

Insurance cards copied _____
Date _____

BROWN FERTILITY
PATIENT INFORMATION

Account# _____
Insurance#: _____
Co-Payment\$ _____

PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW!

PATIENT'S PERSONAL INFORMATION Marital Status _____ Single _____ Divorced _____ Widowed _____ Sex: Male _____ Female _____

NAME: _____
LAST NAME FIRST NAME INITIAL

Street Address: _____ (Apt# _____) City: _____ State: _____ Zip: _____

Home phone:(____) _____ Work phone(____) _____ Cell phone(____) _____

Date of Birth: ____/____/____ Driver's Lic.: (State&#) _____ SSN: ____ - ____ - ____

How would you like to be addressed? _____ E_mail _____

Employer/Name of School: _____ Full Time _____ Part Time: _____

Spouse's Name: _____ Date of Birth: ____/____/____ SSN ____ - ____ - ____

Last First Initial

PATIENT'S RESPONSIBLE PARTY INFORMATION

Responsible Party: _____ Date of Birth: ____/____/____

Relationship to Patient: Self _____ Spouse _____ Other _____ SSN ____ - ____ - ____

Responsible party's home phone: (____) _____ - _____ Work phone (____) _____ - _____

Address: _____ (Apt# _____) City: _____ State _____ Zip _____

Employer's name: _____ Phone number (____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Your Occupation _____

Spouse's Employer's name: _____ Spouse's Work #(____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION

PRIMARY insurance company's name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of Birth: ____/____/____

Relationship to insured: Self _____ Spouse _____ Child _____ Other _____

Insurance ID number: _____ Group number: _____

SECONDARY insurance company's name: _____

Insurance address: _____ City _____ State _____ Zip _____

Name of insured: _____ Date of Birth: ____/____/____

Relationship to insured: Self _____ Spouse _____ Child _____ Other _____

Insurance ID number: _____ Group number: _____

PATIENT'S REFERRAL INFORMATION

Referred by : _____ If referred by a friend, may we thank him or her? YES/NO

Name(s) of other physician(s) who care for you: _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number (home) (____) _____ - _____ Phone number (work) (____) _____ - _____

I hereby confirm that the above information given by me is accurate and complete.

PATIENT SIGNATURE: _____ DATE: _____

Brown Fertility Associates, P.A.

Billing Address: 14286-19 Beach Blvd, #385, Jacksonville, FL 32250

Office Address: 14810 Old St. Augustine Rd, Ste 201., Jacksonville, FL 32250

Office Phone: (800)750-8823 or (904)260-0352

Patient Financial Policy

In order for Brown Fertility Associates (BFA) to maintain a strong financial position, it is necessary to implement and adhere to collection policies. The policies and procedures listed below will enable BFA to remain a viable health care provider.

Insurance Coverage: The patient or his/her legal guarantor is ultimately responsible for all services incurred. BFA will bill insurance plans if the patient provides the required insurance information and signs an Assignment of Benefits statement. BFA may bill for non-contracted insurance plans as a courtesy, however, the services must be paid in full at the time services are rendered. If the patient has dual coverage, and we do not participate with your primary insurer, the services must be paid in full at the time services are rendered. All information given regarding the ability to pay, third-party insurance, employment, etc., will be subject to verification. Patients with a contracted insurance plan that covers only a portion of the services must pay the difference between the charges and the anticipated insurance payment at the time the services are rendered. All patients receiving medical services are required to provide their social security number prior to services being rendered. Patients with no social security number are required to pay prior to or at the time of service. Patients may be requested to make full payment of unpaid balances when insurance payments are not received after 60 days from the date of billing. A pre-pay deposit may be required prior to all services beginning.

Uninsured Patients/Non-covered Services: Uninsured patients are required to pay all services in full prior to the services being incurred.

Payment Methods: The following payment methods are accepted: cash, check, money order, credit cards (MasterCard, Visa, Discover, American Express) and outside lending institutions. Returned checks will be handled in accordance with Patient Financial Services Department NSF procedures. A \$40.00 bank fee / administrative fee will be assessed for each returned check. Patients receiving services at our satellite offices may be required to pre-pay for all services to be rendered. If payment is made by credit card via telephone, a credit card receipt will be mailed to the patient after the payment has been processed. Credit cards will be kept on file and used for payment if no other payment is available.

Cryopreservation and Storage: If you have consented to freeze your embryos, oocytes, and/or sperm, a storage fee will occur. If storage fees are not paid within a 30 day period, the fee will be considered delinquent and will enter a collections process that may result in reporting the debt to a credit bureau. Cryopreservation is not included in the deposit estimate and is due within 15 days of transfer. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees.

Cancellation of Scheduled IVF Cycle or Surgical Procedures: If a scheduled IVF cycle or Hospital Surgical Procedure is cancelled for any reason, you will be charged \$250.00 for physician/staff time lost. Donor egg recipient cycle cancellation will lead to a \$400 cancellation fee. IVF Cancellation is defined as discontinuation after oral contraceptive pill start date and Surgical Cancellation is defined as cancellation for any reason two weeks prior to surgery date. Any difference between the cost of the actual procedures performed and the deposit amount will be refunded to the patient/guarantor once the patient has been released from care and all insurance dispositions received.

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FMLA Form fees & New Patient "No Show" fees: FMLA forms will be completed by Brown Fertility staff for a fee of \$25.00 and any scheduled New Patient consultation will cause a \$50.00 "No Show" fee if our office is not notified within 24 hours from scheduled appointment despite routine reminder calls.

Fees for Copying Medical Records: In the event that you would like to have a copy of your medical records, we charge \$1 per page as per **Florida Statutes Chapter 64B-10: Medical Records.** "64-B140.003 1) Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records. 2) Reasonable costs of reproducing copies of written or typed documents of reproducing shall not be more than the following: A. For first 25 pages, the cost shall be \$1 per page. B. For each page in excess of 25 pages, the cost shall be 25 cents. C. Postage."

Refunds: Overpayments or credit balances greater than \$5.00 will be refunded to the appropriate party after review of account. Patient refunds will not be processed until the patient is released from care and all insurance dispositions have been received.

In-House Collections: All patient balances must be paid within 30 days of the time of service. Patients with unpaid delinquent accounts for over 90 days old will be referred to outside collection, reported to Merchants Credit Bureau and will be denied of receiving further services at BFA.

Referral for Outside Collections: All accounts that cannot be collected at BFA will be referred to a collection agency, magistrate, or attorney for further collection action in accordance with established guidelines as deemed appropriate by the Fair Debt Collection Practices Act. BFA may take legal action, including the lien on personal property, small claims court, in order to collect balances owed. Any fees assessed will be the responsibility of the debtor.

"I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable copayment and deductibles, are my responsibility."

Print Patient Name: _____ **Date:** _____

Signature of Patient: X _____ **Date:** _____

Assignment of Benefits

"I hereby assign to Brown Fertility Associates, P.A. any insurance or other third-party benefits available for health care services provided to me. I understand that Brown Fertility Associates, P.A. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Brown Fertility Associates, P.A., I agree to forward the practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt. "

Signature of Patient: X _____ **Date:** _____

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Insurance Coverage Waiver

"I understand that my eligibility for coverage by _____ (name of insurance company) cannot be confirmed at this time. I wish to receive medical services from Brown Fertility Associates, P.A. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided."

Signature of Patient: X _____ Date: _____

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CONSENT FORM

CONFIDENTIAL HUMAN IMMUNODEFICIENCY VIRUS (HIV) TEST

HIV testing is a process that uses FDA-approved tests to detect the presence of HIV, the virus that causes AIDS and to see how HIV is affecting your body. The most common type of HIV test detects antibodies produced by the body after HIV infection. Test results are highly reliable, but a negative test does not guarantee that you are healthy. Generally, it can take up to three months for HIV antibodies to develop. This is called the "window period". During this time, you can test negative for HIV even though the virus is in your body and you can give it to others. A positive antibody HIV test means that you are infected with HIV and can also give it to others even when you feel healthy.

If you test positive, by law we must notify the local Health Department. They will contact you to help with counseling, treatment, case management and other services if you need them and want them. You will be asked about sex and/or needle-sharing partners, and voluntary partner counseling and referral services (PCRS) will be offered to you. The HIV test result will become part of your confidential medical record. If you are pregnant, or become pregnant, the test results will become part of your baby's medical record.

Finding HIV infection early can be important to your treatment, which along with proper precautions, helps prevent spread of the disease. If you are pregnant, there is treatment available to help prevent your baby from getting HIV. If you have any questions, please ask your provider, or call the ***Florida AIDS Hotline (1-800-FLA-AIDS or 1-800-352-2437) before signing this form.***

CONSENT GIVEN

_____ YES. I, _____ agree to be tested for HIV and I have been informed about HIV testing and its benefits and limitations. I understand that some tests require a second specimen to be taken from me for further testing.

Date

Signature of Patient or Legal Representative

Patient's Printed Name

Witness Signature

Legal Representative's Relationship to the Patient

Florida State guidelines recommend results be released by a face to face appointment and not by phone. If this is not convenient and you prefer to be notified by phone, please initial below:

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Patients Initials _____

_____ NO. I, _____ do not want to be tested for HIV,
because:

(Reason for refusing test required)

Patient: _____

DOB: _____

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Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. **Please designate which type of information each person may receive** by checking the items we may release and any item we should not disclose. Make your own notes if necessary for clarification.

Definitions:

All information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information.

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal PAPs, Herpes, GC, Chlamydia, Syphilis, vaginitis, Trichomonas, etc..

Pregnancy/Abortion: Information related to pregnancy and abortion

Contraceptives: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUDs, etc....

<u>Relationship</u>	<u>Name of person allowed to receive information</u>	<u>Type of information which may be released</u>
Mother	_____ <input type="checkbox"/> All info	<input type="checkbox"/> Appts only <input type="checkbox"/> STDs/HIV <input type="checkbox"/> Preg/Ab <input type="checkbox"/> BC
Father	_____ <input type="checkbox"/> All info	<input type="checkbox"/> Appts only <input type="checkbox"/> STDs/HIV <input type="checkbox"/> Preg/Ab <input type="checkbox"/> BC
Husband	_____ <input type="checkbox"/> All info	<input type="checkbox"/> Appts only <input type="checkbox"/> STDs/HIV <input type="checkbox"/> Preg/Ab <input type="checkbox"/> BC
Other	_____ <input type="checkbox"/> All info	<input type="checkbox"/> Appts only <input type="checkbox"/> STDs/HIV <input type="checkbox"/> Preg/Ab <input type="checkbox"/> BC
Other	_____ <input type="checkbox"/> All info	<input type="checkbox"/> Appts only <input type="checkbox"/> STDs/HIV <input type="checkbox"/> Preg/Ab <input type="checkbox"/> BC
<input type="checkbox"/> No Information to be released		

This consent to release information will be in effect until revoked in writing.

Signature Patient _____
 Staff Witness _____

Date: _____
 Date: _____

