VFA | VIRGINIA FERTILITY ASSOCIATES Vaivf & Andrology Center

Patient Information Form

Date Completed _____

Patient Name_____ Sex □M □F □_____
Full Legal Name – First MI Last

Address_____ City_____ State___ Zip_____

Birth Date_____ Social Security #_____ □Married □Single □Other

Ethnicity_____ Email_____

Home Phone_____ Cell Phone_____ Best Contact # □Home □Cell

May we leave detailed phone messages that contain protected health information (PHI)? □Yes □No

May we send automated appointment reminders/messages to the above numbers/email? □Yes □No

Patient Employer_____ Occupation_____ Work Phone_____

Emergency Contact_____ Phone_____ Relationship_____

How did you hear about us? □Physician, name_____ Phone _____

□Friend □Internet Research □Resolve □Advertisement □Other_____

Who is your OB/Gyn? _____ Phone_____

Who is your PCP? _____ Phone_____

What is your preferred Pharmacy? _____ Phone_____

INSURANCE INFORMATION

If your insurance company requires a referral, please give it to the receptionist when you return this paperwork. If a referral is required and you do not have one, you will be asked to sign a waiver to be responsible for the cost of this visit or reschedule.

□ No Insurance/I Elect Not to File Insurance (no claim will be filed) □ Insurance Information Listed Below

Primary Insurance _____ Phone_____ ID#_____ Group #_____

Policyholders's Name_____ Date of Birth_____

Employer_____ Relationship to Policyholder: □Self □Spouse □Child □Other

Secondary Insurance _____ Phone_____ ID#_____ Group #_____

Policyholders's Name_____ Date of Birth_____

Employer_____ Relationship to Policyholder: □Self □Spouse □Child □Other

PARTNER INFORMATION

Fertility evaluation and treatment will usually involve your partner, if you have one. Providing partner information can be critical to linking test reports, electronic consents and other information between couples.

□ No Partner will ever be Involved in Treatment
□ Partner is Already a Patient **(please provide name and date of birth below)**

Partner Name_____ Birth Date_____
Full Legal Name – First MI Last

Sex □M □F □_____ Social Security #_____ Cell Phone_____

Email_____ Ethnicity_____ Employer/Occupation_____

Address_____ City_____ State___ Zip_____

Patient Information Form/Consent

Patient Name_____ Date of Birth_____

NOTICE OF PRIVACY PRACTICES & OPTIONAL DISCLOSURE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we revise our notice, you may obtain a revised copy. I agree that I have been offered a copy of Virginia IVF and Andrology Center' Notice of Privacy Practices and have been given an opportunity to read the Notice. I understand that I may ask questions if I do not understand any information contained in the Notice of Privacy Practices.

We may disclose information related to your condition, services or account to any physicians who may be treating you. If you wish to allow Virginia IVF and Andrology Center to disclose protected health information (PHI) to any other individuals, authorize them below:

Name _____ ☐spouse ☐parent ☐other Name _____ ☐spouse ☐parent ☐other

If you wish to remove any previous authorization, list the individuals below:

Name _____ ☐spouse ☐parent ☐other Name _____ ☐spouse ☐parent ☐other

STANDARD DISCLOSURES OF PATIENT INFORMATION

ORDERING PHYSICIAN: Test results and procedure information is automatically provided to the physician referring you for service at Virginia IVF and Andrology Center, if applicable.

LABCORP: We perform most semen analysis under subcontract with LabCorp.I understand and agree that if I have a semen analysis, whether a separate test or part of a diagnostic test, information about me and the semen analysis may be released to LabCorp for billing and payment purposes.

ANESTHESIA: Anesthesia services are provided by an independent contractor. I understand and agree that if I have anesthesia services, information about me and my diagnosis and treatment will be available to this provider for treatment and billing/payment purposes.

PARTICIPANTS IN THE WINFERTILITY PROGRAM: I understand that if I am a participant in the WINFertility Program, in the course of regular operation of this program; Virginia IVF and Andrology Center will need to exchange information about me and my diagnosis and treatment. This exchange will allow my treatment and payment by WINFertility to Virginia IVF and Andrology Center for my services. I understand I am financially responsible for all charges incurred by me outside of the WINFertility Program. INSURANCE WILL NOT BE BILLED FOR WINFertility Program services.

AUTOMATED MESSAGES: By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Virginia IVF and Andrology Center to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue exam, or any other healthcare related function that Virginia IVF and Andrology Center elects to send via this system. I also authorize Virginia IVF and Andrology Center to disclose to third parties (such as family members), who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day, when necessary. I consent to allowing detailed messages being left on my voicemail, answering system, or with another individual, if I am unavailable at the number provided by me.

TREATMENT AS A COUPLE

TREATMENT AS A COUPLE: Infertility involves treatment with both partners of a couple. Your signature below allows us to share medical information with your partner. **Your partner's signature below allows us to share medical information with you.**

I understand that Virginia IVF and Andrology Center strongly encourages all patients to attend appointments in person. If agree that if I choose to allow my partner to bring in my specimen for procedures/testing; I allow Virginia IVF and Andrology Center to obtain and share my information from/with my partner as necessary to complete services. I also give permission for Virginia IVF and Andrology Center to rely on information provided as accurate and as if it was provided directly by me.

VIRGINIA IVF AND ANDROLOGY CENTER: Virginia IVF and Andrology Center is a Virginia limited liability company owned and operated by the following individuals: Drs. Edelstein, Matt, Shah, Steingold and Tidey. Dr. Matt is the Laboratory Director for Virginia IVF and Andrology Center. All other owners are physicians who provide treatment and procedures at the laboratory as an extension of their office practices. Patients electing In vitro fertilization services will receive care at Virginia IVF and Andrology Center. Virginia IVF and Andrology Center also provides sperm preparation services for intrauterine insemination, same day hormone testing, donor egg services, and storage of cryopreserved sperm. I agree that Virginia IVF and Andrology Center may provide or receive copies of any of my laboratory test results or other records to or from Virginia Fertility Associates if such records are necessary for treatment of me or my partner.

Patient Name_____ Date of Birth_____

ACCEPTANCE OF ELECTRONIC SIGNATURE

Patient, **and partner if signed below**, acknowledge and agree that Virginia IVF and Andrology Center and Virginia IVF and Andrology Center, as a convenience to their patients, routinely provide documents for electronic signature. If email addresses are provided here, Virginia IVF and Andrology Center and Virginia IVF and Andrology Center are authorized to send documents to these addresses for electronic signature and may legally rely on the electronically signed documents.

Patient Email _____ Initials _____

Patient may NOT provide an email address on the behalf of partner

Partner Email _____ Initials _____

FINANCIAL CONSENT

I understand that Virginia IVF and Andrology Center is not participating with any insurance plans and that I am responsible to pay all charges at the time of service, unless otherwise directed by Virginia IVF and Andrology Center.

I further understand it is Virginia IVF and Andrology Center's policy NOT to file insurance for any services which are paid in full by me, unless requested to do so below. This election will remain in effect for all future services unless updated in writing

□File Claim to Insurance Carrier

□Do NOT File Claim to Insurance Carrier

For services that have not been paid in full or those requested by me to be filed to insurance, hereby consent to allow Virginia IVF and Andrology Center, LLC, LabCorp, and/or any anesthesia provider to release information regarding my services to the insurance company(ies) whose information is provided by me. I authorize payment of benefits directly to Virginia IVF and Andrology Center, LabCorp, and/or anesthesia provider. I understand that Virginia IVF and Andrology Center is unable to bill my insurance carrier if I do not provide correct insurance information. I understand that I am responsible for obtaining any referrals or authorizations.

I understand that I am financially responsible for all charges incurred by me and in the event my account is referred to an attorney for collection, I will also be responsible for attorney's fees in the amount of 33⅓% of the unpaid balance due, court costs, and interest.

I also understand the following charges may apply:

Fee for returned checks or failure of your bank to honor your payment	$30.00
Fee for providing a copy of your medical records, to be paid at the time of request	$15.00

SIGNATURE

Patient Signature _____ **Date**_____
My signature confirms that I have read, understand, and agree with all sections of this document.

Patient may NOT sign on behalf of partner

Partner Signature _____ **Date**_____
My signature that I have read, understand and agree with all sections of this document as they relate to me.

NOTICE OF 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

We understand that medical information about you and your health is personal and we are committed to protecting that information. This information is referred to as Personal Health Information (PHI). VAIVF is required by law to maintain the privacy of your PHI. This Notice describes our legal duties, privacy practices and your patient rights as determined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. We follow the terms of this Notice.

Changes to this Notice

We may change the terms of our Notice, at any time. The new Notice will be effective for all PHI that we maintain at that time. You may obtain a copy of our current Notice from our website www.vaivf.com, call our office and request that a revised copy be sent to you, or ask for one at the time of your next appointment.

How We May Use or Disclose Your Health Information (PHI)

The following categories describe the different ways that VAIVF may use and disclose your PHI. The examples provided are not meant to describe every circumstance, but to give you an idea of the types of uses and disclosures that may be made by our office. Other uses and disclosures of your PHI that are not listed or described below will be made only with your written authorization. You may revoke this authorization, at any time, in writing, but it will not apply to any actions we have already taken.

- **Treatment:** Your PHI may be used and disclosed for the purpose of providing medical treatment to you by VAIVF or another health care provider. For example, a nurse obtains treatment information about you and documents it in your medical record and the physician has access to that information. In addition, your PHI may be provided to a physician to whom you have been referred or are otherwise seeing to ensure that the physician has the necessary information to diagnose or treat you.
- **Payment:** Your PHI may be used and disclosed to obtain payment for your health care bills for VAIVF or another health care provider. For example, we may submit requests for payment of your services to your health insurance. If you are insured under another person's health insurance policy, we may also send invoices to the subscriber whose policy covers your health services.
- **Healthcare Operations:** Your PHI may be used and disclosed to support our daily operations or those of another health care provider. For example, we may disclose your medical information to medical school students that see patients at our office or to determine where we can make improvements in the services and care we offer.
- **Photos:** Baby/Family photos you provide us may be displayed in our office or on our website.
- **Business Associates:** We will share your PHI with third party "business associates" that perform various activities for VAIVF. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written agreement that contains terms that will protect the privacy of your PHI. For example, VAIVF may hire a billing company to submit claims to your health care insurer.
- **Others Involved in Your Health care:** Unless you object, we may disclose to a member of your family, a friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your PHI to notify a family member or any other person that is responsible for your care of you. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in (1) disaster relief efforts and (2) to coordinate uses and disclosures to family or other individuals involved in your health care.
- **As required by law:** The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by the law, of any such uses or disclosures.
- **Public health activities:** We may disclose your PHI for public health activities and purposes, such as controlling disease, injury or disability, to a public health authority or any collaborating government agency permitted by law to collect or receive the information.
- **Food and Drug Administration (FDA):** We may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, or to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.
- **Communicable disease exposure:** We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Employer:** We may disclose your PHI concerning a work related injury or illness to your employer if you are covered under your employer's policy, in accordance with the law.
- **Abuse or neglect:** We may disclose your PHI to a public health authority that is authorized by law to receive reports of adult abuse or neglect or if we believe that you have been a victim or abuse, neglect or domestic violence as may be required or permitted by Virginia and/or federal law.
- **Health oversight:** We may disclose your PHI to a health oversight agency for activities authorized by law.
- **Legal proceedings:** We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena or other lawful request.

- **Law enforcement:** We may also disclose your PHI, so long as all legal requirements are met, for law enforcement purposes such as (1) information requests for identification and location purposes, (2) pertaining to victims of a crime or apprehension of an individual, (3) suspicion that death has occurred as a result of criminal conduct. (4) in the event that a crime occurs on the premises of the Practice, and (5) in a medical emergency where it is likely that a crime has occurred (6) lessen an imminent threat to the health or safety of a person or the public.

- **Research:** We may disclose your PHI to researchers when their research has been established as required by federal and state law.

- **Military activity and national security:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

- **Workers' compensation:** Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

- **Regarding inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your medical information in the course of providing care to you.
- **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 the Health Insurance Portability and Accountability Act and its regulations.

Specific Uses and Disclosures that Require Your Authorization: Uses or disclosures of your PHI for marketing purposes or the sale of your PHI require your advance authorization.

Your Rights

- **You have the right to inspect and copy your PHI.** You may inspect and obtain a copy of your PHI that we maintain. The information may contain medical and billing records and any other records that we use for making decisions about your care. However, under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled related to a civil, criminal, or administrative action; and PHI that is subject to law that prohibits access to PHI in certain circumstances. We may deny your request to inspect your PHI. In some circumstances, you may have a right to have this decision reviewed.
- **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment or unless we otherwise notify you that we can no longer honor your request. With this in mind, please discuss any restriction you wish to request with your physician.
- **You have the right to request a restriction of your PHI when you pay for a service in full before or at the time of service.** If you pay for a service in full with your own funds, you may request that VAIVF does not release any information about the service to your insurance company. VAIVF is required by law to agree to and comply with such a request. VAIVF requires that you make this request in writing and will provide the form to you.
- **You have the right to request that we accommodate you in communicating confidential PHI.** We will accommodate reasonable requests, but we may condition this accommodation by asking you for information as to how payment will be handled or other information necessary to honor your request.
- **You may have the right to ask us to amend your PHI.** You may request an amendment of your PHI as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a disagreement with us and we may respond in writing to you.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made pursuant to your authorization (permission), made directly to you, to family members or friends involved in your care, or for appointment notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- **You have the right to be notified when a breach of your PHI has occurred.** VAIVF will provide notice to you as required by law if a breach of your PHI should be discovered.
- **You have the right to obtain a paper copy of this notice from us.**

Complaints

You may complain to us if you believe your privacy rights have been violated by us. To file a complaint, please contact our Privacy Officer. We will not retaliate against you for filing a complaint. If you do not wish to file a complaint with us, you may contact the Secretary of Health and Human Services.

Effective Date

This notice was published and became effective on April 14, 2003 and was last revised on March 29, 2013.

If you have questions about this Notice or require additional information, please contact our Privacy Officer by phone at (804) 323-9980 or write to us at 9030 Stony Point Parkway, Suite 390, Richmond, VA 23235.