Virginia IVF and Andrology Center
Supplemental Patient Information Form

Patient Name ___________________________________ **Date of Birth** ___/___/_____ **Social Security #** ____/___/______

NOTICE OF PRIVACY PRACTICES

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's 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.

OPTIONAL DISCLOSURES OF PATIENT INFORMATION

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

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.

LABCORP: We perform most semen analyses 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.

VIRGINIA IVF AND ANDROLOGY CENTER PHYSICIANS: Virginia IVF and Andrology Center is a Virginia limited liability company owned and operated by the following individuals: Drs. Edelstein, Gianfortoni, Matt, 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.

I hereby agree that if my partner should seek treatment from one of the Reproductive Endocrinologists (or their partners/employees) listed above, the treating physician will also be considered to be my treating physician. I further agree that information about any of my procedures or tests that are relevant to the diagnosis or treatment of my partner may be released to the physician and discussed with my partner as necessary. Similarly, I agree that Virginia IVF may receive copies of any of my laboratory test results or other records from any of the Reproductive Endocrinologists if such records are necessary for treatment of my partner.

FINANCIAL CONSENT

I/we understand that Virginia IVF and Andrology Center is not participating with any insurance plans and that I/we am(are) responsible to pay all charges at the time of service, unless otherwise directed by Virginia IVF and Andrology Center. I/we hereby consent to allow Virginia IVF and Andrology Center, LabCorp, and/or any anesthesia provider to release information regarding my/our services to the insurance company(ies) whose information I/we have provided, and assign payment to Virginia IVF and Andrology Center, LabCorp, and/or any anesthesia provider. I/we understand I/we am(are) responsible for obtaining any referrals or authorizations for treatment. I/we agree that I/we am(are) financially responsible for all charges incurred by me/us and in the event my/our account is referred to an attorney for collection, I/we will be responsible for attorney's fees in the amount of 33 ⅓% of the unpaid balance, court costs and interest. I/we also agree that any legal disputes will be settled through the court system of the City of Richmond, Virginia.

It is our policy NOT to file an insurance claim for any services which are paid in full by the patient, unless requested to do so.
The election made below will remain in effect for all future services unless an updated election is provided in writing by the patient.
A separate IVF Procedure Financial Consent will be required prior to each IVF Procedure.

☐**File Insurance Claim to Insurance Carrier** (patient is responsible to verify insurance information on record)

☐**Do NOT File Insurance Claim**

SIGNATURE

Patient Signature ____ **Date**____/____/_________

My signature confirms that I have read, understand, and agree with all sections of this document.

Location Signed (county/city and state)____