Patient First Name	**Patient Last Name**	Date of Birth	Age	Sex	Social Security #
Address		City		State	Zip Code
Home Phone Number	Cell Phone Number		Work Phone Number		
Marital Status	Sexual Orientation	Ethnicity	Email Address		
Occupation	Employer		Emergency Contact and Phone#		
Primary Insurance: (Please Provide copy of insurance Card)					
Subscriber ID#	Insured's Name		Insured's Date of Birth		
Secondary Insurance: (Please Provide copy of insurance Card)					
Subscriber ID#	Insured's Name		Insured's Date of Birth		
Preferred Method on contact: ☐ Cell Phone ☐ Email ☐ Home Phone ☐ Work Phone					

Partner First Name	**Partner Last Name**	Date of Birth	Age	Sex	Local pharmacy #
Address		City		State	Zip Code
Home Phone Number	Cell Phone Number		Work Phone Number		
Marital Status	Sexual Orientation	Ethnicity	Email Address		
Occupation	Employer		Emergency Contact and Phone#		

Referral to Center:
Physician Name: _____
_____
Friend/Family Name: _____
_____
Internet? Specify: _____
Yelp__Healthgrades__PFCLA
Resolve __Google__ Yahoo___
Other: _____

Primary Care Physician:
Name: _____
_____
Phone#_____
Address: _____
_____
City: _____
State:_____ Zip Code:_____

OB/Gyn:
Name: _____
_____
Phone#_____
Address: _____
_____
City: _____
State:_____ Zip Code:_____

Your records are considered confidential information and we will not release any information without your consent and signature. Please sign the release below. ***I hereby authorize CMD Fertility to release information t myself, my insurance carrier and to my physician.***

Patient Signature: _____ **Date: _____**

Partner Signature:_____ **Date: _____**

STATEMENT OF PAYMENT POLICY

Patient often ask when payment is due for services provided at CMD FERTILITY. The following information should be address most circumstances, but if you have any questions, please do not hesitate to contact the CMD FERTILITY Financial Coordinator.

PRE-CYCLE LAB WORK

Before you begin any cycle of treatment you may need certain tests that help determine the cause of your struggle with infertility. Payment in full is due at the time of service if you do not have insurance.

HOSPITAL SURGERY

If you need an in-hospital stay we will attempt to pre-authorize all surgeries with your insurance carrier. You should also expect to receive a bill form the hospital and the anesthesiologist.

FERTILITY MEDICATIONS

You may purchase your medications at a pharmacy chosen by you and /or insurance company. You are responsible for payment of all medication dispense to you if they are not covered by your insurance. This includes medication dispensed to your donor and/or surrogate, if applicable.

IVF CYCLES

All programs fees are due in full on the day you (your donor and /or surrogate, if applicable) start stimulation medication.

OUTSIDE LAB CHARGES/SHIPPING COSTS

Our laboratory tests are referred to an outside laboratory facility for processing. The performing laboratory will bill your insurance for you and bill you for what the insurance does not pay. Tests sent a specific laboratory may require that payment accompany the specimens.

METHOD OF PAYMENT

For your convenience, we accept cash, personal checks (US Dollars), American Express, Discover, Mastercard and Visa.

REFUNDS

In the event of a credit balance, it is our policy to issue a refund check within 14 working days.

AUTHORIZATIONS

I authorize my insurance company to mail payment of medical benefits directly to my physician and/or supplier of services. I further understand that I am responsible for paying any charges outstanding after 60 days.

RETURNED CHECKS

There will be a $25.00 charge for each returned check.

FINANCIAL REPONSIBILITY

I accept full financial responsibility for my treatment at CMD FERTILITY.

Patient Name: _____ Signature: _____ Date: _____

CONSENT TO THE USE AND DISCLOSURE FO HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATION

I hereby acknowledge receipt of a written notice of my privacy rights and I consent to CMD FERTILITY using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been given access to the Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that CMD FERTILITY reserves the right to change their notice and information practices and that I may obtain a copy of the revised noticed by written request addressed to: CMD FERTILITY, 10921 Wilshire Blvd Suite #702, Los Angeles, CA 90024.

I understand that I have the right to restrict how CMD FERTILITY uses or discloses my protected health information to carry out treatment, payment or health care operations; that CMD FERTILITY is not required to agree to the restrictions and; that CMD FERTILITY is bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used to disclose:

_____

_____

_____

I have the right to revoke this consent by notifying CMD FERTILITY in writing, except to the extent that CMD FERTILITY has taken action in reliance to my consent.

Patient Name: _____ Signature: _____ Date: _____