BOSTON IVF

IVF New England

PATIENT REGISTRATION

PLEASE FILL OUT FORM COMPLETELY

PATIENT: ☐ Female ☐ Male

Name: ____________________ Birth Date: ____________________

Social Security Number: ____________________ Marital Status: ____________________

Language: ____________ Race: ____________ Ethnicity: ____________

Street Address: ____________ City, State: ____________ Zip Code: ________

Home#: ____________ ☐ Check if okay to leave a message Email: ____________
Cell #: ____________ ☐ Check if okay to leave a message
Work#: ____________ ☐ Check if okay to leave a message

Employer: ____________________ Occupation: ____________________

PATIENT INSURANCE INFORMATION ☐ Female ☐ Male

Insurance Company Name: ____________________ ID#: ____________________

Please include the 1-800 # for Provider/Member Services on back of insurance card: ____________________

Subscriber Name: ____________________ Effective Date: ____________

Co-pay amount for specialist office visit: ________ Are you covered under any other insurance policy? ☐ Yes or ☐ No

If yes, supply insurance name: ____________ ID#: ____________ Effective Date: ________

PARTNER ☐ Female ☐ Male

Name: ____________________ Birth Date: ____________________

Social Security Number: ____________________ Marital Status: ____________________

Language: ____________ Race: ____________ Ethnicity: ____________

Street Address: ____________ City, State: ____________ Zip Code: ________

Telephone: ( ) ____________ ☐ Check if okay to leave a message Email: ____________

Employer: ____________________ Occupation: ____________________

PARTNER INSURANCE INFORMATION ☐ Female ☐ Male

Insurance Company Name: ____________________ ID#: ____________________

Subscriber Name: ____________________ Effective Date: ____________________

Are you covered under any other insurance policy? ☐ Yes or ☐ No

If yes, supply insurance name: ____________ ID#: ____________ Effective Date: ________

Referring and Primary Care Physician (Please print full name and address of referring doctor and Primary Care Physician)

Did a physician refer you to our practice? If yes, who is the physician? ____________ Address ____________

If no, how did you hear about our practice? ____________________

Name of your primary care physician: ____________ Address: ____________________

Name of your OB/GYN: ____________ Address: ____________________

F-Cl-933 rev 3

ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES:
With this Form you have been provided with a copy of our Notice of Privacy Practices which provides a full description of how we will use and disclose your individually identifiable health information, including uses and disclosures for treatment, payment, and health care operation purposes. This Notice also explains important rights you have regarding your health information. Boston IVF Inc. and IVF New England (hereinafter referred to as the "Practice") reserves the right to change its Privacy Notice at any time but you may always obtain a current copy upon request or by going to our website: www.bostonivf.com.

USE AND DISCLOSURE OF INFORMATION:
As described in our Notice of Privacy Practices, we will use and disclosure your individually identifiable health information for a variety of treatment, payment and health care operations purposes. As part of your treatment, we expect that you will want and allow us to share, without restriction, all of your health information related to the treatment of you and your partner. Unless you specify any restrictions in the space provided below, you are hereby consenting to such treatment-related disclosures to your reproductive partner while you are undergoing treatment by our Practice. **The disclosure of your information may be made via mail, telephone, fax, e-mail, and/or Internet as may be necessary for the Practice to complete these purposes**. If your health information contains any privileged or additionally protected information under State or Federal law you will be asked to sign a specific authorization for the release of this information.

ASSIGNMENT OF BENEFITS:
In consideration for services and treatment rendered, I hereby assign, transfer, and set over onto the Practice all health insurance. I hereby direct my insurance company to make all payments for treatment and testing provided by Boston IVF Inc. and IVF New England to be sent directly to the Practice.

RESTRICTIONS ON USES AND DISCLOSURES:
As explained in our Notice of Privacy Practices, you have the right to request how the Practice uses and discloses your health information for the purposes of treatment, payment and health care operations, and disclosures to family members or friends. You also have the right to ask us to send communications including your health information to an address of your choice or that we communicate with you in a certain way (e.g. do not leave messages on my home answering machine). While we are not required to grant any such request, you may indicate your desired restrictions or instructions:

____

ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby give consent to the Practice, and its professionals, employees and agents, to use and disclose my individually identifiable health information as described above. I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I understand that I can contact the Practice Privacy Officer at 781-434-6500 if I have further questions or any complaints. I hereby release Practice, its professionals, employees, and agents, from all liability arising from the use and disclosure of my health information for treatment, payment, and operations purposes. I understand that I may revoke this consent in writing except to the extent the Practice has already taken actions in reliance on it. I understand that if I revoke this consent, the Practice may refuse to provide me with further treatment. I also understand that this consent authorizes the Practice to use and disclose all past information documented in my medical record in accordance with its Privacy Notice.

Patient/Guardian Signature	Relationship	Date	Physician of Record

Patient Printed Name	Date of Birth

TO BE FILLED OUT IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICER OF PRIVACY PRACTICES FROM PATIENT

I attempted to obtain a written acknowledgment of receipt of the Practice Notice of Privacy Practices from the above named patient, but was unable to because:

Check the appropriate box:

☐ Patient declined to sign the Written Acknowledgment.
☐ Other [specify details] ______________________________

By: Date:

IVF New England

Boston IVF

E-MAIL CORRESPONDENCE CONSENT (eIVF version)

APPROPRIATE PURPOSE FOR E-MAIL CORRESPONDENCE

E-mail may be used to request information and ask non-urgent questions. **It is NOT to be used for emergencies or for time sensitive issues related to your medical care.** Please contact your physician by phone with questions or concerns that are time sensitive. E-mail correspondence is reviewed by Boston IVF and IVF New England during regular business office hours. Reply to e-mail may occur on the following business day. If you experience a sudden or severe change in your health, or otherwise need an immediate response, please contact 911 immediately.

PATIENT RESPONSIBILITY

Requests to change your e-mail address on record must be made to our Registration Department or your physician's Administrative Assistant. Changes made in regards to your e-mail correspondence will be documented in your medical record. You may revoke consent to use e-mail as a form of correspondence in writing at any time, except to the extent the practice has already made disclosures.

PRIVACY RECOMMENDATIONS

We cannot and do not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, your employer may view any e-mail sent on your employer's system.

I have been informed of and understand the risks and requirements involved with using e-mail as a form of correspondence. I understand that the confidentiality of my individually identifiable health information may be compromised when sent through electronic transmission via e-mail. I agree to the terms listed above, and I hereby voluntarily accept e-mail as one form of communication with my physician and staff at Boston IVF / IVF New England.

______________________________ Patient/Guardian Signature

______________ Date

______________________________ Print Name

_____/_____/_____ Date of Birth

IVF New England

Boston IVF

UNDERSTANDING YOUR INSURANCE BENEFITS

Welcome to Boston IVF. We know that insurance and financial matters can be complicated. This document is designed to outline important insurance and financial information that you need to know while receiving services at Boston IVF. Please read this document carefully as your signature on this form indicates you have read and understand the information. This document will be valid during your entire time as a patient here at Boston IVF.

- Please contact your insurance company as it is **your** responsibility to obtain your infertility benefits. Your insurance company's customer service representatives, as well as your employer's benefits personnel will help you to understand your plan**, what it covers, and what it does not.**
- Please print out and read the insurance handbook from our website, www.Bostonivf.com (Go to patient resources, user name Boston IVF, password is patient). Our financial counselors are available to answer questions and will assist you in understanding your benefits after you have spoken to your insurance company. Keep your infertility benefit coverage in mind when you are making decisions about your treatment since you will be fully responsible for charges not covered by your insurance.
- Your insurance company may require referrals from your primary care physician for your visits. It is your responsibility to obtain these referrals. If you are not able to obtain a referral from your primary care physician you will be charged for your visit(s).
- If your insurance plan imposes a dollar limit on your treatment, you are responsible for keeping track of the money paid by your insurance. Once you have met this dollar maximum, you will be responsible for the cost of services that are provided to you.
- Please notify us **immediately** of any changes to your insurance. If your coverage terminates while you are undergoing treatment, you will be financially responsible for charges incurred during your lapse in coverage. Due to the pre-authorization requirements of the insurance companies, if you change insurance plans while undergoing a treatment cycle, your cycle may be delayed or cancelled and you may be responsible for the cost of that treatment cycle. If you proceed with any treatment that has not been approved by your insurance company, you will be responsible for those charges.
- Many patients choose to freeze sperm and/or embryos at our facility. This may or may not be a covered benefit under your plan. Please check with your insurance company to determine if these services are a covered benefit for you.
- There are annual storage charges for frozen embryos as well as frozen sperm that are not covered by insurance. Contact your financial counselor for our current prices for these services.
- We require 48-hour notice if you are canceling your appointment. If you do not cancel your appointment with a **48 hour notice** or if you do not appear for your appointment you will be responsible for a late cancellation or no show fee of up to the full cost of the visit.
- All charges on your account are due prior to services being rendered. In the event your account becomes delinquent, you will be responsible for all collection costs including any attorney fees.

CREDIT POLICY: It is our policy that payment is required at the time of service. If you have insurance and your insurance plan provides coverage for infertility services, we will bill them for you. All deductibles, co-pays, or percentages of fees must be paid at the time of service. If insurance is denied, payment in full is required prior to commencement of any services.

UNDERSTANDING YOUR INSURANCE BENEFITS

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize that payment of all insurance claims on my behalf be made directly to Boston IVF.

RELEASE OF INFORMATION: I hereby authorize Boston IVF to release to my insurance company, any medical information, including diagnosis and records of treatment, necessary to process my insurance claims.

AGREEMENT OF FINANCIAL RESPONSIBILITY: I understand that if I do not have insurance I am financially responsible to Boston IVF for any services I receive. I also understand that if I have insurance coverage, I will be financially responsible for any amount not covered by my insurance company. **During my treatment monitoring with ultrasounds and blood work may be required. I understand that if I use a monitoring site other than one of the Boston IVF and IVF New England centers I will be responsible for all charges incurred. I understand that I must provide Boston IVF and IVF New England with any changes to my personal and insurance information immediately and by signing below indicate that the information I reviewed on this form is correct.** Failure to provide this information will result in my account becoming my sole financial responsibility, payable immediately. In the event that this account becomes delinquent, I agree to pay all costs associated with collecting this debt, which may include reasonable collections and attorney's fees.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED IN THIS DOCUMENT.

(Print Name)	(Date of Birth)
(Signature)	(Date)