

# Compassionate Care Program

# 2013 PATIENT ENROLLMENT FORM

Phone: (855) 541-5926 Fax: (919) 415-2870

**PATIENT INFORMATION** Please remember that your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan.

FIRST NAME		LAST NAME		MI
DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	By providing your email address, you consent to receive additional mailings from the Compassionate Care Program. E-MAIL		
HOME PHONE		MOBILE PHONE		
MAILING ADDRESS		CITY	STATE	ZIP CODE
PREFERRED METHOD OF CONTACT <input type="checkbox"/> Home Phone <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Mail <input type="checkbox"/> E-mail		COUNTRY		
If you're unavailable when we call, is it ok for us to leave a message, including the Compassionate Care Program name? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**TREATMENT**

Are you currently undergoing fertility treatment with a fertility specialist?  Yes  No

Have you ever received products through the Compassionate Care Program in the past?  Yes  No

I have been prescribed the following:  
 Any Gonal-<sup>®</sup> (follitropin alpha for injection) product  Cetrotide (cetrotirelix acetate for injection)  Ovidrel (choriogonadotropin alfa for injection)

**Fax or mail your income verification form to the Compassionate Care Program:**  
 Fax: (919) 415-2870 Mail: Compassionate Care Program • 6501 Weston Parkway, Suite 370 • Cary, NC 27513

We will need to know the annual adjusted gross income for the entire household. The following are acceptable income documents that we can use to validate your income:

- 1040 Form
- 1040 - A Form
- 1040 - EZ Form
- 1040 Form Married Filing Separately (MFS) Need a form from both filers
- 1040 - A Form (MFS)
- W2/1099R Form
- 1099 Form
- Pension Notification Letter
- Social Security Award Letter

How many people live in your household?

**Patient Signature and Authorization:**  
 Fax: (919) 415-2870 Mail: Compassionate Care Program • 6501 Weston Parkway, Suite 370 • Cary, NC 27513

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to Use and Disclose health and other personal information.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ PATIENT NAME \_\_\_\_\_

**ART Center Contact or Site Name:**  
 If applicable, please provide an email address for the person who manages the Compassionate Care program at your ART Center.

ART CENTER \_\_\_\_\_

CONTACT E-MAIL \_\_\_\_\_

**For assistance or additional information, call (855) 541-5926 Monday - Friday, 8:00 AM - 8:00 PM EST**

## Authorization to Use and Disclose Health and Other Personal Information

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to EMD Serono, Inc. and its agents and representatives including any company that helps administer EMD Serono's Compassionate Care Program (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

- (1) contact me by mail, e-mail, and/or telephone to enroll me in, and administer EMD Serono's Compassionate Care Program;
- (2) provide me with materials relating to EMD Serono's Compassionate Care Program;
- (3) verify the accuracy of the information I provide in my application for EMD Serono's Compassionate Care Program;
- (4) conduct surveys to measure my satisfaction with EMD Serono's Compassionate Care Program; and
- (5) for such other purposes as may be required or permitted by applicable law.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, there is no guarantee that it will not be disclosed to another third party. However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

**PATIENT MUST SIGN THE BACK OF THIS FORM THEN SEND OR FAX BOTH PAGES**

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive EMD Serono Products, but it will limit my ability to participate in EMD Serono's Compassionate Care Program.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono or its representatives in writing by mail or fax at 6501 Weston Parkway, Suite 370, Cary, NC 27513, fax (919) 415-2870. If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): \_\_\_\_\_

Signature of patient (or personal representative): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Authority/relationship of personal representative (if applicable): \_\_\_\_\_

Signature of patient (or personal representative): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Authority/relationship of personal representative (if applicable): \_\_\_\_\_