

Virginia Center for Reproductive Medicine
Fady Sharara, M.D., FACOG

REGISTRATION INFORMATION

Today's Date: _____ Home # _____ Cell# _____

Work# _____ Email Address: _____

Patient's Name: _____ SS# : _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: Male or Female Age: _____ Date of Birth: _____

Marital Status: Married _____ Single _____ Partner _____ Divorced _____ Legally Separated _____

Employer: _____ Occupation: _____

Spouse or Partners Name: _____ DOB: _____

Name of Primary Insurance: _____

Member ID# _____ Group # _____

Who is responsible for this account: _____ Relationship to patient: _____

In Case of Emergency, who can we call: _____

Purpose for Visit: _____ Referred By: _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims of benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
Name of Insured/Patient Name of Insurance Company

To pay and hereby assign directly to Dr. Sharara and his staff all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received and paid will be credited to my account, in accordance with the above agreement.

Patient's Signature: _____ Date: _____

Patient Payment Policy

Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. **Please sign below that you have read and agree to this policy.**

Payment Policy:

- We accept cash, check, Visa, and MasterCard, American Express, and Discover cards.
- **Please note that a 3% surcharge will be applied to payments made by credit card.**
- All fees are based on the type of service provided for your care and related services. Our fees are competitive for this region.
- If the patient is a minor, the parent or guardian is responsible for payment of the account, in accordance with the policies outlined above.
- For elective or uncovered surgical services, all co-pays, deductibles, and co-insurances are due prior to your surgery.
- All accounts are due to be paid in full in 30 days. Accounts past 30 days will be subject to **finance charges of 18% per month**, regardless of non-payment from your insurance company. If your account is overdue longer than 90 days, it will be referred to our collection attorney. **Should it become necessary to place this account with our attorney for collection, I/We agree to be responsible for all cost, including 35% attorney fees and interest at 1.5% per month.** This is a last resort, done reluctantly and after we have exhausted efforts for voluntary payment. **If a professional courtesy discount has been applied, then the discount will be reversed before being referred to our collection agency.**

Referrals

It is your responsibility to bring any required referrals or authorizations for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you will be financially responsible for the visit.

Verification of Benefits

Please contact your health insurance to obtain your infertility benefits. The infertility benefits we obtain are not a guarantee of payment from your insurance.

I/We have read, understand, and agree to the above Payment Policy. I/We understand that charges not covered by my insurance company, as well as co-payments, deductibles and coinsurance, are my responsibility.

I/We authorize my insurance benefits paid directly to the Virginia Center for Reproductive Medicine, or its affiliates: Virginia Reproductive Surgery Center, and Virginia Reproductive Labs.

I/We authorize Virginia Center for Reproductive Medicine, Virginia Reproductive Surgery Center, and Virginia Reproductive Labs to release any medical or other information to my insurance company when requested.

Patient Signature

Date

Print Name

Spouse/ Partner's Signature

Date

Name Print

OFFICE POLICIES

Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services.

Please sign below that you have read and agree to this policy.

Verification of Benefits

Insurance coverage is the patients' responsibility and any discrepancies or questions should be directed to your insurance company and plan. Please contact your health insurance to obtain your infertility benefits. The infertility benefits we obtain are not a guarantee of payment from your insurance.

Referrals

It is your responsibility to bring any required referrals or authorizations for treatment at, or prior to, the time of your visit. It is NOT THE OFFICE responsibility to obtain referrals. If you do not have a referral, your visit will be rescheduled, or you will be financially responsible for the visit.

Medical Records

Please give advance notice when requesting a copy of your medical records. We require 7-14 days to process your request. **We will no longer be mailing out medical records to patients.** These records must be picked up in person, at the office, when ready. The cost for medical records is \$18 processing and .75 cents per page.

There will be a charge for any form that needs to be filled out by the physician, this includes but is not limited to disability forms, medical leave forms, and any insurance forms. The charge depends upon the complexity of the forms starting at \$20.

Prescriptions

We **DO NOT CALL OR FAX** to mail order pharmacies for maintenance prescriptions. If you use a mail order pharmacy, you must pick up the prescription or get it at the time of your appointment. If you use a local pharmacy and need a refill, please have your local pharmacy **fax the request to our office**. Please allow 24-48 hours for the request to be returned to the pharmacy. There will be a charge of \$25 for refills called in to the pharmacy.

Your cycle medication will be sent to ONE pharmacy, if you wish to use multiple pharmacies, you will need to pick up the prescriptions and submit them to those pharmacies on your own.

I have read, understand, and agree to the above Office Policy. I understand that charges not covered by my insurance company, as well as co-payments, deductibles and coinsurance, are my responsibility.

Patient Signature

Date

Print Name

ATTACHMENT A

REQUEST TO RECEIVE INFORMATION CONFIDENTIALLY

You have the right to receive confidential communications of your personal health information by alternate means or at alternate locations. **Please be aware that you are not required to provide a reason for your request.** *The practice will attempt to accommodate all reasonable requests.*

Patient Name:	Social Security/MRN:
Date of Birth:	Phone Number:
Street Address:	City, State, Zip Code:

Please be very specific as to where or how you wish the practice to communicate with you:

Patient/Guardian Signature: _____ Date: _____

Internal use only:

Request:

☐ Granted

☐ Denied

If denied, reason:

Completed By: _____ Date of Completion: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Virginia Center for Reproductive Medicine for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Virginia Center for Reproductive Medicine. I understand that diagnosis or treatment of me by Fady I. Sharara, M.D may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Virginia Center for Reproductive Medicine is not required to agree to the restrictions that I may request. However, if Virginia Center for Reproductive Medicine agrees to a restriction that I request, the restriction is binding on Virginia Center for Reproductive Medicine and Fady I. Sharara, M.D.

I have the right to revoke this consent, in writing, at any time, except to the extent that Fady I. Sharara, M.D or Virginia Center for Reproductive Medicine has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Virginia Center for Reproductive Medicine's Notice of Privacy Practices prior to signing this document. The Virginia Center for Reproductive Medicine's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Virginia Center for Reproductive Medicine. The Notice of Privacy Practices for Virginia Center for Reproductive Medicine is also provided at 11150 Sunset Hills Rd, Suite 100, Reston, VA 20190 and on the VCRM's website at www.vcrmed.com. This Notice of Privacy Practices also describes my rights and the Virginia Center for Reproductive Medicine's duties with respect to my protected health information.

Virginia Center for Reproductive Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Virginia Center for Reproductive Medicine's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority