CENTER for REPRODUCTIVE HEALTH
...where families begin

2246 Weber Road, Crest Hill, IL 60403
815-725-4161 Phone
815-725-4341 Fax

Dear Patient,

Thank you for choosing the Center for Reproductive Health. Please fill out the enclosed forms and bring them with you on the day of your appointment which is scheduled for

_____@_____.

You will also need to bring in the following items:

1.) **Insurance card(s)**
2.) **Prescription cards(s)**
3.) **Government Issued Picture I.D.**
4.) **Medical records pertaining to any ***prior infertility testing or treatment.***
5.) **In the event that you do not have insurance coverage a fee of $350.00 will be due at the time of your appointment.**

Please try to arrive 15 minutes earlier then scheduled appointment. If for any reason you are unable to keep this appointment please contact our office.

Thank you,

Center For Reproductive Health

Directions to our office:

From the East*—I-80 Ist, exit North on Larkin Ave. (Larkin will change to Weber Road once you pass Rt. 30) Take Weber Road to Root St. & turn right. Turn Right again into our parking lot.*

From the Ist- *I-80 East, exit North on Larkin Ave. (Larkin will change to Weber Road once you pass Rt. 30) Take Weber Road to Root St. & turn right. Turn Right again into our parking lot.*

From the South- *I-55 South exit Rt. 30 and go east (right). Take Rt. 30 to Weber Road/Larkin Ave. and make a left. Take Weber Road to Root St and turn right. Turn right again into our parking lot.*

From the North- *I-55 North, exit South on Weber Road, Take to Root St. and turn Left. Turn Right into our parking lot.*

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Patient Registration Form

Patient Information

_____
LAST FIRST MIDDLE INITIAL

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

_____ _____ _____
BIRTH DATE S.S # E-MAIL ADDRESS

MARITAL STATUS (circle one) SINGLE MARRIED DIVORCED

CELL: _____
HOME: _____

_____ FULL TIME / PART TIME
EMPLOYER

_____
EMPLOYER ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

_____
HOW IRE YOU REFERRED TO US?

Spouse/Partner Information

_____
LAST FIRST MIDDLE INITIAL

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

_____ _____ _____
HOME PHONE # WORK PHONE # CELL PHONE #

_____ _____
BIRTH DATE S.S. #

_____
EMPLOYER

_____
EMPLOYER ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Primary Insurance Information

_____
NAME OF INSURANCE

_____ _____
POLICY ID # POLICY GROUP #

_____
CLAIM MAILING ADDRESS

_____ _____ _____
CITY STATE ZIP

_____
MEMBER SERVICES / ELIGIBILITY PHONE #

_____
POLICY HOLDER

_____
LIST ALL INSURED MEMBERS UNDER THIS POLICY

Secondary Insurance Information

_____
NAME OF INSURANCE

_____ _____
POLICY ID # POLICY GROUP #

_____
CLAIM MAILING ADDRESS

_____ _____ _____
CITY STATE ZIP

_____
MEMBER SERVICES / ELIGIBILITY PHONE #

_____
POLICY HOLDER

_____
LIST ALL INSURED MEMBERS UNDER THIS POLICY

I hereby authorize payment of benefits, as determined by my insurance company and/or companies to be made directly to Center for Reproductive Health and/or Dr. R. Scott Springer. I understand that I may still be responsible for any amounts not paid by my insurance company and/or companies in the event that charges are not made reasonable and customary. I authorize any insurance company, organization, employer, hospital, physician, pharmacist to release any information requested in regards to processing my medical claims.
I certify that the information furnished is true and correct.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
SPOUSE / PARTNER SIGNATURE DATE

Marital Status Attestation

I/We indicate below our current marital status. In regards to unmarried couples attesting to their intimate sexual relationship, we acknowledge that The FDA rules for the handling and storage of HCTPS (i.e., reproductive tissues) are waived. We understand that our signature indicates our understanding that any misrepresentation of our relationship status is a serious infraction. Any attempt to deceive or mislead CRH will constitute a breach of contract and, as such, we hold harmless the Center for Reproductive Health, and all it's current and future employees, from any legal liability or tort action in all aspects of our care and treatment here. We understand the risks and have had an opportunity to ask questions in this matter. Please check one:

- ❑ We are a ***married*** couple engaged in an intimate sexual relationship
- ❑ We are a ***civil union*** couple engaged in an intimate sexual relationship
- ❑ We are an ***unmarried*** couple engaged in an intimate sexual relationship
- ❑ I am a ***single person*** not engaged in an intimate sexual relationship

PATIENT SIGNATURE DATE

_____ _____

SPOUSE / PARTNER SIGNATURE DATE

_____ _____

CREDIT CARD AUTHORIZATION

Please complete the following credit authorization. Due to slow and diminishing insurance reimbursements and our suppliers who expect payment in full each month, i can no longer carry patient balances after 30 days. Any patient portion left unpaid after 30 days will be charged to your credit card on file so that you may make monthly payments to an agency designed for that purpose. This information is kept in a secure location separate from your chart.

NAME ON CARD:_____

TYPE OF CARD: MC VISA AMEX (CIRCLE ONE)

NUMBER: _____

EXP. DATE: _____ SECURITY CODE: _____

ADDRESS :_____
CITY_____ STATE:_____ ZIP:_____

PATIENT NAME:_____
PARTNER/ SPOUSE NAME:_____

I authorize the Center for Reproductive Health SC to transfer my 30+ day patient balance to the card listed above for all parties involved.

_____
Cardholder Signature

If you do not have an active credit card, you will be required to pay a deposit on your account in the amount of your annual deductible and pay your co-insurance amount at time of service. I appreciate your cooperation.

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

I, (Female Patient)_____, understand that as part of my health care, Center for Reproductive Health and Joliet IVF 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 basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A means by which a third-party payer can verify that services billed ire actually provided and
- 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 and
- 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 Center for Reproductive Health and Joliet IVF 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 as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Center for Reproductive Health and Joliet IVF reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal regulations. Should Center of Reproductive Health and Joliet IVF change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

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

_____

_____

_____

You may discuss the following information with my spouse/significant other or other party as listed below:

_____

☐ Financial Information
☐ Clinical Test Results
☐Appointment 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 fax.

I fully understand and accept the terms of this consent.

_____ _____/_____/_____

Patient's Signature Date

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

I, (Significant Other)_____, understand that as part of my health care, Center for Reproductive Health and Joliet IVF 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 basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A means by which a third-party payer can verify that services billed ire actually provided and
- 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 and
- 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 Center for Reproductive Health and Joliet IVF 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 as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Center for Reproductive Health and Joliet IVF reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal regulations. Should Center of Reproductive Health and Joliet IVF change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

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

_____

_____

_____

You may discuss the following information with my spouse/significant other or other party as listed below:

_____

☐ Financial Information
☐ Clinical Test Results
☐Appointment 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 fax.

I fully understand and accept the terms of this consent.

_____ _____/_____/_____

Significant Other's Signature Date

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I understand that Center for Reproductive Health will bill my insurance company at full fee rate. I will be responsible for any amount not paid by insurance subject to the terms of my policy.

I understand that payments for co pays, coinsurance and/ or deductibles are due at the time of service. I understand that any service not covered by my insurance company is my responsibility.

I understand that if I choose package pricing that I must pay by the specified due date of the cycle.

I understand that I must keep my account in good standing and that I am responsible to pay any remaining balance my insurance has left me within 30 days. I understand that any patient portion left unpaid after 30 days will be charged to my credit card on file or deducted from my deposit on the first Monday of each month.

This document does not obligate me to receive services. If I do receive services, I understand that my signature upon this document shall be treated as a contract. If the terms of this contract are not met, services may be suspended or terminated and my account may be referred to a collection agency. I would then be responsible for any collection fees and or attorney fees.

I hereby authorize payment of benefits to be made directly to Center for Reproductive Health for services provided. I authorize the Center for Reproductive Health to release information on my behalf to facilitate third party payment for services that I have incurred. I understand that I am financially responsible for any charges not covered by my insurance.

Patient Signature: _____ Date:_____
Spouse/ Partner Signature:_____ Date:_____

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PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Center for Reproductive Health to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (Center for Reproductive Health's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Center for Reproductive Health reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Center for Reproductive Health's Privacy Officer at 2246 Weber Road, Crest Hill, IL 60435.

With this consent, Center for Reproductive Health may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Center for Reproductive Health, may mail to my home or other alternative location any items that assist the practice in carrying out healthcare operations, such as patient statements and appointment reminder cards. I have the right to request that Center for Reproductive Health restrict how it uses or disclosed my PHI to carry out health care operations.

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

_____

_____

_____

However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Center for Reproductive Health's use and disclosures of my PHI to carry out health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Center for Reproductive Health may decline to provide treatment to me as permitted by Section 164.506 of the Code of Federal Regulations.

_____ ____/___/____

Signature Date

Dear Patients,

As you all know, we are facing many changes in the new legislation which affects health insurance, as well as health care. As your provider, we continue to work and refine our policies to assist you in receiving timely and un-interrupted healthcare services.

We are starting the New Year with renewed communications with your insurance carriers to access up-to-date and correct coverage information. We are finding some current themes already. One is the frequency of high deductible and higher out-of-pocket plans in the new insurance policies. Another is a switch to higher co-insurance amounts.

To this end, we will be quoting you and collecting from you your deductible and out-of-pocket amounts at the time of service. This will mean that you will be asked to pay for your care at the time of service. We have always been required to collect your co-pays, but you will now be expected to pay your patient portion amount at time of service until your deductible has been met. Once your deductible has been met, we will only collect your co-insurance amount, which is a much smaller percentage. As always, non-covered services are still expected to be paid in full at time of service.

We believe that our patients are best suited to determine how much they want to invest in their health care choices. We are also committed to minimizing the stress brought on by unexpected bills. This new policy will assist you in assessing your ongoing costs of care at every step along the way and will avoid any "sticker shock" down the road.
As always, we are available for your questions.

The Billing Office