

Doctor's Initial _____

THE FERTILITY CENTER OF MARYLAND
110 West Road, Suite 102, Towson, MD 21204

Updated

FEMALE REGISTRATION INFORMATION Date: _____

LAST NAME _____ Maiden Name _____ First Name _____ MI _____

Address _____ City _____

State _____ Zip _____ Phone # _____ Date of Birth _____

PLACE OF EMPLOYMENT _____ SS # _____

Work Phone # _____ Cell #: _____ E-mail: _____

PRIMARY INSURANCE

Address _____

City _____ State _____ Zip _____ Phone # _____

Policy Holder's Name _____ Relationship _____

Policy # _____ Group # _____

SECONDARY INSURANCE

Address _____

City _____ State _____ Zip _____ Phone # _____

Policy Holder's Name _____ Relationship _____

Policy # _____ Group # _____

Date of Marriage _____ **How were you referred?** _____

NAME OF OB/GYN _____

Address _____ Phone # _____

NAME OF PRIMARY CARE DOCTOR _____

Address _____ Phone # _____

PARTNER REGISTRATION INFORMATION (REQUIRED)

LAST NAME _____ First Name _____ MI _____

Cell #: _____ Date of birth _____ SS # _____

PLACE OF EMPLOYMENT _____ Work Phone # _____

PRIMARY INSURANCE

Address _____

City _____ State _____ Zip _____ Phone # _____

Policy Holder's Name _____ Relationship _____

Policy # _____ Group # _____

SECONDARY INSURANCE

Address _____

City _____ State _____ Zip _____ Phone # _____

Policy Holder's Name _____ Relationship _____

Policy # _____ Group # _____

READ & SIGN OPPOSITE SIDE

Note: Please fill out completely. If you do not complete the insurance information you will be considered self-pay.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Fertility Center of Maryland (FCM) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I received a copy of FCM’s Notice of Privacy Practices (NP) with a complete description of such uses and disclosures. The FCM reserves the right to revise its NP. A revised NP may be obtained by forwarding a written request to: FCM Privacy Officer.

The FCM may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. The FCM may mail, e-mail or fax to my home or other designated location, to referring, primary or consulting physicians or to my health insurance company any items that assist the FCM in carrying out TPO. I have the right to request that the FCM restrict how it uses or discloses my PHI to carry out TPO. 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 the FCM’s use and disclosure of my PHI to carry out TPO. A photocopy of this assignment is considered as valid as the original. 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, the FCM may decline to provide treatment to me.

FEMALE PATIENT’S SIGNATURE _____ Date _____

PARTNER’S SIGNATURE _____ Date _____

(Both signatures required)

FINANCIAL AGREEMENT

I (We) hereby authorize payment of any medical insurance benefits for which we are entitled to the FCM. If any payment is made directly to us for services billed, we agree to promptly remit it to the FCM. We agree to pay in full the balance of any charges not paid or covered under our insurance plan before restarting any treatment. If our insurance carrier does not remit payment within 60 days, the balance will be due in full from us. If our insurance requires referrals or prior authorization, and we have not obtained these, we will be responsible for the charges.

I (We) understand that FCM requires a deposit 5 - 10 days **before** treatment starts for any procedures that are not covered or partially covered by our insurance. This deposit is an estimate. I (We) understand that we will be billed for the actual procedures performed and that this total may be more or less than the deposit. I (We) understand that if our bill is referred for collection, I (we) agree to pay the collection agency a fee of 25% of amounts due and to FCM an interest of 1.5% per month (18% per annum) of amounts due. Thereafter, if the account is referred to an attorney for collection, I (we) agree to pay that attorney a fee of 35% of amounts due, plus all court costs and costs of process.

FEMALE PATIENT’S SIGNATURE _____ Date _____

PARTNER’S SIGNATURE _____ Date _____

(Both signatures required)