New Patient Checklist

Please review this checklist before your visit with us!

- ✓ Complete **2 Registration Forms** (your own and your partner/spouse's)
- ✓ Print and sign page 1 of our **Notice of Privacy Practices**
- ✓ Sign the consent to verify insurance benefits
- ✓ Bring both your **insurance ID card and a photo ID** issued by a state or federal government agency (driver's license, passport, military ID, etc.).
- ✓ Make sure that you have a **referral form** from your doctor, if needed. If you are not sure, please call your insurance company via the Member Services phone number on your insurance identification card to find out what is required prior to your visit.
- ✓ We recommend that you bring any **medical records** related to any prior infertility evaluation. The best way to do this is to ask your doctor to provide you with a paper copy of all your medical records. You keep a copy for your own file and bring another copy to your initial visit with us.
- ✓ Check and clarify **directions** to our office well ahead of time. Please allow for extra travel time to arrive promptly for your scheduled appointment. The physicians' schedules are generally full. Therefore, if you are late for your appointment with the physician, we may have to reschedule your visit.
- ✓ Please visit our website (www.InfertilityDocs.com) for more information about how we can help you!

Notice of Privacy Practices

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

I(we) hereby acknowledge that I(we) have been presented with a copy of **ARM's** Notice of Privacy Practices.

____

Print Patient Name　　　　Signature　　　　Date

____

Print Spouse/Partner Name　　　　Signature　　　　Date

Notice of Privacy Practices

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If you have any questions about this notice, please contact Maria Sciancalepore (Director of Operations) or Dr. Gregory Corsan.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Practice Privacy Officer (Dr. G. Corsan).

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the

highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and

the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Dr. Gregory Corsan

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the

information is kept by or for our office. To request an amendment, you must make your request, in writing, to Dr. Gregory Corsan

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Dr. Gregory Corsan

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Dr. Gregory Corsan. ***We are not required to agree to your request.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to Dr. Gregory Corsan. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. 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.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Gregory Corsan. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	**First Name:**

Is this your legal name?	If not, what is your legal name?	**Ethnicity** (please circle): Hispanic or Latino Asian White Black American Indian Decline to Specify	Birth date:	Age:	Sex:

STREET ADDRESS	CITY AND STATE	ZIP CODE
SOCIAL SECURITY #: EMPLOYER:	CELL PHONE #:	HOME PHONE #:

May we leave messages regarding your medical care on your voicemail? (circle): YES NO	What is the name, address and phone # of your **preferred pharmacy**?

INSURANCE INFORMATION

We must be aware of <u>all</u> your insurance plans. Please indicate your primary insurance plan:

Subscriber's name:	Subscriber's S.S. #	Birth date:	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:

Name of your spouse/partner (if applicable):	DOB of your spouse/partner:		

SPOUSE/PARTNER'S EMPLOYER:

Do you have a 2nd insurance plan? Yes No

Please sign and date: ____

Please complete all information above and email this form to: AdvancedReproductiveMedicine@MyUpdox.com. It can also be faxed to **732.339.9400**

2018 07 18 intake form

PARTNER/SPOUSE REGISTRATION FORM

Today's Date:	Email Address:

PATIENT INFORMATION

Patient's Last Name:	**First Name:**

Is this your legal name?	If not, what is your legal name?	**Ethnicity** (please circle): Hispanic or Latino Asian White Black American Indian Decline to Specify	Birth date:	Age:	Sex:

STREET ADDRESS	CITY AND STATE	ZIP CODE
SOCIAL SECURITY #: EMPLOYER:	CELL PHONE #:	HOME PHONE #:

May we leave messages regarding your medical care on your voicemail? (circle): YES NO	What is the name, address and phone # of your **preferred pharmacy**?

INSURANCE INFORMATION

We must be aware of all your insurance plans. Please indicate your primary insurance plan:

Subscriber's name:	Subscriber's S.S. #	Birth date:	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:

Name of your spouse/partner (if applicable):	DOB of your spouse/partner:	

SPOUSE/PARTNER'S EMPLOYER:

Do you have a 2nd insurance plan? Yes No

Please sign and date: ____

Please complete all information above and email this form to:

AdvancedReproductiveMedicine@MyUpdox.com. It can also be faxed to 732.339.9400

2018 07 17 partner form

Consent to Verify Insurance Benefits and Bill Insurance

Name: ____ Date of birth: _________________

I hereby give my permission to the Center for Advanced Reproductive Medicine & Fertility or ARM (or a third party company who it designates) to obtain from my past, present or future health insurance and prescription benefits companies full and complete health insurance and medication coverage information, including, but not limited to coverage related to infertility (if applicable).

The health insurance and medication benefits verification are offered as a courtesy and without charge. I agree to hold harmless ARM, or the third party company performing the verification of insurance benefits and these companies shall have no liability should the information obtained from my insurance company and communicated to me is different form the coverage applied by my insurance company to any claims subsequently filed. I also agree to allow ARM to bill my insurance company for covered services.

Please complete the included Patient Registration Form with your insurance information.

Signature: ____________________________________ Date: ___________

Date of Birth: ______________ Social Security #: ________________________

Attention All Aetna Patients - You may be required to register with Aetna's Infertility Hotline. If a patient is required by Aetna to register with the Aetna Infertility Hotline, but fails to do so, Aetna will not consider paying for any services, and all services rendered will be your responsibility. Call 1.800.575.5999 to obtain your registration number, and complete the below:

My Aetna Registration No. is: ________________________ OR ____ I called Aetna and was informed that I am not required to register.