# Patient Registration Information


□ 201 N. Pennsylvania Pkwy, Suite 205
Carmel, IN 46280
(317) 817-1300
Fax (317) 817-1306

□ 7830 McFarland Blvd.
Indianapolis, IN 46237
(317) 817-1300
Fax (317) 817-1306

**William L. Gentry, M.D.**


Appointment Day ______________________ Date ______________________ Time ______________

Patient's Name
(Last) (First) (Middle Initial)

Maiden Name ______________________ Mother's First Name ______________________

Address ______________________ City ______________ ST __________ Zip __________

Cell Phone ______________________ D.O.B. ______________ Age __________ Sex ______

SS# ______________________ Marital Status ______________ Race ______________

Email Address ______________________________ Do You Smoke? □ Yes □ No

Allergies ______________________________________________

Referring MD ______________________ Address ______________________

City ______________________ ST __________ Zip __________ Phone ______________

How did you learn about our medical practice? ______________________________

**EMPLOYMENT INFORMATION**

Employer ______________________ Bus. Phone ______________________

Address ______________________ City. __________ ST __________ Zip ______________

Occupation ______________________ ______________________ ______________________

**SPOUSE OR SIGNIFICANT OTHER INFORMATION** Spouse Father Mother Other

Name ______________________________ Race ______________

D.O.B. ______________________ Age __________ SS# ______________________

Employment ______________________________ Bus. Phone ______________

Address ______________________ City. __________ ST __________ Zip ______________

Occupation ______________________ ______________________ ______________________

**PERSON RESPONSIBLE FOR PAYMENT** Self ______________ Spouse __________ Other __________

**IN CASE OF EMERGENCY CONTACT: OTHER THAN SPOUSE**

Relationship ______________________________________________

Name ______________________ Home Phone ______ Work Phone ______________________

Employment ______________________________ Bus. Phone ______________

Address ______________________________________________

# INSURANCE INFORMATION

**PRIMARY INSURANCE CARRIER**

Insurance Company Name ______________________________ Phone # ______________

Address ______________________________

Policy Holder Name ______________________ Relationship to Patient ______________

ID# ______________ Policy No. ______________ Group No. ______________

Benefit Code ______________ Other ______________ Effective Date ______________

**SECONDARY INSURANCE CARRIER**

Insurance Company Name ______________________________ Phone # ______________

Address ______________________________

Policy Holder Name ______________________ Relationship to Patient ______________

ID# ______________ Policy No. ______________ Group No. ______________

Benefit Code ______________ Other ______________ Effective Date ______________

**OTHER INSURANCE CARRIER**

Insurance Company Name ______________________________ Phone # ______________

Address ______________________________

Policy Holder Name ______________________ Relationship to Patient ______________

ID# ______________ Policy No. ______________ Group No. ______________

Benefit Code ______________ Other ______________ Effective Date ______________

**PATIENT'S ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT**

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize release of any information regarding services rendered and allow a photocopy of my signature to be used to file insurance and direct my insurer to issue payment for all medical and/or surgical benefits to me for services rendered, direct to the provider.

This assignment and authorization will remain in effect until revoked by me in writing. I understand that I am financially responsible for the fees for all services rendered.

I have read the above and fully understand the terms thereof:

I shall be responsible for any attorney fees required to collect for these services; court costs; and collection agency fees.

Date ______________ Signature of Patient ______________________________

Date ______________ Signature of Spouse or Partner ______________________________

Request for Information

☐ 201 N. Pennsylvania Pkwy, Suite 205
Carmel, IN 46280
(317) 817-1300
Fax (317) 817-1306

PLEASE SEND RECORDS TO:

☐ 7830 McF arland Blvd.
Indianapolis, IN 46237
(317) 817-1300
Fax (317) 817-1306

## REQUEST FOR INFORMATION AND/ OR RELEASE OF MEDICAL RECORDS PURSUANT TO LC. 16-39-1-4

1. Name of Patient_______________________________________ D.O.B ______________

   Street Address of Patient ______________________________________________

   City, State, Zip Code _________________________________________________

2. Doctor/ Hospital Releasing Records ______________________________________

   Street Address of Provider_____________________________________________

   City, State, Zip Code _________________________________________________

   The purpose of the requested release is:
   To obtain records related to fertility or GYN medical problems.

4. The specific information requested is:
   Office Visits, Labs, X-Rays, Surgeries (Operative Reports), Etc.

5. This request is good for 60 days from the date signed pursuant to
   IC. 16-39-1-4 unless otherwise indicated on this form.

6. This request may be revoked by the patient at any time by communicating that intent to the provider.

Patient's Signature ______________________________________________________

Patient's Printed Name_______________________________________________Date __________

PLEASE MAIL OR DELIVER THIS RELEASE TO YOUR PREVIOUS PHYSICIAN RIGHT AWAY.

# PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I____________________________________________ understand that as part of my healthcare, Advanced Fertility Group originates and maintains paper and / or electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided and a tool for routine health care operations such as assessing quality and reviewing the competency of health care professionals.

I understand and have been provided with a NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be disclosed to carry out treatment, payment, or health care operations.

I understand that Advanced Fertility Group is NOT required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand by refusing to sign the consent or revoking this consent, Advanced Fertility Group may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Advanced Fertility Group reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should we change our notice, we will send a copy of any revised notice to the address I've provided via United States Mail.

I understand that as part of this organization's treatment, payment, or health care operation, it may become necessary to disclose my protected health information to another entity, such as a referred health service or M.D. on your behalf, and I CONSENT to such disclosure for these permitted uses, including via fax.

I understand and have been provided with a NOTICE OF PATIENT CONCERNS POLICY AND PRECEDURES that provides information regarding patients' concerns related to Advanced Fertility Group.

In addition to my insurance provider THE FOLLOWING PERSON OR PERSONS may have access to my health information besides indicated providers as previously mentioned. I fully understand and accept the terms of this consent.

___________________________________________________________________________

1. ____________________________________ (Spouse)

3. ____________________________________________

2. ____________________________________(Guardian)

Patient Signature _______________________________________________Date _________________________________________

**Female History**

Date: ______________________________________________

Name: ________________________________________

Partner's Name: ____________________________________

Duration of Relationship: __________________________

Duration of Infertility:______________________________

What type of work do you do?_____________________________________________________________________

Weight:__________________________________________Height:__________________________________________

Dietary Habits:_______________________________________Exercise: ________________________________________

Allergies: ____________________________________________________________________________________________

Check all of the following conditions or problems that apply:

____ Pelvic Surgery
____ Epilepsy/Seizures
____ Syphilis

____ Anemia
____ Appendicitis
____ Arthritis
____ Blood transfusion
____ Breast discharge/soreness
____ Cancer
____ Chlamydia/Gonorrhea
____ Colitis
____ Diabetes
____ Endometriosis

____ Gall Bladder
____ Heart disease/High blood pressure
____ Hepatitis
____ Herpes
____ Hirsutism/Excessive hair growth
____ Kidney problems
____ Liver problems
____ Ovary problems
____ Pelvic Infection
____ Parasitic infection
____ Poor sense of smell
____ Rheumatic fever

____ Thyroid
____ Tuberculosis
____ Ulcers
____ Vaginitis
____ Trichomoniasis
____ Yeast Infection
____ Alcohol use
____ Cigarette user
____ Marijuana use
____ Cocaine use
____ DES exposure
____ Other_____________

_____________________________

Prescription Medication: ______________________________________________________________________________

Over the counter medication/vitamins/herbs: ______________________________________________________________

Age at first period: ______ Date of last menstrual period __________Number of days between periods: __________________

Medications used during period: _______________________________________________________________________

Pregnancy History, including miscarriages and abortions:

| Pregnancy Number | When (yr.)? | Abortion? | Miscarriage? | Ectopic? | Born Alive? | Infertility Therapy? | Is current partner the father? |
|---|---|---|---|---|---|---|---|
| 1st Preg. | | | | | | | |
| 2nd Preg. | | | | | | | |
| 3rd Preg. | | | | | | | |
| 4th Preg. | | | | | | | |

How often do you have intercourse? How many times around ovulation? _

Do you use lubricants or douche? ____________________

Have you had infertility therapy? _________ Describe: ______________________________________________________

_____________________________________________________________________________________________

Did you bring or have you requested your records? _________________________

FERRING PHARMACEUTICALS REPRONEX NOVAREL

**Male History**

Name: ______________________________________

Date: ___________________________________________

Partner's Name: __________________________________

Duration of Relationship: ____________________________

Duration of Infertility: _____________________________

What type of work do you do? _____________________________________________________________

Weight: ____________________________________________ Height: ____________________________________

Dietary Habits: ____________________________________ Exercise: __________________________________

Allergies: _________________________________________________________________________________

## Check all of the following conditions or problems that apply:

___ Heat exposure
___ Chemicals
___ Toxic Fumes
___ Radiation
___ High Fevers
___ Alcohol use
___ Cigarette use
___ Marijuana use
___ Cocaine use
___ Steroid use
___ Anemia
___ Appendicitis
___ Arthritis
___ Blood Transfusions
___ Undescended Testes

___ Breast discharge, enlargement
___ Cancer
___ Chlamydia/Gonorrhea/Herpes/NGU
___ Colitis/Ulcers
___ Circumcised
___ Erection or ejaculation difficulty
___ Heart disease/High blood pressure
___ Hepatitis/Liver
___ Kidney
___ Mumps with testes involved
___ Prostate
___ Neurological problems
___ Surgery in pelvic or testicular area
___ X-rays in pelvic area
___ Other/Describe: ________________________

Prescription Medication: ___________________________________________________________

Over the counter medication, vitamins or herbs: _____________________________________________

_____________________________________________________________________________

Do you have any children or pregnancies with another partner? ________________________________

Have you been treated for infertility or low sperm count? ____________________________________

Have you had a semen analysis? __________________________________________________

Did you bring, or have you requested your records? ___________________________________________

FERRING PHARMACEUTICALS
REPRONEX
NOVAREL

# INSURANCE QUESTIONNAIRE

**William L. Gentry, M.D.**

Before you are seen in our office, it is your responsibility to call your insurance company and/or your Primary Care Physician for referral authorization.

* Thereafter you are responsible for informing the office staff about referral updates, extensions and/or change of insurance.

Do you have a Co-Pay or Co-Insurance for seeing a specialist? Yes __________ No ___________

What is the amount $________________________ or percent ____________________%

Do you have to go to certain labs, hospitals, pharmacies? If yes, please list the names of the required facilities:

Hospital: ______________________________________________________________________________

Labs: _________________________________________________________________________________

Pharmacy: ___________________________________________________ Phone: ___________________________________

* Please note if your insurance allows you to go anywhere, indicate so in the space provided.

If we are seeing you for infertility related services, does your policy cover infertility services? Yes ___________No ___________

If so, does your policy require precertification or a pre-determination letter for these services? Yes ___________ No ___________

I understand that this form must be completed accurately, which may require that I call my insurance company PRIOR to my first visit, and that it is part of my medical record.

Patient's Signature _________________________________________________________________ Date _____________________

# FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. The following information is provided to ensure that each patient understands their financial responsibility prior to seeking treatment at Advanced Fertility Group.

1. All patients must schedule a financial consultation once they have received a treatment plan and prior to starting treatment. _______________ (initial)

2. Patients are responsible for obtaining prior authorizations from their Primary Care Physicians (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 first visit. We will preauthorize with your insurance carrier all surgical and hospital treatments. ______________ (initial)

3. After the initial consultation, it is your responsibility to confirm [1] that your PCP or insurance company has provided us with authorization prior to any treatment. Any services not authorized by your insurance company will be denied and ultimately will become your financial responsibility. Remember that prior authorization does not guarantee benefit payment. Contact your insurance company for verification of benefits. _____________ (initial)

4. We request payment in full be made for the following treatments:

   a. Artificial Insemination
   b. Donor Sperm
   c. Tubal Reversals ______________ (initial)

5. For patients undergoing IVF or GIFT, a down payment is required for both the physician's office and hospital charges. Remaining balances due at predetermined times. This will be discussed in detail during your financial consultations.

6. No one is as interested in your insurance coverage as you are. For this reason, you have more influence with your insurance company than we do, and we count on your participation when there is a problem with payment for services, you received. **WE ENCOURAGE YOU TO TAKE AN ACTIVE ROLE IN UNDERSTANDING YOUR INSURANCE BENEFITS AND COVERAGE PRIOR TO BEGINNING ANY FERTILITY THERAPY.**

7. Insurance authorizations for treatment can take up to 6 weeks to obtain from insurance companies and can be procedure specific or cycle specific. When a treatment plan has been determined, and authorization received, you will be notified by our office. If you choose to start treatment before insurance authorization has been received, a deposit will be required prior to starting. This deposit will be applied on the account until services are authorized and full payment received. Unless the insurance company denies the claim, a refund will then be issued minus any co-payments or deductibles. _________ (initial)

[1] advn

8. If your insurance plan covers IVF or GIFT, we must have complete benefits and authorization directly from your primary insurance company. This must be received in our office prior to starting your medications. This is for your protection as well as ours and no exceptions will be allowed. We will collect any co-payment, deductible or out-of-pocket expenses before medications begin. A detailed explanation will be given during your financial consultation.

9. For patients undergoing fertility treatment we require that all expenses incurred from a previous cycle of therapy be paid in full prior to beginning a new cycle of treatments. ____________ (initial)

10. We accept payment by cash, check, Visa, or MasterCard and request that payment be made at the time services are provided. Any co-payments, deductibles and non-covered services will be collected at the time of service for those insurance carriers that are participating providers.

11. As medical professionals, we deal ethically and honestly with every insurance provider and with every service claim we file. We will submit only for services rendered, specifically as they are rendered with the appropriate diagnosis.

It is our sincere desire to develop and maintain a strong relationship with each one of our patients. Feel free to contact our Financial Counselor or Office Manager to answer any question you may have regarding financial issues. Please do not direct any financial questions to the physician or medical staff. They will not be able to assist you in that area.

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 Signature Date

______________________________________________ ________________________

AFG Employee Signature Date