WESTCHESTER FERTILITY
&
REPRODUCTIVE ENDOCRINOLOGY

REGISTRATION (Please Print & Fill Out)

Date_____ Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex: ☐M ☐F Age_____ DOB _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Spouse _____
Last Name First Name Initial

Soc. Sec. # _____ Sex: ☐M ☐F Age _____ DOB _____

Address _____ City _____ State_____ Zip_____

Spouse employed by _____ Occupation _____

Business Address Business Phone

PRIMARY INSURANCE

Person responsible for account _____
Last Name First Name Initial

Relation to patient _____ DOB _____ Soc. Sec # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber name _____ Relation to patient _____ DOB _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec.#_____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have Insurance coverage with _____
Name of company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

____ Payment by cash

____ Payment by check

____ Payment by credit card

____ Automatic monthly billing to your Visa and MasterCard

____ Guarantee your insurance co-payments with Visa and MasterCard

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa/MasterCard Health Care Incentive Program* which will enable you to use your Visa/MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____

Print your name here and sign below

X _____

Date: _____

ASSISTED REPRODUCTIVE TECHNOLOGIES
INSURANCE VERIFICATION WORKSHEET

The following is a personal plan worksheet that you may use when contacting your insurance carrier. Contacting your insurance carrier by phone to obtain benefit information is helpful but it is always a good idea to also obtain your benefits in writing prior to beginning a treatment cycle. Most insurance companies will not commit to paying for a procedure before a claim has been filled, but they may confirm if certain procedures are covered under your policy and at what percentage those procedures will be paid. To obtain written verification, call your insurance carrier and request the address and the name of a person to whom you may send your "predetermination for benefits request". Be very specific in your letter, which should include your situation and the treatment program specific CPT codes. The CPT codes (or billing codes) are included on the price list in your packet. A copy of this price list is often sufficient information for the insurance carrier.

When you contact your carrier:
Verify if you have the following services covered: Diagnostic testing for infertility, injectable infertility drugs, artificial insemination, in vitro fertilization, and/or surgeries to correct or restore fertility (depending on your individual situation).

If the carrier states that infertility drugs and monitoring are covered, verify that you still have the benefit if your treatment includes artificial insemination or IVF. Sometimes, insurance companies will only cover medications and monitoring if they are not used in conjunction with "artificial means of conception." However, it is possible that the carrier will cover medications and monitoring but not the actual insemination. Always be very specific in your request.

If you have coverage for artificial insemination or IVF, verify what the benefit includes. Does your benefit include a lifetime maximum, and if so, what is that maximum? Does the maximum include past services rendered with previous insurance companies? Ask your carrier if drugs are included in the benefit amount or if there is a separate benefit for drugs.

Verify if there are certain criteria that need to be met before starting treatment. Often carriers require that one meet certain criteria such as providing a letter of medical necessity, verifying length of time attempting conception, or length of employment before the benefit is effective.

There are many different types of health insurance and many variables within each type of plan. Most people are covered by group insurance through their employers. Most employers offer a choice of several different plans to their employees. Employees should investigate the benefits of each health plan being offered before selecting one. When an employer contracts with an insurance carrier for their employees, they negotiate or purchase policies that provide specifically requested benefits, such as infertility benefits.

Procedure and diagnosis coding for infertility treatment can easily be mistaken for diagnostic testing when the billing is filed. Please remember that your insurance company may request access to your medical records and we are required to code according to the treatment you receive. Please do not request that we falsify claims or diagnoses codes for you to obtain benefits you do not have. Many times insurance companies will pay in error leading to a patient believing they have coverage, even though the benefit for infertility does not exist. Office visits, labs, and ultrasounds are sometimes paid by an insurance carrier without the carrier realizing the services are treatment related (rather than for diagnosis). Usually, if paid in error, within a few months the error is corrected and the payments returned. You would then be billed for these services.

INSURANCE WORKSHEET

Insurance Company Name: _____

Insurance Phone Number: _____

Insurance address: _____

Contact Name: _____

My Insurance ID #: _____

Questions to Ask:

Do I have coverage for diagnostic testing for infertility? _____

Do I have coverage for treatment for infertility? _____

Do I need a referral or prior authorization from my primary care physician before visiting my reproductive endocrinologist? _____

Do I have a lifetime maximum benefit for infertility treatment? _____
Does this maximum include medications? _____

Do I have coverage for infertility drugs (Clomid, Follistim, Repronex, Pergonal...)? _____
If so, do I need prior authorization for these drugs? _____
If prior authorization is required, how and by whom is this accomplished? _____

Are there specific pharmacies that participate with my plan? _____

Do I have a lifetime maximum benefit for infertility drugs? _____

Does my plan exclude coverage for artificial insemination (WIUI)? _____
If not excluded, do I need separate prior authorization for this procedure? _____

Does my plan exclude coverage for In Vitro Fertilization? _____
If not excluded, do I need prior authorization for IVF? _____

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

PARTICIPATING INSURANCES
If we participate with your insurance, we will submit the claim to your carrier for all covered services. For any non-covered services, payment will be responsibility of the patient before services are rendered. Services deemed non-covered by your carrier remain your responsibility.

NON-PARTICIPATING INSURANCES
Payment is due at the time of service. We will provide you an itemized bill which you can submit directly to your insurance company for reimbursement. Please note, this is not a guarantee of payment. Please check with your insurance company for out of network benefits.

MEDICARE/MEDICAID INSURANCE
We are not a participating provider with Medicare or Medicaid. Therefore, your payment is due at the time of service.

COPAYS, COINSURANCE, and DEDUCTIBLES
By law we must collect your insurance carrier's copay at the time of service. We will bill you for the coinsurance amount that is designated by your insurance company if necessary. Please note some insurance companies may apply more than one copay per visit and deductibles may apply.

UNINSURED PATIENTS
Payment is due at the time of service. Our financial counselor is available to answer any questions you may have.

MISSED APPOINTMENTS
A $25.00 service fee will be charged for any missed appointment.

FINANCE CHARGES
A 1.75% interest charge will be applied to any unpaid balances after 30 days.

The finance department can provide general guidelines, but ultimately it is your responsibility to understand your infertility treatment coverage under your plan. Please check with your carrier to verify if any pre authorizations/referrals are required for insurance coverage prior to obtaining any services.

We accept cash or certified bank checks for IVF procedures.

Patients and/or responsible party agree to pay all costs for collection, including legal fees and court costs if the need arises. I have read the above information and agree with the terms.

Signature:_____Date:_____

Print Name:_____

WESTCHESTER FERTILITY
& REPRODUCTIVE ENDOCRINOLOGY

Michael B. Blotner, M.D., FACOG
Subspecialty Board Certified
in Reproductive Endocrinology

Telephone (914) 949-6677
Fax (914) 949-5758

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Individual's Name: _____
Last First Middle

Telephone Number: _____ **DOB:** _____

Address: _____

_____

CONSENT REGARDING GENERAL INFORMATION

By my signature below, I hereby consent to the use or disclosure of my health information in order that Westchester Fertility and Reproductive Endocrinology (the "Practice") may carry out treatment, payment of health care operations. For purposes of this consent, health information shall mean any and all information relating to health care services provided to me by the Practice, including, without limitation, information relating to services provided to me prior to this date.

HIV Related Information.
If applicable, I further consent to the Practice's use or disclosure of my health information relating to an HIV-related test, infection or illness AIDS or any information which could indicate that I have been potentially expose to HIV, but only to the following persons/entities:

- A third party payor or its agent to the extent necessary to reimburse the Practice for my treatment;
- Accreditation/oversight review organizations, government agencies, or the Practice's committees, in accordance with New York State law, in order to carry out the monitoring, evaluation, supervision, regulation or service review of the practice;
- Certain individuals within the Practice who are authorized to access my medical records, provide healthcare to me, or maintain/process my medical records for billing or reimbursement;
- Health care professionals or entities outside of the practice when necessary for my treatment;
- Health care professionals or entities in relation to the procurement or use of a human body part or fluids for use in medical education, research, therapy or for transplantation.

Psychotherapy Notes.
I understand that my consent to the Practice's use or disclosure of psychotherapy notes to carry out treatment, payment or healthcare, payment or health care operations will be limited solely to the following circumstances: (1) use by my mental health provider who created the psychotherapy notes and (2) use or disclosure by the Practice to defend a legal proceeding brought by me.

Additionally.
The practice provided me its Notice of Privacy Practices (the "Notice") that explains, among other things, the definition of treatment, payment and health care operations and the types of uses or disclosures that the Practice can make if I sign this consent. I have had an opportunity to review the Notice before I signed this consent. I further understand that the Practice may change the terms of the Notice from time to time, and that I may contact the Practice's Office Manager, at the address listed below, to obtain a revised version of the Notice at any time.

I understand that I may at any time submit a request in writing to the Office Manager, at the address listed below that the Practice restrict how my health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to my requested restriction. In the event that the Practice does agree to the requested restriction, however, the restriction will be binding on the Practice.

I understand that this consent will remain in effect until I provide a written notice of revocation at the address listed below. The revocation will be effective immediately up on the Practice's receipt of my written notice, except that the revocation won't have any effect on any actions the Practice took before it received my written notice.

The address of the Office Manager is: 136 South Broadway, White Plains, NY 10605. Tel # 914-949-6677, Fax # 914-949-5758.

I understand that if I refuse to sign this consent of if I revoke this consent in the future that the Practice will not provide any treatment to me or arrange for treatment on my behalf, and may discharge me as a patient, to the extent permitted by law.

_____ _____

Signature of Patient Date