Outside Monitoring Patient Registration Form

Henry Fertility ***Michael A. Henry, M.D.***

Appointment Day Appointment Date Appointment Time

PATIENT INFORMATION: ** FEMALE PATIENT ONLY **

Last Name: First Name: Middle Initial:

Maiden Name: E-Mail Address:

Address: City: State: Zip Code:

Home Phone: Cell Phone: DOB: Age: Sex:

SS#: Ethnicity: Marital Status:

PHYSICIAN INFORMATION

Ordering Physician: Address:

City: State: Zip Code: Phone:

Referring Agency: Address:

City: State: Zip Code: Phone:

Contact at the Agency:

INSURANCE INFORMATION (if applicable)

Company ID#: Group#: Phone:

Insurance through (circle one): Patient Spouse Significant Other Parent Other

Please list social security number and date of birth of person who carries you on insurance if not already listed above:

SS#: DOB:

IN CASE OF EMERGENCY CONTACT: (OTHER THAN SPOUSE)

Name: Relationship:

Home Phone: Work Phone: Cell Phone:

Address:

Consent to Treat: I request and give consent to Henry Fertility to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as considered necessary or beneficial by my ordering physician/agency for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial_____

Assignment and Release: I authorize Henry Fertility to release information from my medical record to my insurance carrier(s), ordering physician and referring agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Henry Fertility on my behalf.

Initial_____

Financial Agreement: I understand the fees for all services rendered are the full responsibility of the patient or referring agency. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to Henry Fertility. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initial_____

I understand the above and fully understand the terms thereof:

SIGNATURE OF MONITORED PATIENT OR RESPONSIBLE PARTY DATE

Financial Policy

Henry Fertility ***Michael A. Henry, M.D.***

Monitoring Patients Only

1. *Self-Pay Monitoring Patients*: If you **DO NOT** have insurance coverage and are a self-pay patient, or if your insurance does not cover these services you will be required to pay for services rendered on the day of your visit with the clinic. You will be required to pay for any additional fees generated during your visit._____(Initial)

2. *For the insured monitoring patient*: Patients are responsible for obtaining prior authorizations or referrals from their Primary Care Physician (PCP) and/or insurance company. Please bring this authorization with you to your first visit or have your PCP office mail or fax it to us prior to your visit. If you do not have a referral on the date of service, you will be asked to sign a waiver or you will be given the option of rescheduling your appointment._____(Initial)

3. *For the insured monitoring patient*: Any services not authorized by your insurance company will be denied and will become your financial responsibility. **Remember that prior authorization does not guarantee benefit payment.** Contact your insurance company for verification of benefits._____(Initial)

4. *For the insured monitoring patient*: There is a $50.00 per service, per visit co-management fee for insured patients due on each date of service. We accept payment by cash, check, Visa, MasterCard or Discover._____(Initial)

Please feel free to contact our Billing Manager to answer any questions you may have regarding financial issues. Call 317.817.1800 – opt. 2

I have read and fully understand the financial policy listed above. I understand that I will be given a copy of this policy for my records.

Patient's signature _____ Date _____

Witness _____ Date _____

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Outside Monitoring Insurance Verification Form

Henry Fertility ***Michael A. Henry, M.D.***

Please complete this insurance verification form prior to your visit with the doctor.
Use this form as a questionnaire when calling the member services number on your insurance card.

**It is your responsibility to call your insurance company and/or your primary physician for referral authorization. Thereafter you are responsible to inform the office staff of referral updates, extensions and/or change of insurances.

Today's date:

Insurance Company: Effective Date of Policy:

Insurance phone number for verification:

Policy Deductible: Amount Met: Coinsurance:

Is there a Specialist Office Visit Co-Pay? YES / NO If YES, Amount?

Does your policy require a referral to see a Specialist? YES / NO

Please contact your insurance company prior to your appointment and ask the following questions*

Does your policy cover infertility services?	Yes	No
If YES, does your policy require precertification or a pre-determination letter for these services?	Yes	No
Are ultrasounds and blood draws with an infertility diagnosis considered diagnostic CPT codes: 76857 (ultrasound) AND 82670 (blood test) with Diagnosis of N97.9	Yes	No

Notes:

I understand that this form must be competed accurately, which may require that I call my insurance company **PRIOR** to my first visit, and that it is part of my medical record. I also understand that if I do not fill out this form to completion, claims for infertility treatment will not be sent to my insurance as Henry Fertility will assume I do not have infertility benefits on my policy.

I understand that Henry Fertility charges a **$50.00 per service, per visit Outside Monitoring Program Fee** that is due on the date services are rendered. This is charged prior to filing services with my insurance. Once claims have been processed, a bill will be sent to the the address provided on the registration sheet.

Patient Signature Date

1/19

Contract for Outside Monitoring Patients

Henry Fertility ***Michael A. Henry, M.D.***

Monitoring Patients Only

1. As an outside monitoring patient, I understand that Dr. Henry is not my physician and the staff at Henry Fertility is not responsible for answering questions or giving opinions on the services rendered or the treatment ordered.

2. I will be on time for my monitoring appointments and realize that there are situations in which the patients under the care of Dr. Henry and the Henry Fertility staff will come first. Although I am on time, I realize my appointment time could be subject to delay.

3. All questions relating to my care will be directed to the ordering physician and staff. The staff at Henry Fertility's job as the clinic is to facilitate the orders as sent by the ordering physician and report the results to them. If I have questions about the tests or results, I will direct my inquiry to my doctor's office.

I have read and fully understand the contract and understand the relationship with Henry Fertility.

Patient's signature Date

Witness Date

Outside Monitoring Protected Health Information Authorization

Henry Fertility ***Michael A. Henry, M.D.***

I, _____

(Patient name) (Address)

_____

(City, state, zip code) (Date of birth)

request that the following options be followed for the disclosure of my Protected Health Information, (which would include your name, diagnosis, test results, and dates of service) as described in the Notice of Privacy Practices for Protected Health Information.

PLEASE LIST ALL THAT APPLY:

Henry Fertility may disclose information to the following persons (you must list name, phone number and relationship).

Name	Phone Number	Relationship

_____

(Patient's Signature) (Date)

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the Office Manager at Henry Fertility.

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wwwhenryfertility.com