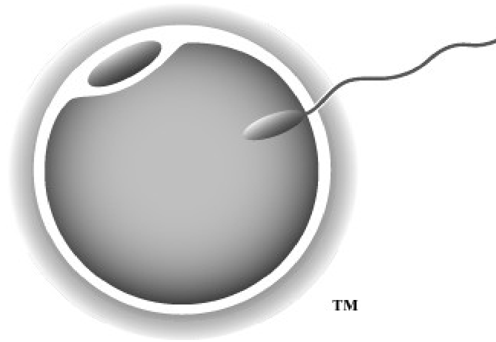


Center for Assisted Reproduction

1701 Park Place Ave. Bedford, Texas Phone: (817) 540-1157

4461 Coit Rd Ste 307 Frisco, Texas Phone: (972) 661-9544

Kathleen M. Doody, MD: Kevin J. Doody, MD: Anna C. Nackley, MD: Rinku Mehta, MD
Board Certified Reproductive Endocrinologists

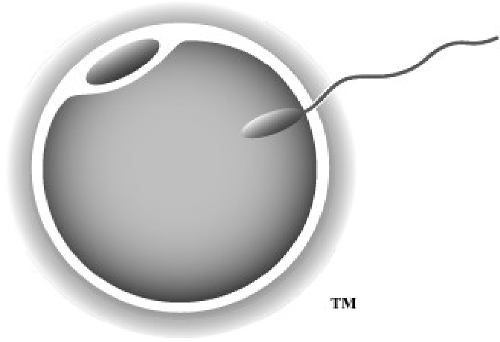
Dear Patient,

Enclosed is our New Patient Information packet. This purpose of this packet is to prepare you for your initial appointment as well as to provide the Center with all necessary information to proceed with your initial consultation. We understand that undergoing this type of treatment may be very stressful. It is not our intention to overwhelm you with policies, but rather educate you to the best of our ability prior to your appointment. This information will also serve as a reference for you if you have questions regarding our policies. Please review it carefully. Our friendly staff will be happy to assist you if you have any questions or concerns about the information provided. So please feel free to call us at our main office (817)-540-1157, or contact our New Patient Coordinator directly at (817)-540-7067.

The following information is included in the packet:

Fax Cover Letter (Please use to fax the enclosed info. You may also mail it to us if you prefer)
Patient Demographic Sheet (Your general information)
Nursing Visit Check List (The things you will need to know & the things you will need to bring)
CAR Financial Policy (The information we need from you for insurance, financing, etc.)
CAR Office Policies (Our rules to protect our patients)
CAR Treatment Guidelines (Our health guidelines for patients prior to treatment)
CAR HIPAA Policy (Health Insurance Portability and Accountability Act)
CAR Credit Card Authorization Form (For Medical Services to be Rendered)
CAR Phone Consultation Policy (Only necessary if you do your physician consult via telephone)
CAR Phone Consultation Credit Card Authorization (Necessary if your physician consult is via telephone)
CAR Direct Dial Phone List (How to reach important people quickly)
CAR Marketing Survey (How did you find out about us?)

We look forward to meeting you!



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To:	Michelle Giosio , New Patient Coordinator	**From:**	
Fax:	(817)-545-2164	**Pages:**	
Phone:	(817)-540-7067	**Date:**	/ /

Name: (First) ________________________________ (MI)_____ (Last) ________________________________

Date of Birth _ _-_ _-_ _ _ _ Age ____ Sex: M F Marital Status: S M

Ethnicity: ________________

Address: ____Zip____ ____________

1. Phone Contact #:_________________ (circle Home/Work/Cell) 2. Phone Contact #___________________ (circle Home/Work/Cell)

Social Security #: ______________ Driver License #:_____________ Employer: ___________________________

Fax #:________________________ Email address:____

Referring Physician (Name): ____________________________________Phone #: _________________________

Address: ____ ___________

Primary Care Physician (Name): _________________________________ Phone #: _______________________

Primary Reason for Appointment: Tubal Reversal Infertility Re-current Loss Other

Please explain your condition: ____

SPOUSE OR PARTNER INFORMATION

Name: _______________________________________ Relationship to Patient: ___________________________

Date of Birth _ _-_ _-_ _ _ _ _ Age ______Sex: M F

Ethnicity:___________________________________

Address: ____ ___________

Phone #: ______________________Social Security #: ____________________ Driver License #: _____________

Work #: ______________________

Employer____

PRIMARY INSURANCE INFORMATION

Please make sure that you enclose a copy of all insurance cards (front & back) and policy books (benefits & exclusions). If this information is not received, we may not be able to verify your benefits for your appointment.

Insurance Co: ____Phone #: ______________________________

Insurance Address: ____

Group #: _______________________________ Policy or I.D. # ____

Insured's Name: ____ Relationship to Patient: Self Spouse

Insured's Employer: ____ Phone #: ___________________________

Insured's Social Security #: ____________________________ Date of Birth: ______________________________

SPOUSE / MALE PARTNER INSURANCE INFORMATION

Please make sure that you enclose a copy of your spouse or male partner's insurance card (front & back). This information needs to be provided prior to your initial visit with the phyisican.

Insurance Co: ____Phone #: _____________________________

Insurance Address: ____

Group #: _______________________________ Policy or I.D. #: ____

Insured's Name: ____ Relationship to Patient: Self Spouse

Insured's Employer: ____ Phone #: __________________________

Insured's Social Security #: ___________________________________ Date of Birth: _______________________

I hereby assign, transfer, and set over to Dr. Doody all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature ___________________________________ **Date** ____________________________

_______Enclosed forms have been completed and returned to CAR (preferably prior to your initial appointment with the nurse.)

_______Please note we would like for you to arrive 10 minutes prior to your appointment to review and sign
paperwork.

_______Please review your Patient Demographic section to be certain you completed the **“Primary Reason for Appointment”** section. (This is important because it helps our billing office to appropriately verify your benefits.)

_______Please carefully review and abide by our Office, Financial, and Treatment Policies (each is included in this packet).

_______Please bring a copy of your Medical Records pertaining to any previous infertility testing, treatment or surgeries you or your spouse may have had (**Please make a copy for yourself prior to your appointment. We will not be able to copy them for you**).

_______Please mail or fax a copy of **you and your spouse or male partner’s** driver’s licenses.

_______Please mail or fax a copy of you and your spouse or male partner’s insurance cards (front & back) along with copies of your policy and/or benefits booklet (copy pages related to infertility **benefits and exclusions only**). If booklet does not specify infertility benefits and exclusions, you will be required to obtain additional information from your insurance company. If you do not provide our office with this information **before** your appointment, you will be considered a **self-pay** patient. (Please see financial policy for additional information).

_______Please obtain a referral for your initial visit with the physician if required by your insurance company.
(**Referral is not required at the nursing visit. Please review the financial policy for more information**).

_______If you **do not** have insurance coverage, you will be required to pay $315.00 at your nursing visit. This fee includes your nursing visit, physician visit, a sonogram and examination.

_______**If you have had the following lab work done within the last twelve months** please bring in results:

Female: OB Panel (Hepatitis BsAg, CBC, Rh factor, blood type, RPR, and Rubella titer IgG) HIV, Hepatitis C Antibody, and RBC Anitbody Screen.

Male: RPR , Hepatitis BsAg, Hepatitis C Antibody, HIV

These tests are **not** required for the nursing visit, but **needed** prior to receiving treatment.
(Please see the “Treatment Guidelines” section for additional information).

_______Please understand you **will be expected to pay in full** if you are seeking a reversal of sterilization unless you can provide written verification from your insurance company.

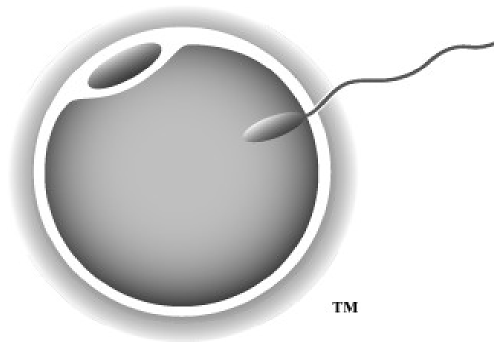
_______Hearing impaired or non-English speaking patients, please bring an interpreter to all appointments.

_______Please note if you arrive late for nursing visit (depending on the day's schedule) your appointment may
need to be rescheduled.

I have read the above and understand that it is my responsibility to provide the above stated information as well as comply with the Center for Assisted Reproduction's office procedures.

____ ___________________________

Patient's Signature **Date**



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BENEFIT VERIFICATION

The Center for Assisted Reproduction (CAR) understands that this is a sensitive time for you, and our billing department wants to assist you with verifying your benefits. We will make every effort to contact your insurance company to verify your benefits verbally prior to your initial consult. If we are able to reach your insurance company prior to your initial consult, we will notify you if do not have coverage for the initial consultation. Though many insurance companies offer verbal benefit verification through the 800 number on the back of your insurance card, verbal verification **is not a guarantee of benefits.** Therefore, we ask all patients to provide a written verification from your insurance company of your covered fertility and family planning benefits as well as the exclusions prior to beginning any treatment or surgery. This information is used as a safeguard for our patients to protect them if an insurance company denies a claim. This also helps our financial counselors to appropriately advise you about your cost responsibilities when they meet with you after your initial physician consultation. It is necessary for you to have the physician consult prior to the financial consult because a specific treatment plan will have to be discussed and determined with you by one of our physicians before an appropriate cost analysis can be determined. There are several ways to obtain written verification of your benefits.

Obtaining written verification:

Most insurance companies provide a printable version of your benefits online. If your benefits are not available to you online, you may also obtain benefit information from your insurance policy booklet. We ask that you provide us with copies of your infertility benefits and family planning as well as infertility exclusions. If you do not already have a policy booklet, your employer or your insurance carrier may provide you with one.

If you are unable to obtain written verification through a policy booklet or online, or if the information provided is unclear, our billing office will provide you with a letter of pre-determination to your insurance after you have had your initial consultation with a physician and a treatment plan has been recommended for you. A pre-determination letter is a request to your insurance company to review your policy and determine benefits accordingly. The insurance should respond to your inquiry by sending you a written response.

All covered treatment must have written verification prior to starting a treatment cycle, (i.e. Policy Book, Pre-determination letter from insurance) unless you are a cash patient. Having written verification protects you if your insurance denies a payment.

RESTRICTIONS OR LIMITATIONS

There may be certain restrictions or limitations on your policy that you and our office are not aware of (without proper documentation.) Just because we receive verbal verification of a particular service does not always mean that patients have coverage. This is due to certain limitations or restrictions in your insurance policy.

INSURANCE REQUIREMENTS

If your insurance:

- Requires its own claim forms, it is your responsibility to provide CAR with these forms.
- Does not pay on claims submitted within 90 days, the charges will become your responsibility.
- Denies claims for a treatment cycle, the following treatment cycle will need to be paid at the time of service.

It is imperative that you visit with one of our financial advisors to review the cost of treatment options that have been recommended. Each treatment cycle varies in cost. There is a possibility that your treatment may change. If so, it is important that you again consult with a financial advisor to ensure that you are well informed about potential benefit changes and cost differences.

IMPORTANT INFORMATION FOR MALE TESTING

Husbands or male partners have the option of having services such as semen analysis and infectious disease screenings filed separately to their own insurance (as opposed to being cash procedures). However, in order to file any procedure to their insurance, they must first be an established patient. If a husband or male partner chooses to be an established patient for insurance filing, he must attend his wife's or female partner's initial physician consult. This will mean the patient and spouse or partner will be subject to separate insurance co-pays at the initial visit. If patients choose for the husband or male partner to be considered a cash patient, they will have to pay cash prices for semen analysis or any bloodwork. It is up to the patient (upon scheduling their initial appointment) to determine if their husband or male partner will be an established patient. If the husband or male partner is unable to be present for the initial physician consult, we will not be able to file any of their testing to insurance.

REFERRAL AND PRE-CERTIFICATION

Referrals and pre-certification are the responsibility of the patient. It is your responsibility to provide a current referral prior to beginning any cycle. This allows for proper pre-certification to be obtained.

Most insurance plans must have preauthorization for all infertility related services that are eligible. You must notify our office 7-10 business days prior to the start date of your treatment. If proper authorization is not obtained, you must pay for the unauthorized service in full. It is your responsibility to know whether your plan requires pre-certification.

DIAGNOSTIC TESTING VS.TREATMENT

Most insurance companies cover diagnostic testing. The following tests are considered diagnostic:

- Lab work to determine the cause of infertility (i.e. hormone levels)
- HSG
- Ovulatory monitoring without medication
- Clomid Challenge Test

Many plans cover surgical treatment to correct an underlying problem.

- Tubal Reconstruction (This is not the same as a tubal reversal.)
- Treatment of endometriosis or uterine fibroids

Fewer plans cover the following treatments (depending on your individual policy):

- Ovulation with medications (i.e. Clomid/FSH) induction
- Intra-uterine Inseminations (IUI)
- Assisted Reproductive Techniques (ART)
  - In Vitro Fertilization (IVF)
  - Intracytoplasmic Sperm Injection (ICSI)
  - Preimplantation Genetic Diagnosis (PGD)
- Tubal Reversal

Insurance coverage will be specific to your own insurance policies. Please consult with our financial advisors to find out what your insurance may or may not cover.

YOUR DIAGNOSIS

The Center for Assisted Reproduction treats patients for the following diagnosis:
Health Issues Unrelated to Infertility (i.e. pain, bleeding, fibroids, anemia)
Health Issues with Fertility Issues (i.e. blocked tubes, pain, and bleeding)
Infertility Issues (i.e. inability to conceive after 1 year of unprotected intercourse or 6 months if female is over 35)
It is possible to have more than one diagnosis. Depending on your specific insurance policy, your particular diagnosis may be fully covered, partially covered, or not covered at all by your insurance company. Your physician determines your diagnosis based upon your medical history, which you provide during your nursing visit. **CAR will not unlawfully change your diagnosis code to obtain payment from your insurance company under any circumstance, even if your policy does not cover your true diagnosis.** However, if there is a filing error on CAR's part i.e. (the incorrect diagnosis was filed), please notify the billing office to review the claim and correct it. We will be happy to re-file if we have made a filing error.

NEW PATIENT CONSULTATION

You will incur a $100.00 fee for a nursing visit and administrative fees. This fee will be part of your future initial consultation with the physician. If we have verified that you have insurance coverage for your physician consult, the nursing visit will be filed to your insurance along with the physician consult. In the event that you do not attend your appointment with the physician within six months of your nursing visit, you will be billed for the nursing and administrative fees. **Under no circumstances will this fee be waived or billed to your insurance.**
All patients who do not have insurance coverage for either visit will be required to pay $315.00 at the nursing visit. This fee includes the nursing visit, physician consultation, sonogram and examination. It does not include any lab work that might be needed. **If any additional services are rendered the day of the consultation, payment will be due at check out.**

RETURNING PATIENT APPOINTMENT

If you discontinue treatment for more than 12 months you will be required to have another nursing visit to update your history. You will incur a $35.00 fee for a nursing visit and administrative fees. This fee will be part of your future initial consultation with the physician. If we have verified that you have insurance coverage for your physician consult, the nursing visit will be filed to your insurance along with the physician consult. In the event that you do not attend your appointment with the physician within six months of your nursing visit, you will be billed for the nursing and administrative fees. **Under no circumstances will this fee be waived or billed to your insurance.** All patients who do not have insurance coverage for either visit will be required to pay $290.00 at the nursing visit. This fee includes the nursing visit, physician consultation, sonogram and examination. It does not include any lab work that might be needed. **If any additional services are rendered the day of the consultation, payment will be due at check out.**

PREPAYMENT DISCOUNT POLICY

Filing insurance claims can be timely and costly to CAR. Verbal authorization of insurance payment is never a guarantee of payment. It can often result in hours spent doing follow-ups and appeals. Even after making a payment to CAR, insurance companies may review records and require that the payment is returned if they determine that the claim was paid erroneously. However, prepayment avoids all of these time-consuming costs, and is a guarantee of payment. CAR patients who prepay save CAR the substantial time and expense of obtaining authorization and filing insurance claims. Therefore, CAR is able to offer prepayment discounts to these patients. If the patient opts to utilize these discounts, they must understand that CPT codes are not available. CAR will not file a claim after prepayment, nor will it accept any payment from an insurance company for claims filed by the patient for any pre-paid services because of the additional cost of managing claims, follow-ups, and appeals.

PAYMENTS TO LABORATORY AND ASC

Our Ambulatory Surgical Center and Laboratories are onsite. However, they are considered separate facilities by the state of Texas. They have a different tax ID number and are regulated under different state guidelines than our clinic. We are currently negotiating and contracting with several different insurance companies. However, our laboratory and ASC are only currently contracted with Blue Cross and Blue Shield, Cigna (not including Cigna PPO), and Tricare insurance companies. **Therefore, services in the laboratory and ASC may not be covered, or benefits may be reduced because they will be out-of-network**.

CANCELLING YOUR APPOINTMENT

CAR understands that at times it may be necessary to cancel an appointment or reschedule due to an unexpected conflict. We ask that you please be courteous to our staff and other patients, and provide a 24-hour notice prior to canceling any appointment (i.e. new and returning consults). Failure to give a 24-hour notice will result in the following fees

New patient consultation - $100.00

Existing and returning patient consultation - $55.00

These fees are not billable to your insurance company.

SURGERY FEES

In most cases when a surgery is scheduled you will receive a contract in the mail stating what your responsibility will be. If for some reason you need to cancel your surgery, you must contact us at least 14 days prior to the scheduled date. Failure to do so will result in a $150.00 fee that is not billable to insurance. All tubal reversal costs must be paid in full prior to scheduling the surgery.

ANESTHESIA FEES

An outside group (Pinnacle Anesthesia) provides services for all of our procedures in which anesthesia is necessary.

Cash patients will pay fees directly to CAR, and CAR will reimburse Pinnacle.

Insured patients will be billed directly by Pinnacle. For questions please contact them at (972)-233-1999

CONTRACTED LABORATORIES

Most insurance companies require their member to use certain laboratories for diagnostics tests. It is the patient's responsibility to know and inform CAR which laboratory is contracted with their insurance company. If any charges are denied because the wrong laboratory was used, CAR will not be held financially responsible.

AFTER HOURS CALLS

After hours calls must be limited to emergencies only. Non-emergency issues such as prescription refills, instructions and test results must be taken care of during normal business hours. Non-emergency after-hours calls will be subject to a $25.00 fee. **Under no circumstances will this fee be waived or billed to your insurance.**

PHONE CONSULTATIONS

Phone consultations are available for patients who live greater than 60 miles from the center. These consultations are approximately $200.00, and are not billable to insurance. All New Patient Paperwork and payment must be received prior to any telephone consultation.

REFUNDS

CAR will be more than happy to refund patients for all services in which pre-payment has been made, but services were not rendered. However, if there is still an outstanding balance (patient or insurance), you will not be refunded until your account is paid in full. Please allow 2-4 weeks after your account has been paid in full for your refund to be complete. To initiate a refund, please contact the billing department.
If your prepayment is with a loan that is paid directly to CAR such as Capital One, Medi Credit, Medical Business Solutions, etc. the refund will be issued directly to the institution that issued the pre-payment.

OBTAINING MEDICAL RECORDS

According to the guidelines of the Texas State Board of Medical Examiners, the fee for medical records is $25.00 for the first twenty (20) pages of medical records and $.15 per page thereafter. The Center for Assisted Reproduction charges $10.00 for records five (5) to twenty (20) pages. For records that are twenty-one (21) pages or more, there is a flat fee of $20.00. A Medical Records release form must be completed prior to records being copied.

ARBITRATION / LEGAL ISSUES

Any dispute arising out of or in connection with Center for Assisted Reproduction shall be finally settled by arbitration in accordance with the Arbitration Rules of the International Chamber of Commerce. "This company is pledged to settle customer disputes through an arbitration program operated by the Better Business Bureau of Fort Worth". I agree to handle any disputes with Center for Assisted Reproduction through this independent arbitration program if I am unable to resolve the issues directly with the billing office. The non-prevailing party will pay for arbitration cost.

I (the patient) and/or my representative agree not to bring a frivolous medical malpractice case or cause of any action against (the physician or physician's legal entity providing care).

Furthermore, should be a meritorious medical malpractice case or cause of action to be initiated or pursued, I (the patient) and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as (physician). Furthermore, I agree that these expert witness(es) will adhere to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. Finally, you (the patient) agree that council for me (physician) shall have the right and be free to depose such expert witnesses at least 120 days before any scheduled trial date. In consideration for this, I, (the physician), agree to the same stipulations.

POLICIES AND FEES ARE SUBJECT TO CHANGE

Please keep in mind that all office policies and fees are subject to change at any time without notice. Our office will do everything we can to help you receive the maximum benefit your insurance company allows. Ultimately the charges you incur are your responsibility, and the Center for Assisted Reproduction provides insurance filing and inquiry as a courtesy to our patients. If charges filed to insurance are not paid in full and are not required to be written-off due to a contract with the insurance company, they will become the responsibility of the patient.

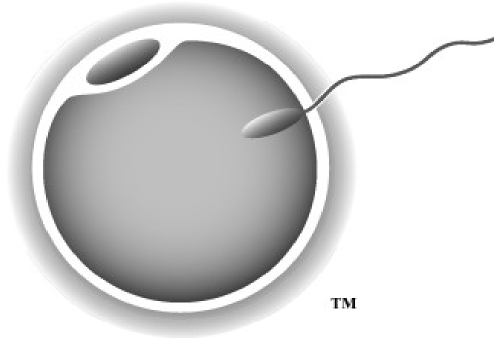
BILLING QUESTIONS

Direct any billing questions to our billing office at (817) 540-1157.

I have read and agree to all of the above policies.

____
Printed Name

______________________________ ____________________
Signature **Date**



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OFFICE HOURS

Bedford clinic
7am to 6pm Monday – Friday
7am to 3:30pm Saturday and Sunday
Closed Christmas Day
Frisco clinic
7am to 6pm Monday – Friday
Closed Christmas Day

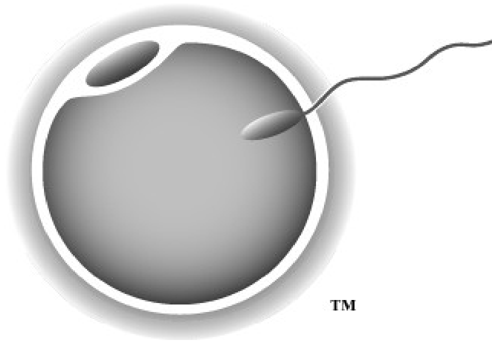
NO CHILDREN POLICY

Due to the sensitive nature of infertility treatment as well as safety concerns, we ask that if you have children, you make alternate arrangements for childcare during your visits to our office.
There is an hourly playcare located just off Hwy 121 and Glade Rd (North of Bedford near Target). It is called Kidztime Hourly Playcare. Their contact information is:
website: www.kidztimehourlyplaycare.com phone: 817-685-0200.
Also, there is a nearby McDonalds with an indoor playground less than a block from the Center. If a spouse or another adult accompanies you to your appointment with your children, it would be an appropriate place to pass the time outside of the Center.
If you arrive at the Center with a child or children (with the exception of emergencies), we are required to reschedule your appointment for a date in which you are able to obtain childcare.
This policy is in effect for the safety of your children as well as out of concern and respect for our patients. We appreciate your cooperation in this matter.

I have read and agree to all of the above polices.

____
Printed Name

____________________________ ____________________
Signature **Date**



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CAR GUIDELINES FOR PRE-CONCEPTUAL SCREENING PRIOR TO TREATMENT

CAR requires that all patients have current pre-screening bloodwork complete prior to treatment. This includes the following:

- OB panel within past 12 months
- HIV, hepatitis B & C, syphilis screening on couple within past 12 months
- Genetic screening should be considered in high risk groups (e.g. – cystic fibrosis in Caucasians; sickle cell anemia in African Americans; Tay-Sachs in Jews)
- Prenatal vitamins / folic acid – all patients
- No herbal supplements – impact on fertility and early pregnancy development unknown

CAR BODY MASS INDEX (BMI) GUIDELINES FOR TREATMENT

Body Mass Index (BMI) is the correlation between height and body weight. Obesity is when a person's BMI is greater than 30. Morbid obesity is when a person's BMI is greater than 35. Our treatment limitations based on Body Mass Index are listed below:

- Ovulatory monitoring, IUI, clomiphene citrate – BMI 45 or less
- IVF, surgery, gonadotropins – BMI 40 or less

(These guidelines are set because obesity is associated with lower pregnancy rates as well as higher complication rate in pregnancy).

CAR GUIDELINES REGARDING ILLNESS AND TREATMENT

If a patient has serious medical illness (diabetes, chronic hypertension, liver disease, etc.) we require clearance by the appropriate medical specialist prior to treating the patient.

I have read and agree to all of the above polices.

____
Printed Name

________________________________ _______________________
Signature **Date**

CENTER FOR ASSISTED REPRODUCTION, P.A. AND CENTER FOR ASSISTED REPRODUCTION LABORATORY AND SURGERY CENTER, INC.

NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES

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.

Purpose and Policy:

This office is committed to compliance with all federal and state laws that pertain to any aspect of the clinical practices of business procedure of this office. In particular, privacy and security rules relating to the Health Insurance Portability and Accountability Act (HIPAA), along with related state laws, are integral to matters of privacy, medical records, the confidentiality of communications, and other topics addressed throughout this policy and procedure manual. The HIPAA Privacy Rule applies to all protected health information (PHI) in this office including, but not limited to: your name, address, phone number, social security number, health history, symptoms, examination and test result, diagnoses, procedures, treatment, and plans for the future care or treatment, information stored and transmitted electronically, paper records, and oral communications. PHI includes any information as it is related to the past, present, or future physical or mental health condition of any of our patients; any treatment they have received; and health care payment information.

This Notice of Privacy Practices describes how Center for Assisted Reproduction may use and disclose your information and the right that you have regarding your health information. When using, disclosing or requesting you information, we are normally required to make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. This limitation does not apply in situations involving disclosures to you or made pursuant to your authorization, to a health care provider for treatment, to the Secretary of Human Services for HIPAA compliance and enforcement purposes, or as otherwise required by law.

Uses and Disclosures of Health Information Without Authorization:

When you obtain services from Center for Assisted Reproduction, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose you information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment. *Example:* Disclosure of medical information about you may be made to doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in you care. Information may be shared with pharmacies, laboratories, or radiology center for the coordination of different treatments.

Your health information will be used for payment. *Example:* Health information about you may be disclosed so that services provided to you may be billed to an insurance company or third party. Information may be provided to your health plan about treatment you're going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.

Your health information will be used for health care operations.
Example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

Business Associates: There are some services that we provide through contracts with third party business associates. *Examples:* External laboratories, Pharmaceutical companies, financial agencies, computer technicians. To protect your health information, Center for Assisted Reproduction will require these business associates to appropriately protect your information.

Disclosures Required by Law or otherwise Allowed Without Authorization or Notification:

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

- When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse, or responding to court orders;
- For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to food, medications, or devices;
- For health oversight activities, such as audits, inspections, or licensure investigations;
- To organ procurement organizations for the purpose of tissue donation and transplant;
- To coroners and funeral directors for the purpose of identification, determination of the cause of death, or to perform their duties as authorized by law;
- To avoid a serious threat to the health or safety of a person or the public;
- For specific government functions, such as protection of the President of the United States
- For Worker's compensation purposes;
- To military command authorities as required for members of the armed forces;
- To authorized federal officials for national security and intelligence activities as authorized by law;
- To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by law.

Other Allowable Uses and Disclosures without Authorization: Other uses or disclosure of your health information that may be made include:

- Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives, relay patient instructions, and provide

test results via the phone number(s), fax number(s), mailing address and/or email address(es) that you have provided for us.

Notifying you of health-related benefits and services that may be of interest to you.

(In order to provide excellent patient care, effective communication between CAR's staff and patients is imperative. Physicians and staff of CAR will attempt by any means necessary to communicate important treatment information to patients by utilizing the contact information our patients provide for us. The Center's employees are very discreet in relaying patient information, and take every measure to protect the privacy of our patients. However, methods of communication such as phone, voicemail, fax, mail, and email still leave risk of third party access that is beyond our control. Patients who wish to remove or modify the contact information they have provided must request a "Change of Communication Information" form from our office to specify the information you wish to have removed or modified. You must then complete the form, sign it, and return it to our office.)

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

Uses and Disclosures Requiring Authorization: Any other uses of disclosures of you health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

Your individual rights under HIPAA:

You have the right to request restriction on certain uses and disclosures of your PHI or amend your PHI. In some cases we may require these requests to be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address and phone number changes. Regardless of your request, please know that the HIPAA rules allow our office to share your PHI with the Covered Entities, and our physicians may deny the request for an amendment, in whole or in part if it; 1) is not created by the physician, 2) is not part of the designated record set, 3) is not available for inspection because of an appropriate denial to access of the information, or 4) is accurate and complete;

You have the right to receive your PHI in a confidential communication from our office, such as the U.S. Mail;

You have the right to inspect and copy your PHI. Copies of you PHI are available for a reasonable fee paid to our office to cover our expenses of reproducing them;

You have the right to receive, upon request, an accounting of your PHI that we have provided to Non-Covered entities;

If you have read and responded to this notice through electronic media such as our practice website or email, you have the right to receive a paper copy of this notice upon request.

In keeping with HIPAA compliance, the Center for Assisted Reproduction has appointed a Privacy Officer to continually evaluate our privacy practices, train our staff about privacy issues, supervise the sharing of information with third parties, and address any complaints from patients. All staff members will be trained on this policy and procedure manual, which will help ensure that the procedures in effect in our office are in keeping with both state and federal law. The privacy Officer is responsible for both the training of staff, as well as continual review and of this manual as necessary. A Notice of PHI Privacy Practices is reviewed by all patients to increase their understanding of how their PHI is stored, used and shared beyond this practice, and to notify them of their new rights created under HIPAA.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for the entire PHI we maintain. In the event we elect to change the terms of this notice, a new notice will be posted in our office. In addition, you may receive notification by mail, e-mail, or other such communication as our practice makes any new provisions.

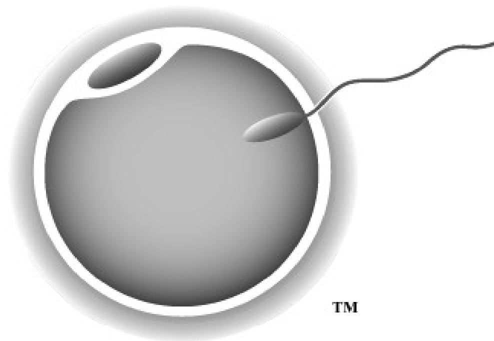
Should you ever believe your privacy rights have been violated, we request you file a complaint with our Privacy Officer, Gina Gomez, at 817-540-1157. You may also register your complaint with the Secretary of the U.S. Department of Health and Human Services, office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy. Any complaint you file will be used strictly to improve our operating procedures, and in doing so, you will not be retaliated against for filing a complaint.

I have reviewed the above Notice of Privacy Practice, which explains how my medical information will be used and disclosed. By signing below, I acknowledge that I have read and understand the above and understand my rights to privacy of Protected Health Information.

____
Printed Patient Name

__________________________________ _______________________
Patient Signature/Legal Representative **Date**

____
Relationship of Representative



Center for Assisted Reproduction

1701 Park Place Ave. 4461 Coit Rd Ste 307
Bedford, Texas Frisco, Texas
Phone: (817) 540-1157 Phone: (972) 661-9544

Kathleen M. Doody, MD: Kevin J. Doody, MD:
Anna C. Nackley, MD: Rinku Mehta, MD
Board Certified Reproductive Endocrinologists

To Our Patients:

In order to benefit both patient and provider, the Center for Assisted Reproduction now requests a signed credit card authorization form at the time you check in. This information will be held securely until your insurance(s) have paid their portion and notified us of the amount you owe. At that time, a statement will be generated and mailed to you prior to your credit card transaction Please, do not use a debit card for this transaction.

The advantage to the patient is that you will no longer have to write checks and mail them. This will, in no way, compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays and applicable coinsurance/deductibles will still be due at the time of service.

Credit Card Authorization:

____

**** Credit cards only – no debit transactions.**

Patient Name: ____

Services being paid for:___Medical Services to be Rendered______________________

Type of Card: **Visa** **Mastercard** **Discover**

Name that appears on the card: ____

Number: ____

Expiration Date: ____

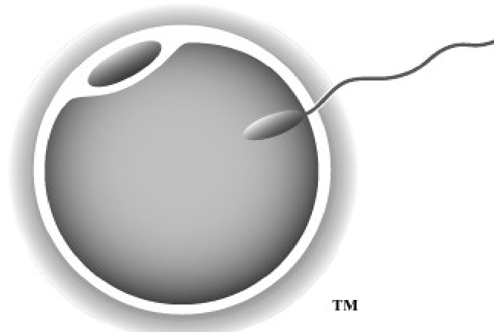
V Code: 3 digit code located on the back of the card: ___________________________

I authorize CAR to charge services rendered listed above.

Patient Signature:____

Date:___________________________

CAR Witness:____



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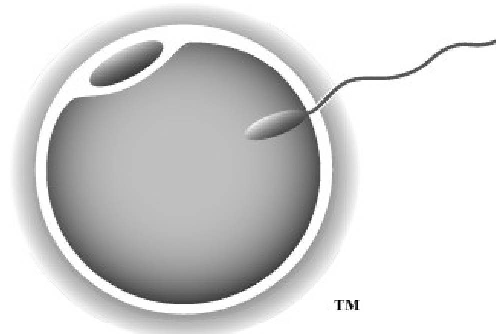
Phone Consultation Policy

I have elected to have my consultation with Dr. Doody/Dr. Nackley over the phone, instead of a face-to-face. I understand that my insurance company only covers consultations if they are face-to-face with my physician. I will assume full financial responsibility for my phone consultation and understand that it is not a covered benefit with my insurance. I will provide a credit card number that will be charged by the Center for Assisted Reproduction (C.A.R.), immediately following my phone consultation. If I am unable to provide a credit card number, I will mail a personal check that will be received by C.A.R., prior to my phone consultation.

____
Patient Printed Name

____
____
Patient Signature **Date**



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Credit Card Authorization for Telephone Consultations

Date: ____

Patient Name: ____

Services being paid for: ____________________________________

Type of card: **Visa** **MasterCard**
Discover

Name that appears on the card: ______________________________

Number: ____

Exp. Date: ____

V Code: 3 digit code located on the back of the card:________________

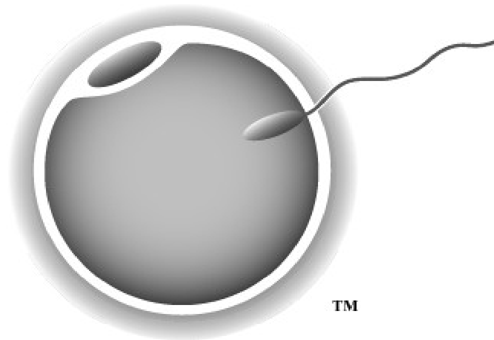
Amount being charged: __________________________________

I authorize C.A.R to charge services rendered listed above.

Patient Signature: ______________________________ Date: ______

CAR Employee: ______________________________ Date: ______

**This form must be completely filled out including the exact amount being charged. If you are unsure of the amount please contact us.



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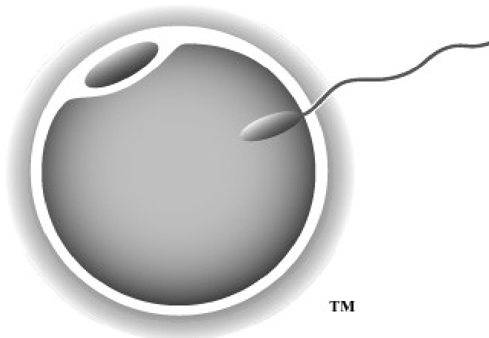
CAR Direct-Dial Phone List

Number	**Name**
817-540-7070	IVF Coordinator
817-540-7071	Egg Donor Coordinator – Jennifer Leonard
817-540-7072	Study Nurse – Leeann Hoffman
817-540-7073	Callback Nurse
817-540-7074	Referrals – Mayra Linera
817-540-7078	Surgery Scheduling & Billing Manager – Amy Williamson
817-540-1157 ext 1134	Patient Statements , Claims & refunds

	– Alyssa Burleson
817-540-7077	Insurance Verification – Kellie McKinney
817-540-7075	Financial Consultant – Tammy Buck
817-540-7067	New Patient Coordinator – Michelle Giosio
817-540-1157 ext 1125	Schedule Coordinator –Ashley Moffat
817-540-7086	Lab Supervisor – Martin Langley
817-540-7087	IVF Lab
817-540-7090	Andrology
817-540-7091	Embryologist - Laurie Weiand
817-540-7069	Embryologist – Cassie Crane
817-540-7092	Recovery Room



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Board Certified Reproductive Endocrinologists

Dear New Patient,

Welcome to the Center for Assisted Reproduction! In order to efficiently reach our new patients, we are making an effort to track the means by which our patients discovered us. Please assist us by completing the following survey and returning it with your New Patient paperwork. Thank you so much for your help. We wish you the best of luck!

Sincerely,

Dustee Morris

Dustee McKinney-Morris
Marketing Coordinator
Center for Assisted Reproduction

CENTER FOR ASSISTED REPRODUCTION TREATMENT GUIDELINES/MEDICAL POLICIES

Please circle the answer that best describes how you first discovered the Center for Assisted Reproduction.

1. Television

2. Physician
Name of Physician________________________
____

3. Magazine Ad or Article (Please specify)
A. *Fort Worth, Texas Magazine*
B. *Texas Monthly Magazine*
C. *M.D. News*
D. Other________________________
____

4. Friend or Family Member

5. CAR Employee
Name of Employee________________________
____

6. Internet

7. Yellow Pages (Please specify)
A. Southwestern Bell
B. Verizon
C. Yellow Book
D. Everyday Yellow Pages

8. Newspaper Ad or Newspaper Article
Specific Newspaper____________________
____

9. Former or Existing Patient
Name of Patient________________________
____

10. Other
Please Explain________________________
____