Patient Registration

Today's Date: ____________________ Ver 6/1/17

Patient's Name:	Spouse/Partner's Name:
Birth date: Age:	Birth date: Age:
Race: ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Hispanic or Latino ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Other ❑Unknown	Race: ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Hispanic or Latino ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Other ❑Unknown
Employer: ____________________	Employer: ____________________

Home Address:______________________________ City/State/ Zip: ______________________________

Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried ❑ Single in a committed relationship ❑ Single

Referral Source(s): ❑ Not Applicable

❑ PCP/ObGyn Physician (if applicable): ______________________________

❑ Patient/Friend/Relative ______________________________ ❑ Other ____________________

❑ Marketing: ❑ Google ❑ Yahoo ❑ Bing ❑ Facebook ❑ CDC/SART Website ❑ Other____________________

❑ LGBT Media or Event ____________________ ❑ ____________________

❑ Phoenix Magazine ❑ ____________________

❑ Insurance: ❑ Banner ❑ Blue Cross/Shield ❑ United ❑ Aetna ❑ Cigna ❑ Humana ❑ ____________________

Email Address:

Phone Contact List: Please list all contact phone numbers below	Call Order	√ **if NOT OKAY to leave detailed message**
Home Phone:		❑
Work Phone:		❑
Cell Phone:		❑
Spouse/Partner:		❑

EMERGENCY CONTACT #	Name:	Relation:

Preferred Pharmacy Name: ____________________	**Phone #:** ____________________
Address or Cross Streets: ____________________	**Fax #:** ____________________
City: ____________________	

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 (AFC), Arizona Advanced Surgery Center, LLC (AASC), and/or Arizona Advanced Reproductive Laboratory, LLC (AARL). I further authorize AFC, AASC, and AARL 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, unless specific arrangements have been made with AFC, AASC, and/or AARL in advance.

Date____________________ Signature______________________________

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

HIPAA PATIENT PRIVACY NOTICE

(Effective Date: December 19, 2005, Revised April 15, 2016)

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 HIPAA Compliance 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 (AFC), Arizona Advanced Surgery Center, LLC (AASC), and Arizona Advanced Reproductive Laboratory (AARL) are 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.azfertility.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.azfertility.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/provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of appointments by telephone, text messaging or email.

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 (i.e. revoke permission) 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, will 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 both hard copy and electronic 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 HIPAA Compliance Officer.

3. Patient Portal: AFC, AASC, and AARL use an electronic secure Patient Portal operated by eClinical Works electronic medical records system. We encourage our patients to embrace the use of this system for means of electronic communication between you and our office. This system is largely relied upon during the course of In- Vitro Fertilization (IVF) and Injectable IUI treatment cycles to relay concise medication instructions to patients as well as providing timely responses to non-urgent patient inquires. This system is integrated through your email account

and the email address you provide to the practice. You will receive notification via email advising you of the need to log into the secure patient portal to view your new message.

4. Baby Photographs: AFC is proud to share encouraging examples of patient success stories by displaying non-identifiable baby photos that are voluntarily submitted to us by birth announcement, holiday card, etc.

By voluntarily submitting photos you as parents understand, agree, and authorize that your submitted photograph(s) become the property of AFC or it's representatives, will not be returned, and may be disclosed, used, or displayed in materials used by AFC including but not limited to in-office baby boards/displays, the website for AFC (www.azfertility.com) and printed materials.

5. Electronic Appointment Confirmations: AFC, AASC, and AARL may use a number of electronic means for appointment confirmations and reminders for patient convenience. Text messaging would be the primary method of notification. If you select text messaging as your preferred option you agree all individuals associated with your account may receive alerts referencing the account guarantor. Text message charges and/or data rate from your cell phone provider may appl; contact your wireless provider for specific information regarding text usage and charges.

By selecting the option of text messaging you represent, warrant, and agree that you are the person legally responsible for all use of the account, you are at least 18 years of age, you agree and consent to the use of personal information to provide the text notification message including but not limited to your name, address, cell phone number, AFC provider office and location, appointment dates and times, account information, and customized content by AFC. AFC is not liable for any delays that may be experienced during the transmission of any message as delivery is based on your wireless provider.

Should you desire to change your method of appointment notifications you must send written notification of the requested change to AFC.

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 AFC, AASC, and AARL 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. There is no charge for your first request however 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. AFC, AASC, AARL 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.

7. **Restrict Disclosures When You Have Paid For Your Care Out-Of-Pocket**: You have a right to restrict certain disclosures of Protected Health Information (PHI) to a health plan (insurance company) when you have paid out-of-pocket in full for services at AFC.

8. **Notification If There Is A Breach Of Your Unsecured Protected Health Information (PHI):** You have the right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards: and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

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

Questions and Complaints

If you have questions or concerns about this notice or believe your privacy rights have been violated, you may contact our HIPAA Compliance Officer at (480) 874-2229 or 9819 N. 95th Street, Suite 105, Scottsdale, AZ 85258. **All complaints must also be submitted in writing.** You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have specific rights under the Privacy Rule. Your provider/Advanced Fertility Care will not retaliate against your for exercising your right to file 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.

HIPAA Compliance Officer: Kristen Vogt
Telephone Number: 480-874-2229

This notice first became effective on December 19, 2005. It was most recently revised on April 15, 2016.

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

HIPAA PATIENT PRIVACY ELECTIONS & SIGNATURE FORM

By signing below, I acknowledge that I have been offered and/or provided a copy of the "HIPAA Patient Privacy Notice" that is applicable for Advanced Fertility Care, PLLC (AFC), Arizona Advanced Surgery Center, LLC (AASC), and Arizona Advanced Reproductive Laboratory, LLC (AARL) and have therefore been advised of how health information about me may be used and disclosed by AFC, AASC, and AARL, and how I may obtain access to and control of this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates

Under HIPPA Guidelines, I hereby authorize release of my medical records to my physician(s), surgeon(s), anesthesiologist, or any other medical/laboratory care providers who have aided in my care at Advanced Fertility Care PLLC, Arizona Advanced Surgery Center, LLC, and/or Arizona Advanced Reproductive Laboratory, LLC.

In addition to the above, I also permit you to discuss my protected health information for any purpose with the following person(s):

❑ Partner/Spouse: _______________________________ Tel #_______________________

❑ Ob-Gyn and/or PCP Physician(s): 1. ____

2. ____

❑ Other: _______________________ Relationship: ___________ Tel #_________________

❑ I do not permit discussion of anything related to my care with any other person, except where mandated by legal authority.

***While not mandated under the HIPPA privacy act, in order to safeguard your privacy, our internal practice policy requires a signed written authorization for release of medical records to either yourself or any outside party, **regardless** of your selections above.

Print Name: ____________________________________ DOB:________________________

Signature: _____________________________________ Today's Date: _________________

ADVANCED FERTILITY CARE
ARIZONA ADVANCED REPRODUCTIVE LAB

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

CONSENT TO TREATMENT

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, understand, and agree to 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: _________________________________

ADVANCED FERTILITY CARE

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

AFC 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.

For patients who wish to use credit cards as form of payment for ART Treatments (IVF or FET/FBT), a 3% convenience fee will be assessed in addition to the treatment cycle cost.

INSURANCE

We are providing our professional services to you – not the insurance company, consequently you are ultimately responsible for payment of our fees. ***As the patient, it is your responsibility to know what your insurance covers and does not cover.***

Our staff will assist you in providing a good faith estimate for your portion of the fee for services based on the information provided to us by your plan however, we cannot guarantee what your insurance company will pay on a claim; as the patient, ***you are ultimately responsible for payment of all charges not covered by your insurance***.

Please be aware that filing of claims is a courtesy our office provides to our patients, it does not guarantee payment to us. If we have received all of your insurance information at least 48 hours prior to the day of the appointment and we are able to confirm eligibility, we will be happy to file claims to contracted health plans on your behalf for covered services at AFC (Advanced Fertility Care).

BENEFITS ARE NOT DETERMINED BY OUR OFFICE

Benefits quoted by your insurance plan are not a guarantee of coverage or payment. Coverage and payment is determined by your insurance when the claim is actually processed.

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.

Some insurance plans also limit the type of services covered for example; if your insurance states that they will cover diagnostic testing only, this mean that they will not pay for a mid cycle or follicular ultrasound of a treatment cycle. This particular type of ultrasound would be considered part of treatment, not diagnostic, and therefore would be self pay and not billable to your insurance plan.

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 is simply not accurate.
Insurance companies set their own fee 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, a 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 consultation to discuss the upcoming treatment and identify the estimated 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.)

FEE FOR SERVICE AND PAYMENTS

All estimated 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.

Patients are required to pay ALL estimated deductibles, co-payments, and co-insurance amounts AT THE TIME OF SERVICE. In the cases of some types of treatment cycles, these amounts will be collected at the onset of the treatment cycle.

Should there be any cost difference resulting in an under or over payment of the provided estimate vs. the actual cost of services, the patient will be invoiced for any balances due or the account will be credited any over payment amount. Refunds are only considered at the conclusion of all treatment services with AFC.

ASSIGNMENT OF BENEFITS

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 understand the ***AFC AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS*** and agree to be responsible for all charges incurred by me and to pay my account balance. 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.

My signature on this document confirms that I have read, understand, and agree to the AFC AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS.

Signature: ______________________________________ Date: ___________

Printed Name: ______________________________________

AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments for outpatient treatment center facility fees and 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 and payment is governed and determined by your health insurance plan when the claim is actually processed.

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	-ENT	-GYN Surgery	-PESA/MESA/TESA

Outside Testing: Arizona Advanced Surgery Center, LLC and the operating surgeon will send any required laboratory testing and/or tissue pathology to an appropriate CLIA Certified laboratory for testing. If radiological studies are required, an approved center will be used for testing. All effort will be made to provide insurance information to the performing lab/clinic, however if no insurance and/or coverage is available **then you, the patient, will be directly responsible for the total cost of the testing**.

This arrangement may not be modified by a verbal agreement.

****PLEASE NOTE: Patients will be required to pay ALL ESTIMATED deductible, co-pay, and co-insurance amounts AT THE TIME OF SERVICE. ****

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 Arizona Advanced Surgery Center (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, understood, and agree to the AASC payment terms and conditions.

Signature: ____ Date _____________

Printed Name: ____

Scottsdale
9819 North 95th St, Ste. 110
Scottsdale, AZ 85258

Phoenix
1701 E. Thomas Rd, Ste 202
Phoenix, AZ 85016

South East Valley
1550 S. Alma School Rd, Ste 100
Mesa, AZ 85210

ADVANCED FERTILITY CARE
ARIZONA ADVANCED REPRODUCTIVE LAB

Nathaniel Zoneraich, MD, FACOG
Frederick Larsen, MD, FACOG
Nicole Kummer, MD, FACOG
Reproductive Endocrinology & Infertility

LABORATORY TESTING & FINANCIAL 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 most insurance plans. However, many insurance plans may partially or fully reimburse for testing done through AARL, especially if the policy has coverage for out-of-network benefits.

There are certain hormone tests that must be preformed 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 and may incur out-of-pocket costs in addition to the insurance coverage: **FSH, Estradiol, LH, Progesterone, and either serum or urine HCG**.

In addition to these, ALL andrology services (male testing including **Semen Analysis, Sperm Chromatin Structure Assay, IUI sperm preps, and biological tissue freezing**) will be performed by our certified andrologist and/or embryologist as part of AARL.

Finally, **all laboratory procedures done in connection with a fertility treatment** such as IVF, IUI, and 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 an itemized statement for your insurance company for your reimbursement purposes.

The remainder of any additionally ordered blood work (general medical or infectious disease screening, endocrine screening or genetic testing) will be sent to a 3rd Party outside laboratory who will bill your insurance company or you directly if you are not covered by an insurance plan.

By signing below, I acknowledge that I understand that Nathaniel Zoneraich, MD has a financial interest in Arizona Advanced Reproductive Laboratory, LLC, and that I agree to have the above mentioned tests and any future endocrinology/embryology/andrology services performed at Arizona Advanced Reproductive Laboratory, LLC.

I have read the above information and understand the policy in regards to AARL and 3rd Party laboratory services.

Signature: ____ Date ________

ADVANCED DIRECTIVE NOTIFICATION FORM

HIPAA PATIENT PRIVACY NOTICE & PATIENTS BILL OF RIGHTS

My signature below indicates that I have been offered a copy of an **Advanced Directive/Living Will** Form by Arizona Advanced Surgery Center, LLC and understand that I may choose to utilize or not utilize the form at my own discretion.

I have been offered a copy of the **HIPAA Patient Privacy Notice Form** and **Patient's Bill of Rights** for Arizona Advanced Surgery Center, LLC and understand my rights under this policy.

Signature: ____ Date: ______________

DISCLOSURE OF FINANCIAL INTEREST

The purpose of this disclosure is to make patients of Advanced Fertility Care, PLLC aware that a portion of your testing and potential future operative procedures will be performed in conjunction with an outpatient surgery and/or treatment center (Arizona Advanced Surgery Center, LLC) licensed by the State of Arizona Department of Health Services.

Dr. Zoneraich and Advanced Fertility Care, PLLC are committed to providing exceptional patient care and welcome the opportunity to assist patients with their operative needs. Because of Dr. Zoneraich's direct financial interest in Arizona Advanced Surgery Center, PLLC, he is able to provide the optimum care possible for his patients that utilize the surgery center. Therefore, his patients receive both a professional and personal experience with their pre-operative and surgical care.

As always, you the patient have the choice to schedule your surgical procedures at any outpatient facility where Dr. Zoneraich has active privileges.

By signing below, I acknowledge that I have read the above information and understand that Nathaniel Zoneraich, MD has a financial interest in Arizona Advanced Surgery Center, LLC, and that I agree to have my future outpatient testing and operative procedures scheduled at Arizona Advanced Surgery Center, LLC.

Patient's Signature:____ Date: __________________

Printed Name: ____