New Patient Information Form
Form must be filled out completely to ensure correct claim processing.

Patient info:

Name ____ SS#_________________________

How would you like to be addressed? ____

Address ____

Date of Birth _____________________ Home Phone _____________________

Work Phone _____________________ Cell Phone _______________________

E-Mail _____________________________________ Marital Status ☐ Married ☐ Single ☐ Widow

Employer ____

Referring Physician ____

Primary Care Physician _____________________________________

Spouse/Partner info:

Name ____ SS#_________________________

Address (if different than above) ____

Date of Birth _____________________ Home Phone (if different than above) ______________________

Work Phone _____________________ Cell Phone _____________________

E-Mail _____________________________________

Emergency Contact, not living with you:

Name ____ Phone Number______________________

Pharmacy Info:

Name, Phone #, Fax # and address

____

____

Patient initials ____
Partner initials ____

Insurance info:

Primary Insurance ____

Subscriber (Insured) Name ____

Subscriber Date of Birth ____________________ Subscriber SS# ____________________

ID# ____________________ Group Name and number # ____________________

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child

Insurance Address ____

Secondary Insurance ____

Subscriber (Insured) Name ____

Subscriber Date of Birth ____________________ Subscriber SS# ____________________

ID# ____________________ Group Name and number # ____________________

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child

Insurance Address ____

Patient's Referral Information:

Referred by: ____

If referred by a friend, may we thank him or her? Yes / No

I understand that I am directly and primarily responsible to Brown Fertility for their customary fee for the services rendered to me. I realize that if my insurance company fails to pay or if there is any delay in paying Brown Fertility it is my responsibility to pay my doctor's bill directly. I further understand and agree that if I fail to make timely payments to Brown Fertility that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to the physician who submits the claim. I agree to hold Brown Fertility harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

I understand the office may employ an Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) and if I am scheduled with them, I am willing to see them instead of the doctor. I acknowledge that I have read this authorization and fully understand its contents.

For Brown Fertility use:
Insurance card scanned/copied ☐ Yes ☐ No
ID Scanned/Copied ☐ Yes ☐ No

Patient initials ____
Partner initials ____

Brown Fertility Insurance Waiver for NON-COVERED SERVICES & NO INSURANCE REFERRAL

1. **NON COVERED SERVICES**

   I understand that my insurance will only pay for services and supplies that it determines are covered benefits under my particular plan and medically necessary for my care and treatment. I have been informed by Brown Fertility that the following service *is or may be a Non-Covered Service under my insurance plan*:

   I desire to have the service or supply provided with the understanding that the charge(s) will not be filed with my insurance, or if the charges are filed and my insurance company denies payment, *I will be financially responsible for the total cost of the service.*

   Brown Fertility will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance.

2. **NO REFERRAL**

   I understand that if I do not have a referral for today's visit, I will be seen as a "Private Pay" patient today.

Patient Signature ____

Guardian or legal representative signature (if applicable) ____

Date ________________________

This waiver is not to be used for Medicare Beneficiaries. Please advise our office if you are covered by Medicare as they require their own Advanced Beneficiary Notice (ABN) is used.

Patient initials ____
Partner initials ____

INFORMED CONSENT FOR PELVIC EXAMS/INSTRUMENTATION
(Florida Statue SB-698)

I ____ hereby authorize, consent and agree to have Brown Fertility conduct all necessary pelvic exams and instrumentation pertinent to my infertility treatment for the duration of such and any treatment performed at Brown Fertility.

I am also aware that Brown Fertility may use numerous physicians, residents, nurse practitioners, physician assistants, or nurses who may participate in or perform the pelvic examinations. I authorize the following personnel with their assistance in participating and/or performing these exams.

1. Samuel Brown M.D.
2. Bruce Rose M.D.
3. Casey Evans M.D
4. Fernando Gomez M.D.
5. Rafael Cabrera M.D.
6. Lindsey Kral R.N.
7. Tiffany Baker R.N.
8. Maria Saravia R.N.
9. Callie Neuman R.N.

For the purposes of this Consent Form, a "pelvic examination" means a series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs, prostate, penis or scrotum; using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation. It may also include, ultrasounds, ovarian cyst aspiration, paracentesis, or any other pelvic instrumentation deemed necessary by the provider.

By signing this form, you agree and understand that pelvic examinations and instrumentation as indicated above are necessary for effective infertility treatment.

Further, I release Brown Fertility or medical personnel conducting the examination, and Brown Fertility's employees, officers, and successors from any liabilities, claims, and causes of action, known or unknown, contingent or fixed, that may result from this pelvic examination.

I have read and understand this Informed Consent Form, and I consent to such evaluation and treatment.

Patient Name (print): ____

Patient Signature: ____

Witness Name/Signature: ____

Date: _____________________

Patient initials ____
Partner initials ____

BROWN FERTILITY FINANCIAL AGREEMENT

- **PRIVACY NOTICE ACKNOWLEDGMENT**

  I acknowledge that I have the opportunity to, at any time, request a copy of the Brown Fertility Privacy Notice dated September 1, 2013 ("Notice"). I understand that I am responsible to read this Notice and notify Brown Fertility in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. Brown Fertility has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and our website. Brown Fertility will provide me with a copy of its most recent Notice upon my request.

  I understand and acknowledge that all calls (inbound and outbound) may be recorded and that facilities are under recorded video surveillance. Both phone and video recordings can be used for internal quality assurance/training and possible legal purposes.

- **FINANCIAL RESPONSIBILITY and INSURANCE COVERAGE**

  I understand that in consideration of the services provided to the patient, I am directly and ultimately responsible to pay the amount of all charges incurred for services and procedures rendered at Brown Fertility. Brown Fertility will verify my insurance and ascertain if the services are covered. If the services are not covered (not payable) under my insurance plan, I understand I must pay for all non-covered Services. I will be provided with an estimate of my total financial responsibility and the date by which this amount must be paid in full. A pre-pay deposit may be required. Some insurance companies may require a program enrolment as well as other prerequisites before covering infertility and I understand it is my responsibility to be familiar with my policy and such requirements.

  If any services are covered by my insurance, I am responsible for any applicable deductible, co-insurance or co- payments prior to the provision of services. I understand that it is my responsibility to provide Brown Fertility with a copy of my current insurance card. If required, a waiver will be completed for each Private Pay visit or Non- Covered Service. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Brown Fertility. If provider is not contracted with your primary carrier, the services must be paid in full at the time the services are rendered. I understand that Brown Fertility may charge for non-contracted “facility” fees related to in-office procedures. Such fees cannot be submitted to insurance and are to be paid prior to the procedure being performed.

  If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. All patients receiving medical services are required to provide their social security number prior to services being rendered and are required to pay prior to or at the time of service. Patients with no social security number must provide a valid ID. If services are sent to an outside lab, services will be billed to my insurance or I by the lab and I will receive a separate invoice.

  I understand and acknowledge that Brown Fertility uses third party providers for services such as anesthesia and labs and that all fees for such services are separate from Brown Fertility’s fees and are due to directly to the third party company used.

- **CRYOPRESERVATION and STORAGE**

  If you have consented to freeze your embryos, oocytes, and/or sperm, a storage fee will apply. If storage fees are not paid within a 30 day period from invoice issuance, the fee will be considered delinquent and will

Patient initials ____
Partner initials ____

enter a collection process that may result in reporting the debt to a credit bureau. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees and cryopreserved specimens may be transferred to an outside storage facility.

In case of discontinuation of business or force majeure which includes, without limitation, fire, hurricane, flood, tornado, earthquake, elements of nature, or event described as an act of God, global pandemic, acts of war, terrorism, riots, civil disorders, rebellions, revolutions or strikes, lockouts or labor difficulties, Brown Fertility shall transfer all cryo preserved specimens to an outside facility such as Reprotech.

- **CANCELLATION OF SCHEDULED IVF CYCLE OR SURGICAL PROCEDURES**

  If a scheduled IVF/FET/Donor cycle or hospital/office surgical procedure is canceled for any reason a cancellation fee will apply. A cancellation is fee is defined as 30% of the cycle cost or surgery security deposit. IVF cancellation is defined as discontinuation of cycle once engaged (initiation fee paid and calendar received) and surgical cancellation is defined as cancellation for any reason prior to surgery date.

- **CONSENT TO TREAT**

  I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment.

- **ADDITIONAL INFORMATION**

  Payment may be made to Brown Fertility in the form of: Cash, Check, Debit and Credit Cards and outside lending institutions. If payment is made by credit card via telephone, a credit card receipt will be e-mailed to the patient after payment is processed. Patients receiving services at our satellite offices may be required to pre-pay for all services to be rendered.

  I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. Should the account be referred to an outside collection agency or attorney for collection, the undersigned shall pay all fees for collection up to thirty three (33%), including a reasonable attorney's fee. Any patient credits (refunds) will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

  I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, FMLA forms, and for other administrative expenses including medical records copying. No Show fee of $50 is charged if our office is not notified within 24 hours from the scheduled appointment.

- **ASSIGNMENT OF BENEFITS**

  I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to Brown Fertility. I hereby authorize Brown Fertility to release medical information necessary to obtain payment. I agree to hold Brown Fertility harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney’s fees, resulting directly from the release of my medical records pursuant to this consent. I understand that I am financially responsible for all charges not covered by my insurance plan.

Patient initials ____
Partner initials ____

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.
- **Preg/Ab:** Information related to pregnancy and abortion.
- **BC:** Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Relationship	Name	Type of information that may be released				
Mother	____________________	☐ All info	☐ Appts	☐ STDs/HIV	☐ Preg/AB	☐ BC
Father	____________________	☐ All info	☐ Appts	☐ STDs/HIV	☐ Preg/AB	☐ BC
Husband/Partner	____________________	☒ All info	☐ Appts	☐ STDs/HIV	☐ Preg/AB	☐ BC
_______________	____________________	☐ All info	☐ Appts	☐ STDs/HIV	☐ Preg/AB	☐ BC

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

Patient initials ____
Partner initials ____

Authorization for Use of Answering Machine, or Cell Phone Numbers & Email

We consent to Brown Fertility leaving voicemails containing our medical information on the phone number(s) listed below. This information may include, but is not limited to, demographic information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, diagnosis, medications, test results, etc.).

We consent to voicemails containing our medical information at the following phone number(s):

Patient's primary phone number: ________________________

Husband/Partner's primary phone number: ________________________

This consent to will remain in effect until revoked in writing.

Combined Medical Record Consent

We understand that the medical record at Brown Fertility includes information, records, and test results pertaining to us as a couple. Any request or release for medical records for either partner will potentially include information for both parties. By signing below, we consent to this release of medical records when the proper request has been made for either party.

Signatures for entire document are below:

______________________________________ ________________

Patient Date

______________________________________ ________________

Partner Date

______________________________________ ________________

Witness (Brown Fertility) Date

Patient initials ____
Partner initials ____