SOUTHERN CALIFORNIA CENTER FOR REPRODUCTIVE MEDICINE

Initial Consultation Checklist

Please Review This Checklist Carefully.

Be sure that all items below are provided before sending your information to the office.

Patient Information Packet
Please fill out the patient information form, remember to sign the last page.

Medical Records Release
Be sure to fill out the records release. **YOU HAVE TO SEND THE WHITE COPY OF THIS TO ANY PREVIOUS PHYSICIANS** who may have information that would be helpful on your first visit. You may want to specify the date of your appointment so we will receive the records before your appointment. **Please return the yellow portion of the release form.**

Insurance Cards
Please include a "clear copy" of your insurance card (front and back) and also a copy of your spouse's insurance card, if it is different from yours. In order to fully understand your insurance coverage, we suggest that you contact the carrier to determine your **infertility benefits** and to find out which labs and hospitals are covered by your plan. It will be necessary for us to verify your benefits prior to your new patient visit. **If you are unable to mail or fax a copy of your insurance card to the office prior to your appointment date, it may be necessary for you to pay for your appointment at the time of service.** If we determine that you do have insurance benefits for the visit, your account will be credited upon receipt.

Referral or Authorization (HMO Plans)
Please indicate (or bring with you) a copy of your referral if you have an HMO Plan. If you are using a PPO or POS Plan option on your HMO, first make sure that you have infertility benefits under this option. It is necessary for you to have a copy of the referral authorization prior to scheduling your new patient appointment.

Financial Policy, Patient Agreement & HIPPA Form
Please be sure to read over these forms carefully. Please sign and date each form and keep a copy for your records.

Please send the above information to the office no later than ***2 business days*** before your appointment. If there is not enough time to send it by mail, please bring the completed information with you to the appointment. **Remember, it may be necessary for you to pay at the time of service if benefits cannot be verified in advance.**

Thank you very much.

Southern California Center for Reproductive Medicine

IMPORTANT !!
STATE REQUIRED

Infectious Disease Screening

It is mandated by the State of California that we have infectious disease screening results for you and your partner in your chart prior to beginning your treatment cycle.

Therefore, we do ask that you and your partner have blood drawn for infectious disease screening on the day of your new patient visit. This will enable you to begin treatment as soon as possible.

Thank you for your cooperation,

Sherri Parker
Practice Manager

Robert E. Anderson, M.D.
361 Hospital Road, Suite 333
Newport Beach, CA 92663
(949) 642-8727

Financial Policy

All fees for procedures and treatment are due and payable at the time services are rendered. If you are enrolled in a health plan that is contracted with Dr. Anderson, all services that are a *covered benefit* will be billed directly to your health plan. Your infertility co-pay is due at the time of service. Any treatment that is a *non-covered benefit* will be due at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We bill your insurance as a courtesy for you, however, you are the responsible party if your insurance fails to pay.

Members of Bristol Park Medical Group and Greater Newport Physicians are required to obtain a referral to our office for the initial consultation. Subsequently, all future services need to be pre-authorized by your IPA. Any services that have not received prior authorization, or are a non-covered benefit, *will be the financial responsibility of the member.* Please communicate with the office staff prior to beginning new treatment to ensure that proper authorization has been obtained.

It is your responsibility to be aware of your infertility benefits.

Monthly statements will be mailed to all patients with an outstanding balance.

Our office accepts payments in the form of cash, personal checks, Visa, Mastercard, American Express and Discover. A $25.00 fee will be charged for all returned checks. We also have financing available. Please contact the billing department for details.

Fee schedules are available upon request.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I understand and agree to this financial policy.

X ________________________________ Date____________________
Signature of Patient or Responsible Party

X ________________________________ Date____________________
Signature of Co-Responsible Party

HIPAA Notice of Privacy Practices

Southern California Center for Reproductive Medicine

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name ____________________________ Signature ______________________________________ Date _______________

Southern California Center for Reproductive Medicine
Robert E. Anderson, M.D.
N. Edward Dourron, M.D.

CYSTIC FIBROSIS SCREENING

Cystic Fibrosis, (CF) is one of the most common genetic diseases in the overall population, predominately in Caucasians with a carrier frequency of approximately one in 25-30. Cystic fibrosis is an autosomal recessive disorder. If both parents are carriers, the risk of having an affected child is 25% in each pregnancy. The carrier status of an individual can be investigated by DNA mutation analysis for the most common CF mutations.

If you wish to have this test performed, please indicate by checking the yes box below. If you do not want to have the test performed, please check the no box. **This test is not currently covered by most insurance carriers and the cost to you would be approximately $300.00.**

I have read, or had read to me, the information provided above and I do understand it. Before signing this form, I have had the opportunity to discuss cystic fibrosis testing further with my doctor, someone my doctor has designated or to a genetics professional. I have all the information I need and all of my questions have been answered.

I have decided that:

YES, I would like to have this test performed.

NO, I do not wish to have this test performed.

____
Patient Name (Please Print)

______________________________ ______________
Patient Signature Date

Southern California Center for Reproductive Medicine
Robert E. Anderson, M.D.
N. Edward Dourron, M.D.

26800 Crown Valley Pkwy, Suite 560
Mission Viejo, CA 92691
949-542-7171

361 Hospital Road, Suite 333
Newport Beach, CA 92663
949-642-8727

PATIENT INFORMATION

PATIENT/WIFE:

Last Name:________________________________**First:**________________________**Initial:**____

Last Name on Insurance Plan, if different from above: __________________________________

Home Address: ____

City _____________________________________**State:** _______**Zip Code:**_________________

Mailing Address (if different from above): ____

City: _____________________________________**State:** _______**Zip Code:**________________

Home Phone: _________________________ **Work Phone:** _______________________________

Cell Phone: ___________________________ **Email Address:** _____________________________

Emergency Phone: ______ ____________________ **Relationship:** _________________________

Social Security #:_______________________________ **(necessary for medical insurance claims)**

Driver's License #:_________________________ **Date of Birth:** _________________**Age:**______

Employer/Occupation:____

Marital Status: **Married** **Divorced** **Separated** **Single** **Other**

HUSBAND/PARTNER:

Last Name: ________________________________**First:** _______________________**Initial:**_____

Spouse's Social Security #: __________________________ **Date of Birth:** ___________________

Spouse's Employer: ________________________________**Work Phone:**____________________

PATIENT REFERRED TO THIS OFFICE BY:

Dr. ________________________________ **Patient/Friend:** __________________________

SCCRM Website **Insurance Co:** ___________________________

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE PLAN*:* ____

Name of Policy Holder: ____

Relationship to Patient: Self Spouse Other: ______________________________

Insurance Co. Address: ____

Insurance Co. Phone #: ____

Group Name or Number: ____

Subscriber ID # ______________________________**Policy #** ___________________________

Insured's Employer: ________________________________ **Phone #** _____________________

Address: ____

If the policy is under the patient/wife's name, is the spouse/partner covered on the plan?

Yes No

Does this insurance company cover the following:

Diagnosis of Infertility Only **Diagnosis & Treatment of Infertility**

Treatment to Achieve Pregnancy **No Infertility Coverage**

SECONDARY INS. PLAN (Spouse or Partner's): _______________________________

(Even if you are not on the plan)

Subscriber's Name: ____

Relationship to Patient: Spouse Other: ____________________________________

Insurance Co. Address: ____

Insurance Co. Phone # ____

Group Name or Number: ____

Subscriber ID # __________________________________ **Policy #** _______________________

Insured's Employer: _______________________________ **Phone #** ____ ___________________

Address: ____

If the policy is under the patient/wife's name, is the spouse/partner covered on the plan?

Yes No

Does this insurance company cover the following:

Diagnosis of Infertility Only **Diagnosis & Treatment of Infertility**

Treatment to Achieve Pregnancy **No Infertility Coverage**

Please indicate which Laboratories are contracted with your insurance company:

Westcliff Medical Laboratory	**-**	**Patient**	**Spouse/Partner**
UniLab	**-**	**Patient**	**Spouse/Partner**
Lab Corp	**-**	**Patient**	**Spouse/Partner**
Bristol Park Laboratory Only	**-**	**Patient**	**Spouse/Partner**
Other: ___________________	**-**	**Patient**	**Spouse/Partner**

Please indicate which Hospitals are contracted with your insurance company:

Hoag Memorial Hospital Presbyterian	**-**	**Patient**	**Spouse/Partner**
Irvine Medical Center	**-**	**Patient**	**Spouse/Partner**
Mission Hospital	**-**	**Patient**	**Spouse/Partner**
Newport Beach Surgery Center (out-patient facility)	**-**	**Patient**	**Spouse/Partner**
Other: ________________________	**-**	**Patient**	**Spouse/Partner**

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to: Robert E. Anderson, M.D.
I am financially responsible for non-covered services. I also authorize the physicians to release any information required to process my medical claims.

Patient
Signature: ____ Date: ________________

Spouse/Partner
Signature: ____Date: ________________

Southern California Center for Reproductive Medicine

RECORDS RELEASE REQUEST

Date: ____________

Send Original To Your Physician

To: ____________

Address: ____________

____

I hereby authorize you to release to:

☐ **Robert E. Anderson, MD** ☐ **N. Edward Dourron, MD** ☐ **Sharon E. Moayeri, MD**

Please send to:

☐ **361 Hospital Road, #333**
Newport Beach, CA 92663
(949) 642-8727
(949) 642-5413 FAX

☐ **26800 Crown Valley PkWy #560**
Mission Viejo, CA 92691
(949) 542-7171
(949) 542-7181 FAX

Records to be Included: ____________

Records to be Excluded: ____________

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Potential for Re-disclosure
Information that is disclosed under authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (Print or type) DOB SS#

Signature of Patient Date

Signature of Patient Representative

Relationship of Patient Representative to Patient