, I agree to pay attorney's fees and/or collection agency expenses. The amount of the attorney's fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.

If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to AFC or to the provider group rendering service, for application on my bill. However I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL. In rendering treatment, AFC is relying on my agreement to pay the account.

I have read and understood the AFC payment terms and conditions.

Signature: _____

Printed Name: _____

Date: _____



ADVANCED FERTILITY CARE

Nathaniel Zonerach, MD, FACOG
Reproductive Endocrinology & Infertility

LABORATORY TESTING POLICY

We would like to inform all of our patients that a portion of your laboratory testing for fertility services will be performed by:

Arizona Advanced Reproductive Lab, LLC (AARL)

AARL does not hold contracts for reimbursement purposes with the various insurance plans. However, the majority of insurance plans will reimburse for testing done through AARL. For those patients whose insurance coverage does not allow testing in our lab, we will make every effort to send your specimens to the designated reference lab (Lab Corp, Sonora Quest), with the exception of the hormone tests.

There are certain hormone tests that must be performed by AARL for infertility treatment due to the quality and consistency of the results as well as rapid access to these results. The following tests, if ordered, WILL be performed by AARL:

FSH, Estradiol, LH, Progesterone, and BHCG.

In addition to these, ALL andrology services (male testing including **Semen Analysis and IVF Sperm Testing**) will be performed by our certified andrologist.

Finally, all laboratory procedures done in connection with a fertility treatment such as IVF, IUI, Ovulation Induction will be performed by AARL.

For **ALL** AARL services, FULL PAYMENT will be collected prior to or on the day of service. We will be happy to supply you with a statement for your insurance company for your reimbursement purposes.

I have read the above information and understand the policy in regards to AARL.

Signature

Date

AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments for professional services are due at the time services are provided. We accept cash, personal checks, Visa, MasterCard, and Discover.

Insurance

BENEFITS ARE NOT DETERMINED BY OUR OFFICE. Benefits are not a guarantee of coverage or payment. Coverage is determined when the claim is actually received.

Please be advised that our surgery center is considered **in network** for most insurance plans. We bill a facility fee for each of the following procedures; as long as there is coverage available on your plan:

- | | | | |
|------------------|----------------|------------------|----------------------|
| -HSG | -Egg Retrieval | -Embryo Transfer | -Office Hysteroscopy |
| -Plastic Surgery | -BNT | -GYN Surgery | -PESA/MESA/TESA |

Our facility collects deductibles, copays and co-insurances for procedures at the time of service.

We have been notified that Blue Cross Blue Shield plans will send you the check for these facility services. Once the check has been received, you will need to turn it over to us within 10 days, or an administrative fee of \$150 will be accessed. Furthermore, each month that the balance goes unpaid, interest fees will be applied at 10% per month of the total billed charge.

This arrangement may not be modified by a verbal agreement.

I agree to be responsible for all charges incurred by me and to pay my account. If my account is sent to an attorney or collection agency, I agree to pay attorney's fees and/or collection agency expenses. The amount of the attorney's fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.

If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to AASC or to the provider group rendering service, for application on my bill. However I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL. In rendering treatment, AASC is relying on my agreement to pay the account.

I have read and understood the AASC payment terms and conditions.

Signature: _____ Date _____

Printed Name: _____

HIPAA PATIENT PRIVACY NOTICE

(Effective Date: December 19, 2005, Revised January 26, 2006)

The HIPAA Privacy Rule gives an individual a right to adequate notice of the uses and disclosures of protected health information (PHI) that may be made by this office, and of the individual's rights and the office's legal duties with respect to the PHI.

Patient Privacy Practices

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 our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Advanced Fertility Care, PLLC is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the reception room or at our website at www.advancedfertilitycare.com. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the reception room or at our website at www.advancedfertilitycare.com. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

- 1. For Treatment:** We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail, electronic mail or facsimile.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

2. For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

3. For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, 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, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

4. Business Associates: There are some services provided in our organization through contracts with business associates. Examples include transcription, billing and collections, document shredding, quality assurance and software support. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

1. Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

2. Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you that you have an appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

1. As required by law. We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

2. Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

3. State-Specific Requirements: Many states have requirements for reporting, including population-based activities relating to improving health or reducing health care costs.

Your Health Information Rights

Although your health record is the physical property of Advanced Fertility Care, PLLC and Arizona Advanced Surgery Center, LLC, that compiled it, you have the right to:

1. **Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Advanced Fertility Care, PLLC in writing. As per Arizona law, there is no charge for your first request. The practice charges \$10 for each additional search and \$10 for the cost of copies and postage for copies of the medical record.

2. **Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

3. **An Accounting of Disclosures:** You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Advanced Fertility Care, PLLC will provide the first accounting to you in any 12- month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be \$10.00. We ask that you submit these requests in writing.

4. **Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You

also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

5. Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

6. 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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaint

If you believe your privacy rights have been violated, you may file a complaint with us by calling (480) 874-2229 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must also be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Michele Tucker
Telephone Number: 480-874-2229

ADVANCED FERTILITY CARE, PLLC

9819 North 95th Street, Suite 105
Scottsdale, AZ 85258
(480) 874-2229

HIPAA PATIENT PRIVACY NOTICE

I, _____, have been offered a copy of the HIPAA Patient Privacy Notice Form for Advanced Fertility Care, PLLC and understand my rights under this policy.

Signature: _____ Date: _____

Printed Name: _____



EMAIL AUTHORIZATION FOR SECURE PATIENT PORTAL

(Ver 9-24-08)

As part of our continuing effort at Advanced Fertility Care to bring our patients the latest in customer service and convenience, we will be implementing a feature of our electronic medical record system which will provide a secure patient portal for communication with our office.

Using the secure Patient Portal, we will be able to provide you another means of communicating with our administrative, billing, and clinical staff more efficiently. You will also be able to receive important appointment reminders as well as review previous and future billing statements. In some cases, you may also be able to have access to certain laboratory test results as they are reported by the laboratory.

This system will be integrated through your email account. You will receive notices via email when there is new information to be reviewed on the secure patient portal.

In order to implement this system, we are asking all our patients to provide us with their email addresses. These email addresses will be used for the sole purpose of establishing an electronic patient portal account for you.

Email address: _____

My name and signature below authorizes Advanced Fertility Care, Arizona Advanced Reproductive Laboratory, and/or Arizona Advanced Surgery Center to use my email account in order to establish a secure patient portal account on my behalf linked to my electronic medical record.

Print Full Name

Date

Signature

Scottsdale
9819 North 95th St, Ste. 105
Scottsdale, AZ 85258
Tel (480) 874-BABY
Fax (480) 874-2231

South East Valley
2055 East Southern Ave., Ste. E
Tempe, AZ 85282
Tel (480) 413-BABY
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