N310

CCRM Orange County
Science, Service, Success

Newport Fertility Center
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Welcome! Please bring the following forms to your visit

1. **ASRM Patient History Form**
2. **Patient Policy Form**
3. **HIPAA and CF Forms**

Form N310, Patient Policy

1. AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR BILLING
I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION REGARDING SERVICES BY THE PHYSICIAN/FACILITY TO PROCESS INSURANCE CLAIMS AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO FILE INSURANCE CLAIMS.

2. ASSIGNMENT OF INSURANCE BENEFIT
I *HEREBY AUTHORIZE IRREVOCABLY ASSIGNMENT OF PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PHYSICIAN Dr. Kan or Newport Fertility Center AND FACILITY TO BE MADE DIRECTLY TO THE PHYSICIAN AND FACILITY.*

3. FINANCIAL RESPONSIBILITY FOR NON-MEDICARE INSURANCE PATIENTS, REGARDLESS OF MY *INSURANCE BENEFITS, IF ANY, I UNDERSTAND THAT I ALONE AM FULLY FINANCIALLY RESPONSIBLE FOR THE FEES FOR THE SERVICE RENDERED. I AGREE TO COLLECTION CHARGES FOR CHECKS NOT HONORED BY MY BANK. I ALSO AGREE TO SERVICE CHARGES WHICH WILL BE ADDED TO MY PAST DUE ACCOUNTS. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO VERIFY WITH MY INSURANCE COMPANY ABOUT THE TERMS OF INSURANCE BENEFITS FOR THE SERVICES RENDERED AT THIS OR ANY OTHER FACILITY FOR MY CARE.*

4. AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION FOR TREATMENT
I HEREBY AUTHORIZE THE ABOVE PHYSICIAN AND FACILITY TO OBTAIN AND RELEASE COPIES OF MY RECORDS AND INFORMATION REGARDING MY MEDICAL HISTORY, MENTAL, OR PHYSICAL CONDITION FOR THE PURPOSE OF FURTHER TREATMENT AND EVALUATION.

5. CONSENT TO RECEIVE VOICE MESSAGES AND EMAIL MESSAGES
MY SIGNATURE BELOW AUTHORIZES THE DOCTOR AND/OR FACILITY AND/OR STAFF TO IDENTIFY THEMSELVES FROM THE DOCTOR'S OFFICE AND/OR FACILITY WHEN CALLING OR EMAILING TO LEAVE A MESSAGE REGARDING MY APPOINTMENT, RESULTS, OR OTHER MEDICAL INFORMATON ON ANY ANSWERING DEVICE OR WITH ANOTHER PERSON ANSWERING THE PHONE.

6. DISCLOSURE OF FINANCIAL INTEREST
I UNDERSTAND THAT DR. KAN HAS A PRINCIPAL FINANCIAL INTEREST IN Newport Fertility Center, Coastal Conceptions egg donors of NFC, and CCRM Orange County.

7. HEALTH CARE ELIGIBILTY WAVIER *THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE HEREBY CERTIFIES THAT HE/SHE IS ELIGIBLE FOR HEALTH PLAN BENEFITS COVERAGE, AND HAS CHOSEN THE STATED PHYSICIAN AS THE PROVIDER OF HIS/HER CARE. FURTHERMORE, THE PATIENT'S LEGAL REPRESENTATIVE UNDERSTANDS THAT IF HE/SHE IS FOUND INELIGIBLE FOR COVERAGE OF PLAN BENEFITS,* HE/SHE IS *FINANCIALLY RESPONSIBLE FOR ALL COST INCURRED DURING THE DELIVERY OF HEALTH SERVICES, AND AGREES TO PAY THESE CHARGES TO THE PHYSICIAN ACCORDINGLY.*

8. YOUR SIGNATURE INDICATES *YOU UNDERSTAND NEWPORT FERTILITY IS A SEPARATE ENTITY FROM CCRM OC. CCRM OC LAB AND SURGERY CENTER IS NON-CONTRACTED WITH YOUR INSURANCE COMPANY AND ANY UNPAID BALANCE BY YOUR HEALTH PLAN IS YOUR FINANCIAL RESPONSIBILITY.*

9. ROUTINE GYNELCOLOGY AND PRIMARY CARE: *NEWPORT FERTILITY CENTER IS A HIGHLY SPECIALIZED CENTER IN REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY. DURING YOUR CARE HERE YOUR PRIMARY CARE, ANNUAL EXAMS, ROUTINE GYNECOLOGY CARE AND PAP SMEARS/FOLLOW-UP WILL NOT BE PERFORMED HERE AND YOU ARE RESPONSIBLE TO HAVE THESE SERVICES PROVIDED BY YOUR PRIMARY PHYSICIANS.*

Signature Page for Forms Newport Fertility Center Initials

HIPAA Form H101- I have read and understand the HIPAA policy ____ ____

Patient Policies N310- I have read and understand patient policies listed below: ____ ____

1. AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR BILLING ____ ____
2. ASSIGNMENT OF INSURANCE BENEFIT ____ ____
3. FINANCIAL RESPONSIBILITY FOR NON-MEDICARE INSURANCE PATIENTS ____ ____
4. AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION FOR TREATMENT ____ ____
5. CONSENT TO RECEIVE MESSAGES ____ ____
6. DISCLOSURE OF FINANCIAL INTEREST ____ ____
7. HEALTH CARE ELIGIBILTY WAIVER ____ ____
8. NON-CONTRACTED LAB ____ ____
9. PRIMARY CARE/ ROUTINE GYNECOLOGY WAIVER ____ ____

☐ I allow photos/videos of surgery or ultrasounds to be used for teaching/training/instructional purposes provided there are no names or patient identifiers on the photos or videos.
☐ Decline photos/videos of surgery or ultrasounds to be used for teaching/training/instructional purposes

Genetic Screening (Counsyl or other) I have read and understand the Screening Information and:
☐ Decline testing for now, but will inform you if I would like to proceed
☐ Decline testing because I have been tested and informed by my doctor that I am negative
☐ Accept testing and would like an order for testing

_____	_____	_____	_____
Signature	Date	Signature	Date
_____		_____	
Print Name		Print Name	
_____	_____	_____	
Witness	Date	Print Name	