

THE FERTILITY INSTITUTE OF VIRGINIA, LTD.
10710 MIDLOTHIAN TURNPIKE, SUITE 331
RICHMOND, VIRGINIA 23235
(804) 379-9000 FAX (804) 379-9031

PATIENT REGISTRATION FORM

PATIENT: LAST NAME: _____ FIRST: _____ MI: _____
ADDRESS: _____ CITY, STATE, ZIP: _____
PHONE: (H) _____ (W) _____ (CP) _____
DATE OF BIRTH: ____/____/____ AGE: _____ SSN: _____ - _____ - _____
EMPLOYMENT: _____ ADDRESS: _____
SPOUSE/PARTNER: LAST NAME: _____ FIRST: _____
DATE OF BIRTH: ____/____/____ AGE: _____ SSN: _____ - _____ - _____
EMPLOYMENT: _____ ADDRESS: _____
PHONE: (W) _____ (CP) _____
PERSON TO NOTIFY IN CASE OF EMERGENCY: NAME: _____
PHONE: (CP) _____ (W) _____ REL. TO PATIENT: _____

INSURANCE: *IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, PLEASE GIVE IT TO THE RECEPTIONIST AT THIS TIME. IF YOU DO NOT HAVE A REFERRAL, YOU WILL BE ASKED TO SIGN A WAIVER OR RESCHEDULE FOR ANOTHER DAY. IF YOU OWE COPAY IT IS DUE AT THE TIME OF YOUR VISIT.

PRIMARY INSURANCE: _____
MAILING ADDRESS TO SUBMIT CLAIMS: _____
SUBSCRIBER NAME: _____ POLICY ID: _____ GROUP: _____
SECONDARY INSURANCE: _____
MAILING ADDRESS TO SUBMIT CLAIMS: _____
SUBSCRIBER NAME: _____ POLICY ID: _____ GROUP: _____

REFERRING PHYSICIAN: _____ PHONE: _____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____
PHARMACY: _____ PHONE: _____

I hereby authorize The Fertility Institute of Virginia, Ltd., to release my medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to The Fertility Institute of Virginia, Ltd. benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original.

DATE: ____/____/____ PATIENT*/RESPONSIBLE PARTY SIGNATURE: _____

**Please advise if another insurance company covers spouse/partner. If so, please supply copy of insurance card.*

THE FERTILITY INSTITUTE OF VIRGINIA, LTD.

**Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations**

All professional services rendered are charged to the patient or their legal guardian. Payment for services is requested at the time of services unless other arrangements have been made in advance through our business office. The Fertility Institute of Virginia, Ltd. will file claims with your insurance company as a courtesy to you; we ask your understanding of and cooperation with our financial policies. I authorize payment of such insurance benefits to The Fertility Institute of Virginia, Ltd.

I understand that I am financially responsible for my deductible, co payments, and/or balance remaining after my insurance has paid. In addition, if my insurance carrier does not pay for my medical services, I am responsible for all charges for my medical care.

I understand that as part of my health care, The Fertility Institute of Virginia, Ltd., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A basis for planning my care and treatment
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that The Fertility Institute of Virginia, Ltd. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that The Fertility Institute of Virginia, Ltd. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the practice change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use of disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsimile.

Signature of Patient _____ Date _____

HMO REFERRAL INFORMATION

I understand that my HMO plan will not pay for some services or supplies, which are experimental, and I agree to pay for such services or supplies.

Signature of Patient _____ Date _____

THE FERTILITY INSTITUTE OF VA, LTD.
Supplemental Patient Information Form

Patient Name: _____ Date of Birth: _____

New Patient: Complete all sections, sign in the last block.

Repeat Patient: Do not complete form unless changes are desired.

Disclosures To Family Members and Friends

Under HIPAA legislation, you as our patient, are the only person to whom we can release information related to your services or account (with the exception of any ordering physician or designated insurance company).

Do you wish to authorize The Fertility Institute of VA, Ltd to make disclosure of personal information to family or friends as may be needed for treatment or payment? Only information necessary and relevant to current treatment will be disclosed. This authorization will remain in effect unless revoked.

Please note that if your services are based on the order of a physician who is treating your partner, test results will be released to that physician. If you do not want disclosure of your results to your partner, you must contact the ordering physician and put your request on file. The Fertility Institute of VA, Ltd cannot be responsible for the release of information occurring outside of our office.

Individuals Authorized to Receive Information

Name: _____ spouse/parent/other _____

Name: _____ spouse/parent/other _____

Name: _____ spouse/parent/other _____

Remove Individuals Previously Authorized to Receive Information

Name: _____ spouse/parent/other _____

Name: _____ spouse/parent/other _____

Patient Signature (changes only) _____ Date: _____

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we revise our notice, you may obtain a revised copy.

I have received a copy of The Fertility Institute of VA, Ltd's Notice of Privacy Practices. I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions to The Fertility Institute of VA, Ltd if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

If patient is not present:

Partner Signature: _____ Date: _____

FOR USE ONLY notice mailed notice given to partner Employee initials

Dear Patient,

Infertility involves the treatments with both the male and female partners.

Consequently, we ask that you agree to allow us to share medical information with your partner.

We agree to allow information about our medical care contained in our medical records to be shared with our spouse or partner.

Patient's Signature

Date

Name (Printed or Typed)

Partner's Signature

Date

Name (Printed or Typed)

The Fertility Institute of Virginia Ltd.

Kenneth Steingold, M.D.

Michael Edelstein, M.D.

The Fertility Institute of Virginia Financial Policy

We are honored you chose the Fertility Institute of Virginia, Ltd. We are committed to you and to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. All patients must complete this information before seeing the provider.

Regarding Insurance

We may accept assignment of insurance benefits, however co payments must be made at the time of service. We are unable to bill your insurance company if you do not provide your insurance information and an original insurance card to copy and keep on file. Please be aware that there are certain insurances that do not cover all procedures and treatments offered by our practice and you will be responsible for these balances.

Initial _____

Returned Check Fee

There will be a fee of \$25.00 on all returned checks.

Initial _____

Records

Please be advised that due to the time required to complete your records request, there is a fee of \$15.00

Initial _____

Billing Office Hours

For your convenience, our billing office is staffed Monday through Friday from 9:30 AM to 4:30 PM. Our knowledgeable staff will be happy to address any questions or concerns you may have regarding our financial policy or your account.

Initial _____

Thank you for your understanding. Please let us know if you have any questions or concerns.

Your signature below signifies that you have read and agree to our financial policy:

Print name

Date of birth

Signature of patient or person responsible

Date

10710 Midlothian Turnpike, Suite 331 | Richmond, Va 23235

| (804) 379.9000

| F: (804) 379.9031