HART
FERTILITY CLINIC
HOUSTON ASSISTED REPRODUCTIVE TECHNOLOGIES
Dorothy Roach, MD • Ertug Kovanci, MD
111 Vision Park Blvd, Ste 110 • The Woodlands, TX 77384
350 Kingwood Medical Dr, Ste 320 • Kingwood, TX 77339
P: 281-444-4784 • F: 281-444-0429

REGISTRATION FORM

Referred by: _____

Patient Information

Name:			
Address:		City, State:	Zip:
Mobile #:	Home #:		Work #:
Date of Birth:	Age:	Sex:	DL#:
SSN:	Occupation:		Marital Status:
Email:			
Employer:			

Partner Information

Name:			
Address (if different):		City, State:	Zip:
Mobile #:	Home #:		Work #:
Date of Birth:	Age:	Sex:	DL#:
SSN:	Occupation:		
Email:			
Employer:			

Insurance Information

Company Name:
Policy / ID #:
Group #:
Customer Service Phone #:
Policy Holder Name & DOB:

I certify that the above information is true and correct to the best of my knowledge. I authorize Houston Assisted Reproductive Technologies (North Houston Center for Reproductive Medicine) payment of benefits and right to appeal all insurance claims as appropriate on my behalf. I understand that I have a contract with my insurance company, and it is my responsibility to understand my benefits and how my plan works. VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT AS DISCLOSED BY THE HEALTH PLAN. My health plan determines whether a claim is eligible for payment at the time it is received and processed based on plan description, member eligibility, terms, exclusions, limitations, policy guidelines waivers, riders, benefit maximums, pre-existing and coverage at time of service. I understand that legally my insurance has 45 days to pay claims at which point I may be billed in full. I agree to be fully responsible for all lawful debts incurred by myself for services whether or not covered by insurance. I authorize the provider to release confidential and/or protected health information (PHI) or any information necessary to process this or any future or past claim in the course of my examination, treatment, operations or payment as defined by HIPAA. This authorization shall remain valid unless revoked in writing by patient.

_____ _____

Signature Date

As a courtesy to other patients, we request 48 hours' notice for all cancellations. If proper notice is not given, patients will be subject to a $100 no-show fee.

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Office Policy

Welcome to Houston Assisted Reproductive Technologies and thank you for choosing our facility for your medical care. We want to ensure that your visit with us is a pleasant experience. **Please review and initial** our office policies so you will have a better understanding of our office.

_____ **Office Hours**
Our office is open Monday through Thursday 7:30 – 4:00 PM and Friday 7:30 – 4:00 pm.

_____ **Emergencies**
For problems occurring after regular office hours, please call our main office number and follow the prompts to have your call transferred to the answering service. The answering service will then contact the physician/nurse on call. Infertility patients experiencing problems with medications - treatments may use this procedure also.

_____ **Children at appointments**
Because we treat women who are actively trying to conceive, and because children commonly carry viral infectious diseases, which can be easily spread, it is for all our patients' protection that we respectfully ask that you do not bring children to our office. Due to the nature of our specialty, we do not treat patients under the age of 18.

_____ **Cell Phone**: We kindly ask when you are called back to the exam room, please immediately discontinue your call so that our medical assistant, nurse and physician can make your appointment as efficient as possible.

_____ **Billing**
Payment is due at the time of service. We accept cash, personal checks, MasterCard, Visa and Discover as well as debit cards. A $35 fee will be charged on any insufficient or returned check or credit card.

_____ **Billing Records**
HART will provide you with a receipt for your payment at each date of service. Your voided check/receipt, credit card receipt and superbill are your financial record. Please retain these copies for your tax purposes

_____ **Appointments** Patients are seen by appointment only during our normal office hours. This time is reserved just for you. If you are unable to keep your appointment, please let us know so that we may schedule a new time for you. No show or missed appointments will incur a $100 no show fee. This charge is not covered by health insurance. Every effort will be made for you to be seen in a timely manner. Should a delay occur you will be informed of the delay and given an opportunity to reschedule your appointment if necessary.

_____ **Referrals**
If your health plan requires a referral for your visit, it is your responsibility to obtain that referral prior to your appointment.

_____ In consideration for the privacy of ALL patients, it is our policy to limit physician visits only to the PATIENT. Spouses are welcome during consultation, inseminations, embryo transfer and pregnancy ultrasounds.

_____ **Test Results**
Every effort is made to communicate your test results to you in a timely manner. Please allow 5 to 7 business days to receive the results. Some tests may be anticipated to require another visit to further discuss the results and treatment options.

_____ **Prescription Refills**
Prescriptions and refills will be authorized during our normal office hours. It is your responsibility to contact your pharmacy 72 hours in advance for your refills. Once your pharmacy contacts our office, a routine prescription refill will be phoned in within 24 hours. Refills might also require a follow-up appointment. No refills will be made after hours, Fridays or weekends

_____ **Refunds**

Patient account and health plan reimbursement will require an account audit before any refunds are considered. Refunds will be made if there is an account balance either from patient or from your health plan.

_____ **Patient Inquiries**

All questions and requests should be submitted through our secure Patient Portal for the best response time. Inquiries will be responded to during office hours. Every effort is made to respond to your request on the same day. Some questions require physician input and may be answered on the next business day. Inquiries submitted after 3:00pm may be answered on the next business day.

_____ **Medical Record and Confidentiality**

Our office adheres to the Health Insurance Portability and Accountability Act (HIPAA). Your medical record is strictly confidential. Your prior written authorization is required for the release of information. Medical Record fee is $25 prepaid. Records are released only to the patient, we recommend that you make a copy for yourself if providing your records to another physician. Medical record request swill be processed within 10 business days.

_____ **Special Letter or Form Completion Requests**

Requests to complete special forms or letters (i.e., disability, adoption, applications, etc) will be considered on a case-by-case basis, and a prepaid fee may be required prior to completion.

_____**Fraud and Abuse**

Fraud is defined as making false statements, misrepresentations, or intentional deception of material facts to obtain some benefit, such as payment for medical services for which no entitlement would otherwise exist. As a physician I have an obligation to conform to the requirements of the health plan's policy and benefits. Fraud is punishable by restitution, fines, loss of license and/or imprisonment. Our office will not alter records to achieve enhancement of medical benefits or reimbursement.

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SIGNATURE: _____ DATE: _____

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Designation of Personal Representative(s)
For Use and Disclosure of Protected Health Information

Under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) that became effective on April 14, 2003, health care providers and their staffs are limited in the information that they may share with individuals other than the patient or his/her parent or guardian. In many cases, patients would like to involve a member of their family or another person in management of their health care. Such disclosures of information are permitted by HIPAA when the patient (or his/her parent or guardian) designates an individual(s) as his/her personal representative. Therefore, if you would like to designate one or more individuals to serve as your personal representative, please complete the information below.

Patient name_____Date of Birth_____Date_____

I, the patient/parent/guardian hereby designate the individual(s) listed below to serve as my personal representative(s) or the personal representative of the name above. By designating this individual(s) as my personal representative, I am giving permission to the physician and staff of North Houston Center for Reproductive Medicine/North Houston Fertility Laboratory to discuss any information pertaining to my health care, (including appointments, diagnoses, treatment plans, insurance information, and other related topics.

This designation will remain in effect until such time as I revoke it in writing.

Name of Personal Representative	Relationship	Phone Number	Address

Signature of Patient_____

Acknowledgement of Receipt of Our Joint Notice of Privacy Practices

I acknowledge that I have received a Joint Notice of Privacy Practices from HART Fertility Clinic. This Joint Notice of Privacy Practices applies to the privacy practice of HART Fertility Clinic.

This form is used to document (a) an individual's acknowledgement of receipt of our Joint Notice of Privacy Practices or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Signature of Patient: Date:

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No Show and Same Day Cancellation Policy

HART Fertility is committed to scheduling each patient with enough time for the attention necessary to give the best care possible. Every effort is made for you to be seen in a timely manner.

Because we do not over-book, no shows and same day cancellations can pose a significant hardship on our practice.

Appointment times that are booked and then result in no shows or same day cancellations contribute to the length of time it takes for all patients to schedule a timely appointment.

This time is reserved just for you. If you are unable to keep your appointment, kindly let us know 48 hours in advance so that we may schedule a new time for you. Your early cancellation will give another person the possibility to have access to an appointment.

The fee for "no show" and "same day cancellations" is **$100**, as noted in our Office Policy. This fee will be due prior to scheduling another appointment.

Acknowledgement of no show and late cancellation policy.

_____
Printed Patient Name

_____ _____
Patient Signature Date

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Coordination of Benefits Questionnaire

Many families are covered by more than one health plan. Your health plan contract contains a Coordination of Benefits (COB) provision. The coordination of benefits (COB) process determines which plan pays first. If there is any other insurance, this form is required in order for us to process your claims accurately and timely. This process makes sure your doctor is filing with the primary plan first whether or not you have benefits as this is required by the health plan prior to filing with the secondary if you have benefits. If we do not file accurately, correctly and timely this can cause delay in claim payments, incorrect payment or overpayment by health plan.

Primary Insurance through Patient Employer

Insurance #1:

Insurance Carrier: _____Employer: _____

Member Name: _____Subscriber ID #: _____Group #: _____

OTHER INSURANCE:

Are you or any other member of this plan covered by another medical insurance policy?

- **If yes, please complete all the fields below that pertains to the member that has the other coverage.**

Secondary Insurance, through spouse employer or private insurance

Check those that apply: □ Other Health Insurance □ Private Insurance

What type of policy is this? □ Group □ Individual policy □ Student policy

Insurance #2 - Carrier's name: _____

_____

Address City ST Zipcode Phone #

Dependent(s) listed on the other insurance: Effective or Cancel Date, if different from policy holder

_____ ___/___/___

Other policyholder's name: _____

Policyholder's: Date of Birth: ___/___/___ ID#: _____

Effective date of other insurance: ___/___/___ If cancelled, cancellation date ___/___/___

Is the policyholder:

□ Actively working for the group □ Inactive □ Retired, retirement date: ___/___/___

□ On **COBRA**, which began: ___/___/___

Policyholder's Employer: _____

Patient Signature: _____Date: ___/___/___

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	DOB:
Address:	
SSN #:	Phone #:

I hereby authorize Hart Fertility Clinic to : _____ Release to / _____ Receive from

Person or Organization Phone # Fax #

Dates of Service

This information is being released for the following purpose:

_____ Continued Care _____ Legal _____ Insurance _____ Disability Services _____ Other: _____

Information to Release	
_____ OB Record	_____ Lab Results
_____ Complete Record	_____ Other: _____

HIV/AIDS: I CONSENT TO THE RELEASE OF ANY POSITIVE OR NEGATIVE TEST RESULT FOR AIDS OR HIV INFECTION, ANTIBODIES TO AIDS OR INFECTION WITH ANY OTHER CAUSATIVE AGENT OF AIDS WITH THE REST OF MY MEDICAL RECORDS:
INITIAL: _____ DATE_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by Federal or Texas Privacy law.

If information is being released to me, I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Houston Assisted Reproductive Medicine liable for any misinterpretation of the protected health information as a result of not consulting my physician for the correct interpretation.

This authorization shall be valid for 120 days unless revoked in writing by the patient prior to expiration date.

_____ _____
Signature of Patient or Legal Representative Date