2246 Weber Road, Crest Hill, IL 60435
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.) **Picture I.D.**

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 West, 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 West- *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.*

Patient Registration Form

Patient Information

LAST FIRST MIDDLE INITIAL

ADDRESS

CITY STATE ZIP CODE

HOME PHONE # WORK PHONE # CELL PHONE #

BIRTH DATE S.S # E-MAIL ADDRESS

MARITAL STATUS (circle one) SINGLE MARRIED DIVORCED

EMPLOYER FULL TIME / PART TIME

EMPLOYER ADDRESS

CITY STATE ZIP CODE

HOW WERE 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 _____

Prescription Drug Card Information

(If you have a drug card that you present to the pharmacy when you get prescription medications filled, please fill out the information below)

NAME OF COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____

ID # _____ GROUP # _____

BIN # _____

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, we 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. We appreciate your cooperation.

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

I, _____, 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 were 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:

_____

_____

_____

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 / decline the terms of this consent.

_____ _____/_____/_____

Patient's Signature Date

CENTER for REPRODUCTIVE HEALTH
...where families begin

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 with in 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.

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:_____

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