Arizona Associates
for Reproductive Health

Ketan S. Patel, M.D., F.A.C.O.G.

REGISTRATION FORM

Date _____ ❒ Married ❒ Single ❒ Seperated ❒ Divorced ❒ Partnered

Patient last name_____ First Name_____ MI _____ Sex (circle) M/F

Age _____ Date of birth _____ Email _____

Address _____ City_____ State _____ Zip _____

Phone _____ Cell _____ Social Security #_____

May we leave a voicemail message ❒ YES ❒ NO

Employer_____ Phone_____

Address_____ Occupation _____

Primary Insurance_____ Phone_____

Insured_____ ID#_____ Group#_____

Primary care doctor_____ Phone_____

Referring GYN physician _____ Phone_____

Spouse last name_____ First Name_____ MI _____

Age _____ Date of birth _____ Email _____

Phone _____ Cell _____ Social Security #_____

Employer_____ Phone_____

Address_____ Occupation _____

Referring GYN physician _____ Phone_____

Primary Insurance_____ Phone_____

Insured_____ ID#_____ Group#_____

Emergency Contact: Name_____ Phone_____

Authorizations and Release (please initial)

__ If I have no medical coverage and/or benefits, I am aware that payment is due at the time of services when services are rendered.
__ I am aware that I am responsible to pay co-pays and deductibles at the time of services.
__ I hereby authorize to release any MEDICAL information which might be needed in connection with payment for medical services rendered. I request that all amounts payable under my medical insurance policies be made directly to Arizona Associates for Reproductive Health.When a non-contracted health insurance company rejects a claim, the total amount of the fee is due from me. I understand that I am responsible for charges related to any services deemed non-covered by my insurance company.
__ I am aware that if I fail to pay my account and if it is deemed neccessary to turn any past due balances to collections, I have been informed that there will be additional costs accessed in addition to my account balance.

By signing below, I acknowledge that I have read and understand the above statements.

Patient Name _____ Signature _____ Date _____

Arizona Associates
for Reproductive Health

PAYMENT TERMS AND CONDITIONS

Once Dr. Patel has determined your treatment protocol, Arizona Associates for Reproductive Health will provide you with an estimate of charges of the anticipated costs for your treatment. Because each patient situation is unique, additional procedures such as ultrasounds or blood tests may be required and may not be included in your estimate of charges.

Please note, you will be financially responsible for all services provided, even for services not included in your estimate.

Insurance

Please realize that it is your responsibility to know what coverage yot1 have through your insurance. Benefits through each insurance plan vary greatly. For example, some insurance plans limit the number of procedures that will be covered during a treatment cycle. Our charge estimate reflects what we believe your Insurance will cover. However, the estimate is not a guarantee and may not be complete. Co-pays, deductibles, co-insurance and self-pay amount are due at the time of treatment.

Laboratory & Procedure Charges

Due to the technical complexities of our laboratory testing and the need for ·consistency across testing cycles, it is important that we perform a majority of laboratory and ancillary procedures (ultrasounds, etc.) at Arizona Associates for Reproductive Health. If you have insurance that requires you to go to an outside facility, we will make every attempt to utilize these benefits. However, most laboratory procedure charges will be performed at AZARH and charged directly to you.

Cancellation and Prepaid Cycles

If a cycle of packaged services is canceled for clinical reasons such as poor stimulation response or potential for hyperstimulation, your costs will be re-calculated based on actual services provided. Any services that were not provided, but were pre-paid, will be refunded.

Financial Agreement

I agree to be responsible for all charges incurred and will provide payment as requested. If my account is sent to collections, I agree to pay collection fees and/or attorney fees. Delinquent accounts will also be assessed reasonable interest charges.

I HAVE READ AND UNDERSTAND THE ARIZONA ASSOCIATES FOR REPRODUCTIVE HEALTH PAYMENT TERMS AND CONDITIONS. I ALSO UNDERSTAND THAT I AM PRIMARILY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

Patient Name _____ Signature _____ Date _____

8573 E Princess Drive, #101 | Scottsdale, Arizona 85255 | 3885 S Val Vista Dr., #105 | Gilbert, Arizona 85297
Office: (480) 946-9900 Fax: (480) 946-9914

Arizona Associates
for Reproductive Health

PATIENT'S BILL OF RIGHTS

- You have a right to seek consultation with the physician(s) of your choice
- You have a right to contract with your physician(s) on mutually agreeable terms
- You have a right to talk privately with your physician(s) and to have your health care information protected
- You have a right to use your own resources to choose the care of your choice
- You have a right to refuse medical treatment even if it is recommended by your physician(s)
- You have a right to be informed about your medical condition/treatment and take part in decisions about your care. To be informed about the risks and benefits of treatment and appropriate alternatives
- You have a right to refuse third-party interference in your medical care, and to be confident that your actions in seeking or declining medical care will not result in third-party-imposed penalties for patients or physicians
- You have a right to receive full disclosure of your insurance plan explaining the coverage and benefits

_____ _____ _____

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Arizona Associates for Reproductive Health

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

This Notice of Privacy Practices is being provided to you on behalf of Arizona Associates for Reproductive Health with respect to reproductive medical services provided at Arizona Associates for Reproductive Health's facilities (collectively referred to herein as "We" or "Our). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

YOUR RIGHTS

Although your health record is the physical property of Arizona Associates for Reproductive Health, you have the right to:

- request a restriction on certain uses and disclosures of your information as provided by applicable law
- obtain a paper copy of this Notice of Privacy Practices upon request
- inspect and copy your health record as provided for by applicable law
- request an electronic copy of your electronic health record
- request to amend your health record as provided by applicable law
- obtain an accounting of disclosures of your health information as provided by applicable law.
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- request a restriction of disclosure of your healthy information to your health insurer for services for which you pay "out of pocket" in full
- transmit copies of your health information to third parties when request by you, in writing

OUR RESPONSIBILITIES:

We are required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- where required by law, notify you in the event that there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at as **http://www.azarh.com** and our offices and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which re receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect except where we have already relied upon your authorization.

PERMITTED USES AND DISCLOSURES

We will use and disclose your health information for treatment. For example: information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice. We will use your health information for payment. For example: A bill may be sent to you or a third party payor, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. If you indicate your interest in participating in the Attain IVF

Program, we will provide relevant information concerning your medical condition to AzARH for determination of your qualifications for this financing program. We will use and disclose your health information for our health care operations. For example: Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and the reproductive medicine service we provide.

OTHER USES OR DISCLOSURES OF PROTECTED HEALTH INFORMATION

Business Associates: There are some services provided at Arizona Associates for Reproductive Health through contacts with business associates. For example: the management services of AzARH and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do, and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Public Health: As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Note: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections. For More Information or to Report a Problem/Complaint

If you believe your privacy rights have been violated, you should immediately contact: (480) 946-9900

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

If you have any questions or would like further information about this notice, please contact us at the above number. This notice is also available on our website at http://www.azarh.com/

This notice is effective as of August 31, 2017

_____ _____

Patient Name Date of birth

_____ _____

Patient Signature Date

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Arizona Associates for Reproductive Health

INSURANCE PAYMENT TERMS AND CONDITIONS

It is your responsibility to provide AzARH with your current insurance information including primary and secondary policies. If your insurance coverage changes at any time it is your responsibility to inform AzARH immediately to prevent any delay in billing. AzARH will not be responsible for any unpaid fees by your insurance if the information was not provided timely. In addition, we are unable to accept insurance after a cycle has begun due to pre-authorization requirements of insurance plans. It is extremely important you provide us with any insurance coverage changes prior to treatment.

We cannot submit claims for non-contracted insurance plans and full payment is due before starting treatment. If it is determined that you do have benefits through a contracted plan, you will be responsible for paying an estimated deposit of applicable deductibles, co-insurances, and co-pays up front. In the event your insurance does not cover the services billed due to being "non-covered" or "not medically necessary" you will become ultimately responsible for any unpaid claims at AzARH usual and customary rates. If you have a maximum on your plan and that maximum is reached mid-treatment, you will become responsible for the AzARH full usual and customary rates. You will not receive any insurance contractual adjustments on any services unpaid by your insurance due to no coverage, not medically necessary or a benefit has maxed out. If authorization is required for any of your services AzARH will request the authorization, but we encourage you to independently ensure authorization is on file prior to receiving treatment. You will become responsible for payment if you decide to move forward with treatment without prior authorization. We encourage you to independently confirm the exact extent of coverage of benefits, if any, with your insurance carrier. We assume no responsibility for representations made by your insurance carrier.

If a cycle is canceled or stopped mid-cycle for any reason, any credited monies on your account will first be applied to outstanding balances, until determination has been made that account is paid in full; please keep in mind that claims pending out to insurance can take at least 30-45 days for processing. Refunds will only be issued once all claims have been processed and account balance is zero.

- I acknowledge that I have been informed in advance of receiving services that it is my responsibility to provide AzARH with my most current insurance coverage, primary, secondary, and any subsequent policies, to prevent any billing delays.
- I acknowledge that I am responsible to pay an estimated deposit up front.
- I acknowledge that I will be financially responsible for applicable charges as indicated above and will be asked to pay for these services prior to the service being rendered.
- I further acknowledge that I understand and agree to the refund policy as outlined by AzARH.

Patient Signature _____ Date _____

Partner Signature _____ Date _____

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