

Patient Registration Information



William L. Gentry, M.D.

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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



PLEASE SEND RECORDS TO:

William L. Gentry, M.D.

7830 McFarland 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 PROCEDURES 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pelvic Surgery | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart disease/High blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Herpes | <input type="checkbox"/> Vaginitis |
| <input type="checkbox"/> Breast discharge/soreness | <input type="checkbox"/> Hirsutism/Excessive hair growth | <input type="checkbox"/> Trichomoniasis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Yeast Infection |
| <input type="checkbox"/> Chlamydia/Gonorrhea | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Ovary problems | <input type="checkbox"/> Cigarette user |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Marijuana use |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Parasitic infection | <input type="checkbox"/> Cocaine use |
| | <input type="checkbox"/> Poor sense of smell | <input type="checkbox"/> DES exposure |
| | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> 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? _____

Male History

Name: _____ Date: _____
 Duration of Relationship: _____ Partner's Name: _____
 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:

- | | |
|---|---|
| <input type="checkbox"/> Heat exposure | <input type="checkbox"/> Breast discharge, enlargement |
| <input type="checkbox"/> Chemicals | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Toxic Fumes | <input type="checkbox"/> Chlamydia/Gonorrhea/Herpes/NGU |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Colitis/Ulcers |
| <input type="checkbox"/> High Fevers | <input type="checkbox"/> Circumcised |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Erection or ejaculation difficulty |
| <input type="checkbox"/> Cigarette use | <input type="checkbox"/> Heart disease/High blood pressure |
| <input type="checkbox"/> Marijuana use | <input type="checkbox"/> Hepatitis/Liver |
| <input type="checkbox"/> Cocaine use | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Steroid use | <input type="checkbox"/> Mumps with testes involved |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Surgery in pelvic or testicular area |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> X-rays in pelvic area |
| <input type="checkbox"/> Undescended Testes | <input type="checkbox"/> 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? _____

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