

Dr. Louis R. Manara
Center For Reproductive Medicine and Fertility

Welcome to our practice! We have included registration materials in this section of our website to facilitate your initial consultation. Please print each of the items included in this section, complete and sign where indicated, and bring the signed documents to your consultation.

At your initial consultation, you will meet with Dr. Manara for at least one hour depending on the complexity of your situation. You will also meet with members of our staff and any administrative questions you may have will be addressed. The consultation will encompass a thorough and careful review of all pertinent aspects of your medical and reproductive histories as well as a review of any prior evaluation and/or treatment. If you have access to your records from your referring physician or from treatment with another reproductive practice, it would be helpful, though not necessary, to bring those records with you. Husbands or partners are encouraged to be present at this initial consultation although it is perfectly fine if they are unable to attend.

Your initial consultation may include a physical examination and/or vaginal ultrasound. If the timing of your consultation with respect to your menstrual cycle suggests that valuable information may be gained by ultrasonography, it may be done during your initial consultation.

If testing is recommended going forward from the consultation date, these procedures will be described and you will be given written information to take home for review.

While we do have an active email address on our website, (conceive@louismanara.com) and do make every effort to read emails sent to this address, it would be best to communicate with us by telephone at 856-767-0009. Please call our office approximately 48 hours before you are scheduled to confirm your appointment or to cancel if necessary.

We sincerely look forward to meeting and working with you toward achieving your goals.

Dr. Louis R. Manara and Staff

E-MAIL AUTHORIZATION FORM

Name: _____

Date: _____

Date of Birth: _____

E-Mail Address: _____

I authorize the office of Dr. Louis R. Manara to communicate with me via the email address indicated above. I understand that if I have any questions, I should call the office at 856-767-0009.

Signature: _____

Dr. Louis R. Manara - Patient Registration Form

Patient

First Name _____ MI _____ Last Name _____

Social Security Number _____ - _____ - _____ Marital Status: S _____ M _____

Date of Birth _____ Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

E-mail Address _____

Family Physician _____ Referred By _____

Pharmacy # _____

Employer Information

Employer _____ Phone _____

Employer Address _____

City _____ State _____ Zip _____

Spouse/Partner Information:

First Name _____ Last Name _____

Date of Birth _____ Social Security Number _____ - _____ - _____

Spouse Employer Information:

Name of Employer _____

Address _____

City _____ State _____ Zip _____

Insurance Information:

Primary: _____ Secondary _____

Rx Insurance Co. _____

Signature: _____ ***Date*** _____

Important Items For Initial Consultation

1. Current Insurance Card
2. Valid Picture ID for both patient and partner
3. Prescription Card (if separate from insurance card)
4. Any records from prior evaluation and treatment if available

Financial Policy

I understand that claims for services rendered will be submitted to my insurance company for payment. As my insurer may not cover all of the services necessary for my treatment, I will be responsible to pay for and be financially liable for all applicable deductibles, co-pays, and non-covered items as determined by my insurance carrier.

Although, Dr. Louis Manara may as a courtesy convey to me the information that is received from my insurance company regarding the scope of my coverage, I understand that Dr. Manara is not responsible to confirm or verify the scope of my coverage and cannot guarantee the accuracy of the information that is received from my insurer. I understand that both before and during the course of treatment, I am responsible for understanding the scope of my insurance coverage. I am also aware that I should personally verify the scope of my coverage with my insurer if I wish to have confirmation regarding the extent of insurance available for my treatment.

If my insurance plan does not include an infertility benefit, I understand that I must pay in full for services at the time that they are rendered.

For those plans with lifetime maximum coverage for infertility, I will be responsible to pay for and be financially liable for all fees over and above the benefit amount, as determined by my insurance carrier. I understand that any amount not covered or not paid by my insurance plan must be paid by me within 30 days of first invoice.

In the event that unpaid balances become delinquent and require the services of a collection agency, you will be responsible for all past due balances in addition to all legal fees associated with collection services.

Signature: _____ Date: _____

Emergency Contact Information

Patient: _____

Emergency Contact: _____

Relationship: _____

Telephone Number: _____

Alternative Number: _____

Authorization For Treatment and Financial Responsibility

I (or designated guardian) hereby authorize payment directly to Louis R. Manara, D.O. of the benefits otherwise payable to me, but not to exceed regular charges for physician claims. I (or designated guardian) understand that I am financially responsible to Louis R. Manara, D.O. for charges not covered by my insurance carrier, e.g., deductibles, co-pays, coinsurances, or non-covered services.

X _____ Date _____
Patient and/or Guardian Signature

Authorization For Release of Medical Information

I authorize my physician and/or other facility to supply to another physician involved in my medical care a copy of necessary medical records and/or test results requested by Dr. Manara but ordered by my Primary Care Physician. I understand that this is for the release of medical information only. If I am a managed care subscriber, I authorize my physician to allow my Managed Care Organization access to my chart for Quality Review Purposes.

X _____ Date _____

Medicare Patients

Medicare Benefits (Please sign) Patient's certification, authorization to release information and payment request. I certify that the information given by me to applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for physician claims and other related medical claims. I request that payment of claims be made on my behalf for authorized benefits under my health insurance. I hereby authorized direct payment to Dr. Louis Manara for insurance benefits otherwise

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payable to me. Payments are not to exceed the balance due of the practices regular charges for these claims. I understand that I am financially responsible to Dr. Louis Manara for charges not covered by this authorization. I understand that Dr. Louis Manara will bill HCFA using the term "signature on file" and am aware that my signature as written below constitutes that "on file" signature.

X _____ Date _____

Medigap Benefits

Medigap Benefits (Please sign) I hereby give Dr. Louis Manara permission to ask for Medigap payments for my care. I understand that my Medigap insurer needs information about me and my medical condition to make a decision for payments. I give permission for this information if requested by my Medigap insurer. I further authorize payments from my Medigap carrier to be paid directly to Dr. Louis Manara on my behalf for any services furnished to me.

X _____ Date _____

Consent of Treatment For Minor/Incapacitated Patients

I hereby authorize Dr. Louis R. Manara to provide medical treatment to _____ . The patient is unable to consent to medical treatment because he/she is a minor child or other: _____

X _____ X _____
Guardian Name

X _____
Witness

Patient Record of Disclosure

Name: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals home.

I wish to be contacted in the following manner:

Home Telephone:

___ *OK to leave detailed message*

___ *Leave message with call back number only*

Work:

___ *OK to leave message*

___ *Leave message with call back number only*

Written Communication:

___ *OK to mail to my home address*

___ *OK to mail to my work/office address*

___ *OK to fax to this number* _____

Other Instructions:

The "privacy rule" generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to

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accomplish the intended purpose. These provisions do not apply to disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosure of Protected Health Information

Patient _____

Date Disclosed _____

To Whom _____

By Whom _____ Address _____

Date Disclosed _____

To Whom _____ Address _____

By Whom _____

Date Disclosed _____

To Whom _____ Address _____

By Whom _____

Acknowledgement of Receipt of Notice of Privacy Practices

*****I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.***

Patient Name (please print)

Date

Parent or Authorized Representative

Date

Signature: _____

HIPAA Notice of Privacy Practices

Name: _____

**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.*

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health care information to provide, coordinate, or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, we would disclose your protected health care information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your

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protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. The situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight, Abuse, or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity To Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.