Brown Fertility, LLC

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

Social Security____________________**Patient** ____
(*Last*) (*First*) (*Middle Initial*)

Date of Birth_________________**Address**____
(Street #) (City) (State) (Zip)
Home Tel#:________________________**Work Tel#:**_____________________**Patient Cell #** ______________________________
Employer____________________________**Patient E-Mail**___________________________**Marital Status** __________________
(*S M S D W Sep*)
Employment Status -_____________**Student**___________
(FT PT RET N/A) (FT PT)
Referring Physician__________________________________**Primary Care Physician** ___________________________________

How would you like to be addressed? _______________________________________

Spouse's name:___________________________________**Phone #**_________________________**Date of Birth**__________________

Emergency Contact, not living with you_____________________________________(_______) _________________________
(First and Last Name) (Phone Number)
Pharmacy Name, Phone #, Fax # and address____

Primary Insurance:_______________________**Subscriber (Insured) Name** ____

Subscriber: Date of Birth__________________Social Security #____________________________Employer_____________________

ID#_____________________**Group Name & #**_________________________**Patient Relationship to Insured**_________________
(Self, Spouse, Child)
Insurance Address____
(City) (State) (Zip)
Second Insurance:______________________**Subscriber (Insured) Name**____

Subscriber: Date of Birth____________________Social Security #____________________________Employer___________________

ID#_____________________**Group Name & #**_________________________**Patient Relationship to Insured**__________________
(Self, Spouse, Child)
Insurance Address____
(City) (State) (Zip)

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, LLC. 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, LLC., 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, LLC., 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 (Brown Fertility, LLC is a wholly owned subsidiary or North Florida Obstetrical & Gynecological Associates, P.A.) I authorize payment of medical benefits to the physician who submits the claim. I agree to hold Brown Fertility, LLC 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.

This form was last modified on **10/1/2012**. I acknowledge that I have read this authorization and fully understand its contents.

Signature____Date____________________

Insurance card scanned/copied______ ID Scanned/Copied_______

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

PATIENT INFORMATION

PATIENT'S NAME ____
Last First M.I.

ADDRESS____

BIRTHDATE________/________/________ **DAYTIME TELEPHONE NUMBER** __________
Month y Year

SOCIAL SECURITY NO.__________________________**INSURANCE**__________________

NON-COVERED SERVICES and INSURANCE REFERRAL

☐ **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***:

Ultrasounds/Scans: $150-$250; Office Visits: $42 - $500; Lab/blood draw: $10 - $200; IVF Cycle: $3,275.00 - $25,000.00; Other Procedures: $365 - $6,000.00.

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.

☐ **NO REFERRAL**

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

SIGNATURE

Date:____

Patient Signature: ____

Parent, Guardian or Legal Representative Signature: ______________________

Witness Signature:____

06/22/2017

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.

BROWN FERTILITY LLC

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.

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
(patient's printed name)

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 HIV 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.

Patients Initials __________________

___________No, I______________________________do not want to be tested for HIV, because

____.

(Reason for refusing test required)

Patient Name:________________________________ **BROWN FERTILITY, LLC FINANCIAL AGREEMENT**

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **Brown Fertility, LLC's Privacy Notice** dated **September 1, 2013** ("Notice"). I understand that I am responsible to read this Notice and notify Brown Fertility, LLC 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, LLC 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, LLC will provide me with a copy of its most recent Notice upon my request.

Patient Signature:____ **Date of Birth:**_______________________

Parent, Guardian or Legal Representative Signature:____

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, LLC. Brown Fertility, LLC 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, LLC with a copy of my current insurance card. If required, a waiver will be completed for each Private Pay visit or Non-Covered Service. Brown Fertility, LLC is a wholly owned subsidiary of North Florida Obstetrical & Gynecological Associates, P.A. ("PA") who may file a claim for payment with my insurance company. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to the PA. If provider is not contracted with your primary carrier, the services must be paid in full at the time the services are rendered.

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.

CRYOPRESERVATION and STORAGE

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

CANCELLATION OF SCHEDULED IVF CYCLE OR SURGICAL PROCEDURES

If a scheduled IVF/FET/Donor cycle or hospital surgical procedure is canceled for any reason a cancellation fee will apply. 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.

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. Brown Fertility LLC and other PA subsidiaries may share one electronic medical record ("EMR"). To facilitate the provision of my medical care, I consent for Brown Fertility to access my medical records maintained by any other PA subsidiary.

ADDITIONAL INFORMATION

Payment may be made to the PA in the form of: Cash, Check, Debit and Credit Cards (MasterCard, Visa and Discover) 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, including a reasonable attorney's fee. Any patient credits (refunds) will be applied to my other outstanding patient balances prior to any refund issued, including balances owed to other wholly owned subsidiaries of the PA. 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 the PA. I hereby authorize Brown Fertility, LLC to release medical information necessary to obtain payment. I agree to hold Brown Fertility, LLC 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.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Printed name____________________________**Patient's Date of Birth:**______________________

Patient's Signature:____________________________**Date signed:**______________________

Employee's signature who reviewed intake of form:____________________________________

BROWN FERTILITY LLC

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 of person allowed to receive information	Type of information which may be released
Mother	________________	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Father	________________	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Husband	________________	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
__________	________________	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
__________	________________	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC

☐ **NO INFORMATION TO BE RELEASED**

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

______________________________ ______________________________ ____________
Print Patient's Name Signature Patient Date

______________________________ ____________ Brown Fertility
Staff Witness Date

10012012

BROWN FERTILITY, LLC

Main Office: 14540 Old St. Augustine Road, Suite 2497 Jax, FL. 32258

IVF Center/Weekend Address: 8149 Point Meadows Way Jax, FL. 32256

Orlando: 70 W. Gore Street Orlando, FL 32806

Tallahassee: 1405 Centerville # 4200 Tallahassee, FL 32308

904-260-0352 or 1-800-750-8823

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

I,____(name of patient), authorized Brown

Fertility LLC to provide detailed information to me concerning appointments, referrals and test information at:

Please complete and check all that apply:

☐ **_(_________)______________________________Home answering machine number**

☐ **_(_________)_______________________________Cell phone number**

☐ **____Email address**

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

____________________	_________________________	_____________
Print Patient's Name	Signature Patient	Date

_________________________	_____________________________
Brown Fertility Staff Witness	Date

Questionnaire:

What was most important to you when selection of an infertility specialist? (select
□ Reputation/Referral □ Pricing □ Success Rates □ Location □ Appointment availability
ONE)
Is this your first visit with an infertility specialist?
□ Yes □ No, I have been to ____

BROWN FERTILITY
CONCEIVING MIRACLES®

Combined Medical Record Consent

We, ____ and _______________________________ 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.

____ ________________
Female Partner Date

____ ________________
Male Partner Date

____ ________________
Witness (Brown Fertility) Date