Advanced Reproductive Center

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Reproductive Health & Fertility Center

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Advance Reproductive Center and Reproductive Health & Fertility Center **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the **Notice**, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medial assignment benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relation ship to patient

Relationship: _____

Internal Use Only:

If patient or patient's representative refuse to sign **Acknowledgement of Receipt of Notice**, please document the date and time the notice was presented to the patient and sign below.

Presented on (Date & Time): _____

By: (Name & Title): _____

Reproductive Solutions, LLC., & Midwest Reproductive Care, LLC., Financial Disclosure and Agreement

Please retain for your records & review it carefully

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

Patient awareness and understanding of our financial policies and patient expectations are an important element of each and every visit with our Center.

INSURANCE AND BILLING

An insurance policy is a contract agreement between the patient and the insurance company. This contract agreement requires the patient to pay the physician's office for services provided. All questions and disputes regarding how insurance determined and applied benefits are to be directed to your insurance company.

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.

CHANGE OF INSURANCE COVERAGE

It is patient responsibility to notify the Business Office of any changes to insurance coverage on file PRIOR to any scheduled visits. Lack of notification may result in the Business Office requiring payment in full for services provided and may ultimately affect insurance payment.

VERIFICATION OF INSURANCE BENEFITS

The Business Office will 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 managing the financial aspects of patient accounts. 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

Claims will be submitted to insurance as a courtesy service to all patients. Services provided that are not covered by the patient's insurance policy will not be billed to the patient's insurance. Patient assistance is required in contacting the insurance to see that payments due to Reproductive Solutions, LLC or Midwest Reproductive Care, LLC are received in a timely manner. Any charges not paid by insurance within 60 days may be transferred to patient for payment due. As the insurance policy is a contract agreement between the patient and insurance, it is patient responsibility to follow-up with insurance to determine the status of unpaid claims.

Patients are NOT allowed the option of directing to the business office which claims are/are not submitted to insurance. However, patients ARE allowed the option to direct to the business office to either submit all claims or not submit any claims to insurance. In the event the option chosen is NOT to submit claims to insurance, full payment for each scheduled appointment is required the same day service is provided, regardless of benefit coverage.

FINANCIAL RESPONSIBILITY

GUARANTOR

The guarantor of the account is recognized as the patient, to whom services are provided, and is financially responsible for the account. In the event the patient is identified as a minor by age, a parent or legal guardian will be recognized as the guarantor.

OUTSTANDING BALANCES

Payment for balances identified as patient financial responsibility is due in FULL prior to any scheduled treatment procedure(s) and may be requested at any scheduled office visit with or without notification via account statement. Failure to pay an account balance may result in the refusal of appointments for care that is not identified as a medical emergency and finance charges of 1.5% per month may be applicable.

NON-COVERED SERVICES

Payment in full will be REQUIRED for all services on the same day.

PAYMENT

Information received from insurance will be used to determine the amount of payment that will be required from you for each visit. Please arrive for your appointment(s) prepared with payment for co-payments and/or co-insurance. Your co-insurance will be calculated as a percentage of the total fees incurred for the visit.

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CO-PAYMENT

If applicable, your insurance has identified you to pay an assigned payment at the time of your visit. It is the responsibility of the insured member or patient to be aware of the insurance co-pay requirements. It is at the discretion of Reproductive Solutions, LLC or Midwest Reproductive Care, LLC Representative to waive collecting the assigned co-payment. If you fail to pay your co-payment upon request on a day that service is provided, a $25.00 service fee (not billable to your insurance company) may be charged to your account.

PAYMENT OPTIONS

Accepted forms of payment are cash, personal check, Visa, Master Card, and/or Discover. Credit card payments are accepted over the telephone by contacting the Business Office Monday through Friday 700 – 330 pm (receipts will be provided upon request).

NON-PAYMENT

1) If your account is over ninety (90) days past due, you will receive a letter stating that you have twenty (20) days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.
2) Patient request for continued and/or non-medically necessary services are refused. Official dismissal from Reproductive Solutions, LLC or Midwest Reproductive Care, LLC will follow and result in refusal for all requested appointments and services.
3) Notification will be provided to insurance that premise for official dismissal is due to lack of payment, which may affect your health insurance policy for reasons related to breach of contract.

PERSONAL CHECKS and NON-SUFFICIENT FUNDS

In the event a check is returned due to for non-sufficient funds (NSF), the Business 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 or Midwest Reproductive Care, 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 or Midwest Reproductive Care, 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 or Midwest Reproductive Care, LLC.

FEES

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

DISCOUNTS

Cash discounts are not permissible nor offered by Reproductive Solutions, LLC or Midwest Reproductive Care, LLC . Provider discounts recognized and identified under contract agreement with insurance is applicable ONLY to services that are covered by insurance.

COST ESTIMATES

Cost estimates are available upon request and are ONLY an ESTIMATE of fees for duration of which it was requested. Fees are subject to change without prior notice. It is patient/consumer responsibility to request an up-to-date cost estimate. Out-of-pocket expense for services provided CANNOT be determined until AFTER services or course of treatment has been completed.

Our practice is committed to providing high quality care to our patients at affordable prices. Thank you for choosing Advanced Reproductive Center and/or Reproductive Health & Fertility Center. Please let us know if you have any questions or concerns.

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

_____

Signature of patient or responsible party

_____

Date

Advanced Reproductive Center

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Reproductive Health & Fertility Center

CONSENT FOR VERBAL RELEASE OF INFORMATION

1. Please list your preferred numbers/email:

   Home: _____ Cell: _____ Work: _____

   Email: _____

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

3. Check box if we may leave detailed messages, including appointment reminders, on your voicemail and/or in your email*: ☐ Home ☐ Cell ☐ Work ☐ Email

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."

5. 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:

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. 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.
- My consent to the individual(s) who receives my medical/financial information is not my medical/insurance provider covered by the HIPAA Privacy Rule, my released information could be re-disclosed by that/those individual(s). Thus, I will no longer be protected by federal or state law and will not hold the Advanced Reproductive Center and/or Reproductive Health & Fertility Center liable for disclosure.

Signature: _____ Date: _____

Printed Name: _____
(patient, parent or guardian)

Advanced Reproductive Center

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Reproductive Health & Fertility Center

Informed Consent for HIV (Human Immunodeficiency Virus)
Antibody Testing and Information Release

Explanation
This document is an informed consent for testing for antibodies to the Human Immunodeficiency Virus (HIV)

Testing Procedure
The test is performed by the drawing of a blood sample and conducting laboratory tests to determine the presence of antibodies to HIV. The test does not indicate the presence of AIDS (Acquired Immunodeficiency Syndrome) but exposure to the HIV virus. HIV exposure would modify the treatment approach by the Advanced Reproductive Center and/or Reproductive Health & Fertility Center.

Reason of Testing
It is recommended by the CDC (Center for Disease Control) and the ASRM (American Society of Reproductive Medicine) that all patients and partners be tested for HIV prior to any and all treatment that would present with bodily fluids.

Result Reporting
Test results will be released only to the Advanced Reproductive Center and/or Reproductive Health & Fertility Center and the Illinois Department of Public Health (if positive). Under the law in the State of Illinois, test results may only be made to specific persons such as physicians and healthcare providers in the use of any donated organs or tissue, the Illinois Department of Public Health, healthcare facility staff committees and research studies (anonymously) and to healthcare providers that may have accidental contact with skin, membrane or body fluids that have the capability of transmitting HIV.

False Positive and Negative Results
Under certain circumstances false positive (the presence of HIV antibodies) or false negatives (no HIV antibodies present) have been reported. Further testing may be necessary to determine the accuracy of results.

Confidentiality
All reasonable efforts will be made to keep information obtained confidential to the extent provided by the law. Reporting of positive test results to the Illinois Department of Public Health is required.

Waiver of Confidentiality
A waiver of confidentiality may be necessary to obtain financial and/or medical benefits from insurance companies, Public Aid, etc. This means that information regarding this test, including the results, will be disclosed to third party payers.

Decline Testing
Patients may decline consent or withdraw their consent anytime prior to the completion of the laboratory test. However, HIV testing would need to be completed by the patient and partner prior to any procedures being performed.

Consent
I have been advised by my/our physician as to the nature and limitations of the HIV antibody test, and the confidentiality protections surrounding this testing.

_____
Patient Printed Name

_____ _____
Patient Signature Date