PATIENT DEMOGRAHIC INFORMATION

Welcome to Atlantic Reproductive Medicine Specialists. To better serve you, please complete the information below. This form will need to be completed annually.

PRINT FULL NAME:________________________________ **DOB:** ____________

PREFERRED NAME: ____________________ **PREFERRED PRONOUN:** (circle one) SHE/HER HE/HIM THEY/THEM ☐ OTHER:____________

SEX ASSIGNED AT BIRTH: FEMALE or MALE (circle one) **GENDER IDENTITY:** (circle one or more) WOMAN MAN NON-BINARY INTERSEX NON-CONFORMING TRANSGENDER OTHER:__________

MARITAL STATUS: SINGLE MARRIED PARTNERSHIP OTHER (circle one)

ADDRESS:__________________________ **CITY:**__________ **STATE:**_____ **ZIP:**_____

HOME PHONE: ____________________ **CELL PHONE:** ____________________

May we leave messages for you on the numbers listed above? YES or NO (circle one)

EMAIL:______________________________________

EMERGENCY CONTACT: ________________ **RELATIONSHIP TO PATIENT:** ____________ **PHONE:**____________

INSURANCE INFORMATION

INSURANCE:________________ **RELATIONSHIP TO PATIENT:** SELF SPOUSE CHILD OTHER (circle one)

SUBSCRIBER NAME: ____________________________ **DATE OF BIRTH:**____________

SEX: FEMALE or MALE (circle one) **ID#:** ________________________ **GROUP#:**____________

Please indicate below how you heard about Atlantic Reproductive Medicine Specialists:

☐ **By Referral** **Name of Referring Physician/Practice:** ____________________________

☐ **Friend** ☐ **Internet** ☐ **Other** ____________________________

Atlantic Reproductive Medicine Specialists

COMMUNICATION

At Atlantic Reproductive Medicine Specialists, we want to make communication as simple as possible. One of the ways we do this is by giving you access to your medical records and the ability to ask financial questions through separate means of communication. By utilizing these two methods, it streamlines the communication with the appropriate team. This enables specific clinical questions to be handled by the clinical team and specific financial questions to be handled by the financial team.

To ensure HIPAA compliance we require that Patient and Spouse/Partner cannot share an email account. Each registered party must have their own email address.

Please visit our websites Resources tab to find helpful answers to FAQs for New Patients Seeking Treatments https://www.atlanticfertility.com/new-patients-seeking-treatment-faqs/

Below we will review the two communication methods.

1. eIVF CLINICAL PATIENT PORTAL WEB CORRESPONDENCE

The front office staff will give you your username and assign a temporary password, so you can access this private information. The portal is created based on the email provided. The portal does allow you to upload a photo. Patient photos are considered PHI, and therefore, to ensure HIPAA compliance the photo can only include the patient. All other photos will be removed. We do love seeing your photos though!

The Patient Portal is the primary way for you to communicate with our clinical staff. All clinical questions must be submitted through the secure patient portal. If you call with a clinical question, you will be asked to send a portal message. Repeated calls will delay our ability to respond in a timely manner to you and other patients. We respectfully remind patients that the clinical team is managing a multitude of varying tasks and situations, all at the same time. Your needs are very important, please send one portal and we will get back to you as soon as possible. Your patience and understanding are greatly appreciated.

By logging into your Clinical Patient Portal, you may…

- Communicate directly with our clinical care team regarding prescriptions and clarification of in cycle instructions
- View test results
- View future appointments
- View all communications documented in the medical record
- Fertility care is highly personalized, and some questions will require making more space for high quality communication in a Telehealth session

Business Hours

- Monday – Thursday 7:30am – 4:00pm
- Friday 7:30am – 3pm

Atlantic Reproductive Medicine Specialists

On business days

- Web correspondences will be reviewed by our team within 24 hours
- In cycle medication questions will be answered within the 24 hours
- If the question is complex and requires provider input, please allow up to 72 hours for a response
- If you are waiting on same day results, those results will be sent to you before the clinical team leaves, which may be outside of normal business hours.

After hours, on weekends or holidays

- Non-urgent web correspondences will be responded to on the next business day.
- Urgent issues can be handled two ways.
    1. If an issue on the weekend needs a response within 24 hours, put "URGENT" in the subject line.
    2. If an issue needs immediate attention after 3pm on business days, or during a weekend or holiday, do not use electronic communication. One of our physicians can be reached 24 hours a day by calling 919-248-8777. After hours, you will be given an option to leave a message for the physician on call.

DISCLAIMER FOR EMERGENCY OR URGENT MEDICAL CONDITIONS

DO NOT USE ELECTRONTIC FORMS OF COMMUNICATION. IN AN EMERGENCY CALL 911.

2. FINANCIAL EMAIL

Financial is available to answer any questions you may have about our fees, financial policies, or your insurance coverage. You can contact financial by either email at financial@atlanticreproductive.com or phone at 919-248-8777 option 4. You can expect a response within 2-3 business days. When sending emails please include your full name and date of birth.

Business Hours

- Monday – Thursday 7:30am – 4:00pm
- Friday 7:30am – 3pm

On business days

- You can expect a response within 2-3 business days

I hereby acknowledge I have read the above and have been given the opportunity to request clarification of anything not fully understood. By signing below, I fully understand and will use the two different communication methods.

Patient Signature Required _______________ Date _______

Atlantic
Reproductive Medicine
Specialists

PATIENT RIGHTS & RESPONSIBILITIES

Atlantic Reproductive Medicine Specialists is committed to providing a safe, secure, and respectful environment for our patients and staff to work in. To successfully provide care a mutual respect between all the staff and patients must be in place. We respect your rights, values, and dignity. In exchange, we ask that you recognize the responsibilities that come with being a patient, both for your own well-being, and the health care team.

Inappropriate words or actions in person, by phone, via email or any means of communication is not acceptable, and decisive action will be taken to protect our staff. When described incidents occur your physician and the practice administrator will be immediately informed and may result in the individual(s) dismissal from our practice.

To maintain good relations, and to be clear as to what is not acceptable, please read and take note of the types of behavior that are unacceptable:

- Disrespectful or demeaning language/comments
- Yelling or swearing at staff
- Verbal abuse towards the staff in any form
- Persistent or unrealistic demands that cause stress to staff
- Discriminatory remarks, jokes or innuendos that degrade, ridicule, or offend
- Threats or threatening behavior

Listed below are your rights and responsibilities as an Atlantic Reproductive Medicine Specialists patient.

1. PATIENT RIGHTS

You have the right to safe, high-quality medical care regardless of your race, color, national origin, religion, gender, age, sexual orientation, gender identity or expression, genetic information, veteran status, or disability.

You have the right to participate in and make decisions about your care, including refusing care. Your clinical care provider (such as a doctor or nurse) will explain the medical consequences of refusing recommended treatment.

You have the right to have your diagnosis, treatment, alternatives, and outcomes explained in a way that you can understand. You have the right to an interpreter, if needed.

You have the right to bring one visitor whom you designate, including, but not limited to, your spouse, a domestic partner, another family member, or a friend. However, we are not allowing children at any visit.

You have the right to private and confidential treatments, communications, and medical records.

You have the right to have your concerns and complaints addressed. Should you or your designated guardian, advocate, support person, or representative feel, at any time, that your rights as a patient have been violated -- or you wish to share a compliment, concern, or complaint. Please call the Practice Administrator at 919-248-8760. Sharing your concerns and complaints will not compromise your access to care, treatment, and services.

Atlantic Reproductive Medicine Specialists

2. PATIENT RESPONSIBILITIES

You are responsible for providing us with as much information as possible about your health, medical history, and insurance benefits.

You are responsible for asking your care provider for help or clarification when you do not understand medical words or details about your care plan.

You are responsible for visits associated with evaluation of your history, review of options for your care plan and following your care plan. If you are unable/unwilling to follow your care plan, then you are responsible for telling your care team. Your care team will explain the medical outcomes of not following their recommended treatment. You are responsible for the outcomes of not following your care plan.

You are responsible for following Atlantic Reproductive Medicine Specialists policies, rules, and regulations.

You are responsible for acting in a manner that is respectful of other patients, staff, and facility property.

You are responsible for meeting your financial obligation to the facility.

I hereby acknowledge I have read and given the opportunity to request clarification of anything in the policy not fully understood. I also understand and agree the types of behavior listed is not exhaustive and ARMS may amend such terms from time-to-time. By signing below, I fully understand my rights and responsibilities as a patient and accept responsibility for my actions.

Patient Signature Required

Date

Atlantic Reproductive Medicine Specialists

FINANCIAL POLICY

Thank you for choosing Atlantic Reproductive Medicine Specialists, (hereinafter referred as "ARMS"), for your infertility needs. We are committed to providing personalized financial services to each patient. We understand that the cost of fertility treatment can add additional stress to an already stressful process, and ARMS wants to be as upfront as possible about costs associated with your infertility care. One of the toughest aspects of financial is having to inform our patient that they do not have coverage for treatment.

We always want our patients to have a great experience and we do everything we can to ensure we are providing accurate information. However, the information we provide is only going to be as accurate as the information provided to us. We ask that all patients reach out to their insurance member services department to better understand their insurance benefits, coverage, and limitations.

As a courtesy, we will attempt verify your infertility benefits prior to your new patient consultation. There may be an instance that we will require your assistance in verifying your benefits. If we need your assistance, we will reach out to you. Our verification of your insurance benefits is not a guarantee of payment. All benefit quotes provided are based on the information provided by your insurance carrier.

There is such a variance in pricing depending on cycle type, so we do not provide detailed pricing until we have a treatment plan from the physician. After your consultation our financial coordinator will be happy to provide you with a detailed breakdown of the fees based on the recommended treatment and how it relates to your quoted benefit coverage.

Our patients are the most important part of our practice, and we work timelessly to ensure your complete satisfaction, now and throughout your journey. Financial is available to answer any questions you may have about our fees, financial policies, or your insurance coverage. You can contact financial by either email at financial@atlanticreproductive.com or phone at 919-248-8777 option 4. You can expect a response within 2-3 business days.

The following are the financial policies we have established for our practice. Your clear understanding of our financial policy is important to our professional relationship. Take time to carefully review the following information. Please ask if you have any questions regarding our policies.

PLEASE READ EACH SECTION CAREFULLY.

A SIGNATURE IS REQUIRED AFTER EACH SECTION.

Atlantic Reproductive Medicine Specialists

INSURANCE

Atlantic Reproductive Medicine Specialists is IN NETWORK with:

- **AETNA** – Our office does not participate with Duke Select plans.
- **BLUE CROSS BLUE SHIELD** – Our office does not participate with Blue Home/Local plans.
- **CIGNA** – Our office does not participate with Cigna Connect plans.
- **PROGYNY** – A third-party insurance company that provides employer fertility benefits. It is the patient's responsibility to contact their assigned Patient Care Advocate (PCA) through Progyny to receive authorization for their initial appointment and every appointment thereafter.
- **TRICARE** – We do not participate with Tricare. As a courtesy we do accept Tricare for diagnostics only. Prime members must have a referral from their PCM to our physician. It is the patient's responsibility to obtain the referral.
- **UNITED HEALTHCARE** – Our office is a Center of Excellence.
- **ARMS will not file out-of-network claims and does not file secondary claims.**

Please remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full. If your insurance plan requires a referral from your primary care physician for specialist visits, registration before treatment or you use a preferred provider, it is your responsibility to abide by your insurance plan policy guidelines.

Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. It is your responsibility to keep us updated with your correct insurance information and of any changes in coverage. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the misquoted benefits we received. It is your responsibility to make sure we receive prompt payment from your insurance plan.

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service." If your insurance determines that a particular service is not medically necessary, or that a particular service is not covered under the plan or you fail to abide by policy guidelines, you understand and agree you are financially responsible for any amount not covered regardless of reason.

Beneficiary Agreement: I understand that my insurance may deny payment for the services identified above, for the reasons stated. If my insurance denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any copay, deductible, or coinsurance that applies.

Patient Signature Required

TELEHEALTH APPOINTMENTS

Established Patient appointments at ARMS will be telehealth appointments via Microsoft Teams with your physician. You will need to download the app prior to your scheduled appointment. The self-pay fee for an Established Patient Telehealth visit is $185. It is the patient's responsibility to pay their visit responsibility prior to the telehealth appointment. Financial will email you day the before or the morning of your scheduled appointment with your patient responsibility. The self-pay fee for an

Atlantic Reproductive Medicine Specialists

Established Patient Telehealth visit is $185. Please ensure to pay your visit responsibility prior to your scheduled time to prevent any delays.

It is our policy to charge for telephone calls with our physicians that include evaluation and management of your treatment.

Patient Signature Required

PAYMENT

It is the policy ARMS to request payment of any copay, unmet deductible, coinsurance, non-covered charges, or previous balances at the beginning of each visit. The amount you are asked to pay at each visit is an estimate of the charges for the appointment type scheduled. If you do not have insurance coverage payment in full is expected at the time of your visit. The financial coordinator will email you the day before or the morning of your scheduled visit with your patient responsibility. Please ensure to pay your visit responsibility prior to arriving to avoid any delays. The self-pay fee for the New Patient Consultation is $320.

If you do not have insurance information, we require that you put a credit card on file. Payment in full will be processed the morning of scheduled visit and a receipt will be emailed to you.

We accept cash, check, Visa, MasterCard, Discover and American Express credit cards. Please use our contactless payment option via our website at https://www.atlanticfertility.com/pay-medical-bills/

A $35 fee will be charged for any checks returned for insufficient funds. Regretfully, we will not accept any further check payments and you will be asked to bring cash, certified funds, or a money order for future payments.

Patient Signature Required

PATIENT BILLING

All charges may not be captured at the time of service, so you may be asked to make an additional payment at your next appointment or receive a statement. The statement will reflect the amount you owe after your insurance, if any, has processed your claim. Payment in full is expected on receipt of your billing statement. **No further appointments will be scheduled until previous balance is paid in full.**

We understand your need for documentation. We will provide a detailed pricing sheet before treatment begins, which will indicate when payment is due. This will serve as your invoice for treatment. Upon request, once services have been rendered and insurance has processed your claim an itemized receipt will be provided. For all services, please allow 7 business days for charges to be added.

Patient Signature Required

INFERTILITY COVERAGE

Insurance coverage for infertility services can be confusing. It is the patient's responsibility to contact their insurance and become familiar with their benefits. The following are the most common benefits for infertility services and treatment.

1. **No coverage for infertility services.**

Atlantic Reproductive Medicine Specialists

Unfortunately, this means you will not have coverage for any service in our office. You will be considered self-pay and will be expected to pay in full at the time of service.

2. **Only coverage for the diagnosis/treatment of underlying cause of infertility.**
   In this scenario, the insurance plan will usually cover the diagnostic services to determine the cause of infertility. This may include new patient consultation, labs, and other procedures.

3. **Coverage for the diagnostic testing and coverage for infertility treatment.**
   In these circumstances, coverage is provided for diagnostic testing and for some methods of infertility treatment. Understanding your individual coverage will help you anticipate whether a particular service is covered.

NOTE: Most plans exclude coverage of infertility services for couples in which either of the partners has had a sterilization procedure (ex. tubal sterilization or vasectomy), with or without surgical reversal. The inability to conceive in a couple who has undergone a voluntary sterilization procedure is not the result of disease, but the result of an elective procedure intended to prevent conception.

Patient Signature Required

PROCEDURE PAYMENTS

We require payment in full for any procedure prior to scheduling, and any previous balances, this includes spouse/partner accounts. **<u>If you have a previous procedure not processed by insurance, you will need to delay starting future procedures until the prior claim is paid.</u>**

It is your responsibility to reach out to financial to ensure you understand the costs associated with your procedure. The financial coordinator will prepare you a quote and will answer any questions you may have about your financial responsibility. This is an estimate of your responsibility based on your treatment plan and the benefits quoted. We cannot guarantee all services will be performed or that we have missed any fees. If your procedure should change beyond the services included in your quote, it is your responsibility to reach out to Financial for updated pricing. You are financially responsible for any amount not covered regardless of reason.

Your procedure quote will provide you with a listing of Additional and Possible Additional fees not included in the total payment due. If your procedure results in additional fees you will be asked to make the additional payment at your next appointment.

We accept cash, cashier's check, Visa, MasterCard, Discover and American Express. <u>We do not accept personal checks for procedure payments.</u> Please use our contactless payment option via our website at https://www.atlanticfertility.com/pay-medical-bills/

Patient Signature Required

TREATMENT/PROCEDURE DIAGNOSIS MEDICAL CODING

The physicians in our office are specialists in Reproductive Medicine. To request a change in diagnosis solely for securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud. Many insurance plans cover services for the diagnosis and treatment of underlying cause of infertility only. Claims for non-covered services will not be billed to your insurance company.

Patient Signature Required

Atlantic Reproductive Medicine Specialists

PRIOR AUTHORIZATIONS

Every effort will be made to have all services and procedures authorized prior to procedure. We will submit every possible CPT/HCPCS code you may have during your procedure. It is the patient's responsibility to ensure authorization is obtained for covered services. Procedure authorizations must be in place prior to scheduled procedure. If prior authorization is not in place by the date of the procedure, your procedure will be pushed to the following month. You understand if any service is not approved or covered you are financially responsible to pay for any amount regardless of reason.

PLEASE NOTE: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Patient Signature Required

APPEALING PROCEDURE DENIAL

Even with fertility coverage you can have a procedure denied. You Have the Right to Appeal. If your insurance denies coverage for a particular treatment, service, test or procedure, an appeal still gives you another chance to have the service paid. The most important thing to remember when appealing is not to give up, especially if the denial can affect whether you can continue with treatment.

When it comes to appealing, the biggest challenge may be the time and effort it requires to appeal the denial. The process can feel overwhelming, just know that we are here to help guide you. Your health care team will work together to provide you with the information to support your appeal. The ability to have coverage is worth any extra effort that is required. The following are the most common reasons for denials:

1. **Lifetime Maximum Benefit has been reached**
   Unfortunately, we cannot get this overturned. However, you can go to your employers HR to see if they can help you.
2. **Treatment is deemed "Experimental and Investigational"**
   Unfortunately, this denial type cannot be overturned.
3. **Treatment/Procedure determined as "Not Medically Necessary"**
   Your insurance has determined that the treatment/procedure you requested is not medically necessary for your condition. Remember your provider is never going to recommend treatment that they do not feel is medically necessary.
4. **Infertility Benefit Denial**
   The terms of your plan limits coverage with guidelines that must be met. An example of this would be the member must undergo "x" before "y". Unfortunately, ARMS cannot appeal this denial. However, you can still appeal and/or go to your employers HR department to see if they can help by changing the criteria in the guidelines.
5. **Medical Director Denial**
   Requests that do not meet the criteria for immediate authorization are reviewed by the Medical Director. Understanding what exactly is denying will help determine the appeal approach. Does your policy require that you undergo a specified number of treatments or limits how many treatments they will cover?
6. **Administrative Denial**
   The service is not covered under the policy. Unfortunately, this denial type cannot be overturned.

Patient Signature Required

Atlantic Reproductive Medicine Specialists

FERTILITY LIFETIME MAXIMUM BENEFITS

For insurance plans that have a maximum lifetime benefit for fertility treatment, it is the member's responsibility to abide by these plan provisions. Services in our office, bloodwork, and medications, all contribute to lifetime maximums. During treatment if you reach your maximum lifetime benefit, you understand you are financially responsible for the entire balance not covered. Once your lifetime maximum is met all services will become self-pay.

Often patients that have met their lifetime maximum benefit will request that we still bill their insurance. We understand that sometimes the insurance will cover the certain services, because it is hard for insurance companies to distinguish between diagnostic and treatment. However, we are bound by our contracts with insurance companies to not knowing file for services/treatments that we know should not be covered.

Please understand that we are only looking out for your best interest. We do not want to have to inform a patient months later that there is a large balance due because the insurance has reviewed records found they should not have paid. Routinely insurance companies will request medical records when conducting payment audits. These audits are typically 6-18 months after any given date of service, resulting in them recouping their payments. The last thing we want to do is to cause any unnecessary financial stress.

Patient Signature Required

BLOODWORK

If your insurance requires you to use a preferred lab, it is your responsibility to inform the clinical staff. Depending on the type of bloodwork ordered, you will receive bills from the processing lab. Please contact servicing lab with billing questions. Diagnostic bloodwork done in our office will be processed and billed by LabCorp. Please contact LabCorp at 800-762-4344 with billing questions.

Patient Signature Required

ANESTHESIA SERVICES

For procedures performed in our office that requires anesthesia our anesthesia services are provided by Certified Registered Nurse Anesthetists (CRNA). They are independent contractors that are not employed by ARMS and do not accept or file insurance. Therefore, we are unable to bill your insurance for their services. We are unable to provide you with codes or billing information. We will provide a receipt for the payment. Please note that anesthesia services will not count towards any deductible or out of pocket totals and will not be filed to insurance.

The fee for anesthesia performed in our office is $450. There is a cancellation fee of $250 for the failure to adhere to pre-operative instructions resulting in the cancellation of your surgery for any reason.

Patient Signature Required

SURGERY BILLING

We want to help you understand how you will be billed for surgical services. In addition to our physicians performing surgery at ARMS, they also perform surgery at Rex Surgery Center (RSC) and Davis Ambulatory Surgical Center (DASC). We will provide a quote of the charges you will be responsible to pay based on your benefits. Please note ARMS does not verify

insurance coverage for any outside facility. Depending on your place of service, you will have additional fees, described in the following details.

1. Surgery performed at ARMS

- You will pay ARMS directly for the physician surgical fee prior to surgery.
- You will pay ARMS $450 for anesthesia (only if required). Anesthesia is not filed to insurance.
- You will receive a separate bill from the servicing provider of any Labs or Pathology.

2. Surgery at Rex Surgery Center (RSC) 919-415-1360

- Payment in full to ARMS for the physician's fee is required to schedule your surgery.
- RSC will contact you with your estimated responsibility for their facility fee.
- Anesthesia at RSC will be billed separately by East Carolina Anesthesia Associates (919-384-0700).
- You will receive a separate bill from the servicing provider of any Labs, Pathology or Radiology.

3. Surgery at Davis Ambulatory Surgical Center (DASC) 919-470-1000

- Payment in full to ARMS for the physician's fee is required to schedule your surgery.
- DASC will contact you with your estimated responsibility for their facility fee.
- Anesthesia at DASC will be billed separately by Regional Anesthesia (919-384-0700).
- You will receive a separate bill from the servicing provider of any Labs, Pathology or Radiology.

Patient Signature Required

MEDICATION COVERAGE

To provide our patients with a personalized pharmacy experience, we have partnered with Fertility Pharmacy of America (FPA). Your physician will send your prescriptions to FPA. A pharmacy technician from FPA will handle any needed authorizations and delivery of your medications. FPA will forward your prescription to any required pharmacy.

Patient Signature Required

CANCELLATIONS, NO SHOWS & MISSED APPOINTMENTS

If it is necessary to cancel your scheduled appointment, we require 2-day/48-hour cancellation notice. Appointments are in high demand, and your early cancellation will give another person the possibility to be seen sooner.

Failure to provide a 2-day/48-hour notice for cancellation of your scheduled appointment will result in a $150 missed appointment fee. This fee must be paid before another appointment will be scheduled and you will be required to put a credit card on file to schedule a new appointment. Please note this fee will not be billed to your insurance.

Patient Signature Required

Atlantic Reproductive Medicine Specialists

CANCELLATION OF PROCEDURE

Should a procedure be cancelled for any reason, the patient will be responsible for any costs incurred prior to the cancellation. A financial coordinator will review your treatment services rendered up to that point. If proceeding a credit will be issued for the difference between the original treatment cost and the costs incurred to the point of cancellation. Any credit balance can be used against future service costs, or a refund can be requested.

Patient Signature Required

MEDICAL RECORDS FEE

A $30 fee will be charged for copies of medical records given directly to the patient. However, we will forward your records free of charge to another medical office. ARMS will have 10 business days to generate records before making them available for the patient to pick up. The 10 days will commence after payment has been received, and the patient has signed the appropriate medical records release form. It is requested that outstanding balances be paid in full prior to medical records being released. For medical records to be sent to another facility please allow up to 14 business days.

Patient Signature Required

REFUNDS & OVERPAYMENTS

Patient or insurance payments for services resulting in overpayment will receive a refund check during the next refund cycle, as long as the patient and spouse/partner does not have any other patient responsibilities or pending insurance charges.

Patient Signature Required

I hereby acknowledge I have read and have been given the opportunity to request clarification of any policy not fully understood. I also understand and agree that due to changes in the medical and medical insurance industry ARMS may amend such terms from time-to-time. By signing below, I fully understand the financial policy and accept responsibility for any payment that becomes due as outlined previously.

Patient Signature Required

Date

Atlantic Reproductive Medicine Specialists

AUTHORIZED CONSENT FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, ______________________________ hereby authorize Atlantic Reproductive Medicine Specialists to release
Print Full Name
my Protected Health Information (PHI) in the following manner and to the identified persons:

[X] All health information pertaining to insurance payment, any information concerning healthcare, advice, treatment, or supplies provided to me by Atlantic Reproductive Medicine Specialists.

Patient Rights

- I have the right to refuse to sign this Authorization and my treatment will not be conditioned on signing. Understanding that by doing so, Atlantic Reproductive Medicine Specialists will not be responsible for filing any claims to my insurance carrier on my behalf.
- I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the following address: 10208 Cerny Street, Suite 306, Raleigh, NC 27617. My revocation will be effective upon receipt.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal confidentiality law (HIPAA).

I will allow release of PHI and/or financial information to the person(s) listed below:

Name: ______________________ DOB: __________ Relationship to patient: __________

Name: ______________________ DOB: __________ Relationship to patient: __________

Referring MD: ______________________ Primary Care Provider: ______________________

OB/GYN: ______________________ Other Medical Provider: ______________________

In addition, I request that you restrict my information in the following way: ______________________

____

I understand this authorization will remain in effect until revoked by me the patient.

Patient Signature Required

Date

Revised 7.2022

Atlantic Reproductive Medicine Specialists

NOTICE OF PRIVACY PRACTICES w/ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
We are legally required to protect the privacy of your health information. We call this "protected health information," or "PHI" for short. It includes information that can be used to identify you and that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. We reserve the right to change the terms of this notice and our privacy policies at any time. Any change will apply to the PHI we already have. Whenever we make any important changes to our policies, we will promptly change this notice and post the newly updated notice on our website at www.AtlanticReproductive.com under the Resource tab. You can also request a copy of this notice by calling the number listed in Section IV below at any time.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization. We may use and disclose your PHI without your authorization for the following reasons:

1. Treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel to provide, coordinate, or manage your health care or any related services, except where PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription, or to a laboratory to order a blood test.

2. To obtain payment for treatment. We may use and disclose your PHI to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. For example, we may disclose your demographic information to laboratory care providers for payment of their services.

3. For health care operations. We may disclose your PHI, as necessary, to operate this facility and provide quality care. For example, we may use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others to make sure we're complying with the laws that affect us.

4. When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement. For example, we may disclose PHI when a law requires that we report information to the government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. For public health activities. For example, we may disclose PHI to report information about birth, deaths, various diseases, adverse events, and product defects to government officials in charge of collecting that information; to prevent, control, or conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a

person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. For health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; or other activities necessary for appropriate oversight as authorize by law.

7. For organ donation. We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants.

8. For research purposes. In certain circumstances, we may provide PHI to conduct medical research.

9. To avoid harm. To avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather, we contact you at a different telephone number or address.

B. Uses and Disclosures Where You to Have the Opportunity to Object:

1. Disclosures to family, friends, or others. We may disclose your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

***C. All Other Uses and Disclosures Require Your Prior Written Authorization*.** Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have acted in reliance upon authorization.

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental use or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

III. WHAT RIGHT YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI.

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement or restriction.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The Right to See and Get Electronic Copies of Your PHI. We will provide a copy of the requested PHI in electronic form and format requested by the individual. If the requested format is not readily producible, the practice will provide a readable electronic format that is agreed upon. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the

request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI if you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of the instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to our opening date of August 6, 2012. We will respond within 30 days of receiving your written request. The list we will give you will include disclosures made since our opening date of August 6, 2012. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond to your request within 30 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all full future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you we've done it, and tell others that need to know about the change in your PHI.

IV. TO OBTAIN INFORMATION OR ISSUE COMPLAINT ABOUT OUR PRIVACY PRACTICES.
If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint please contact: **Our Office @ 919-248-8777**

V. EFFECTIVE DATE OF THIS NOTICE
This notice is effective upon signature date.

I hereby acknowledge that I have been given an opportunity to read the Atlantic Reproductive Medicine Specialists Notice of Privacy Practices and have been given the opportunity to request clarification of anything not fully understood. located on their website. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 919-248-8777.

☐ **I accept receipt of Notice of Privacy Practices.**

☐ **I DO NOT accept receipt of Notice of Privacy Practices.**

Patient Signature Required

Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I ______________________________ **DOB:** __________ **Chart ID:** __________
Print Full Legal Name

Authorize and Request: ______________________________ **(Name of Facility)**

Phone: ______________________ **Fax:** ______________________

☐ **To release my entire medical record**

☐ **To release specified designated information to:** ______________________

____

by ☐ fax or by ☐ mail to: **ATLANTIC REPRODUCTIVE MEDICINE SPECIALISTS**
10208 Cerny ST., Suite 306
Raleigh, NC 27617
Phone: 919-248-8777 Fax: 919-248-8776

I hereby acknowledge I understand this consent to release includes protected health information including medical treatments, procedures and tests which may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). I hereby give authorized consent to release my specified medical records to the designee stated above.

Please indicate authorization by checking the appropriate box below:

☐ YES, I consent ☐ NO, I do not consent

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire thirty (30) days from the date of my signature unless I revoke the authorization prior.

______________________________ __________
Patient Signature Required Date

Revised 7.2022