



# PATIENT REGISTRATION

PLEASE PRINT. ALL INFORMATION WILL REMAIN CONFIDENTIAL. THANK YOU!

SCHEDULED APPOINTMENT DATE: \_\_\_\_\_ HAVE YOU OR YOUR SPOUSE EVER BEEN HERE BEFORE?  YES  NO

PATIENT \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY PHONE \_\_\_\_\_  HOME  CELL  WORK DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

SECONDARY PHONE \_\_\_\_\_  HOME  CELL  WORK AGE \_\_\_\_\_

SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS  MARRIED  SINGLE  DIVORCED  SAME SEX COUPLE

MAY WE CONTACT YOU VIA EMAIL?  YES  NO IF SO, EMAIL ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

YOUR EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ ARE WE ABLE TO CONTACT YOU THERE?  YES  NO

PARTNER'S NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**INSURANCE COVERAGE (Primary)**  This a FSA or HSA

NAME OF INSURANCE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_

POLICY # \_\_\_\_\_

GROUP # \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_

PARTNER COVERED UNDER THIS POLICY?  YES  NO

**INSURANCE COVERAGE (Secondary)**  This a FSA or HSA

NAME OF INSURANCE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_

POLICY # \_\_\_\_\_

GROUP # \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_

PARTNER COVERED UNDER THIS POLICY?  YES  NO

\*\*\* PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD AND VALID GOVERNMENT ISSUED PHOTO ID TO THE RECEPTIONIST \*\*\*

CONTINUED ON BACK

**REFERRED BY (MARK ALL THAT APPLY)**

- DOCTOR \_\_\_\_\_  MD  DO
- FRIEND / WORD OF MOUTH \_\_\_\_\_  
MAY WE CONTACT THIS PERSON FOR REFERRING YOU?  YES  NO, I PREFER TO BE DISCRETE
- INSURANCE Co. \_\_\_\_\_
- RMA OF MI EMPLOYEE \_\_\_\_\_
- RMA OF MI WEBSITE
- RMA OF MI SEMINAR
- RESOLVE SEMINAR
- INTERNET
- OTHER \_\_\_\_\_

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THIS FACILITY/DOCTOR. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO PROCESS THE CLAIM. I HEREBY AGREE TO PAY FOR ALL SERVICES RENDERED TO THE ABOVE MENTIONED PATIENT AS INCURRED. I UNDERSTAND THERE IS NO GUARANTEE ANY OR ALL SERVICES WILL BE COVERED BY MY INSURANCE COMPANY. IN THE EVENT OF ACCOUNT DEFAULT, I PROMISE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES AS REQUIRED TO EFFECT COLLECTION ON THE INDEBTNESS. I UNDERSTAND THAT SHOULD MY ACCOUNT BECOME DELINQUENT OR SHOULD I FAIL TO PAY AS PROMISED; RMA RESERVES THE RIGHT TO DENY FURTHER CARE TO ME EITHER TEMPORARILY OR PERMANENTLY. I ALSO UNDERSTAND THAT A MONTHLY \$15.00 RE-BILL FEE MAY BE ASSESSED WHEN BALANCE IS CARRIED LONGER THAN 30 DAYS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**HIPAA  
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have been offered, received, read and/or understand Reproductive Medicine Associates of Michigan's Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of Reproductive Medicine Associates of Michigan. I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Please identify those with whom we may share your protected health information, including your spouse/partner. Sharing protected health information with anyone you do not authorize below will require a separate record release to be completed prior to releasing any information.

Name	Results / Medical Info	Bills / Account
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\_\_\_\_\_  
Please Print Patient / Guardian Name

\_\_\_\_\_  
If Guardian, Relationship to Patient

\_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_  
Date



Brad T. Miller, M.D.  
Lynda J. Wolf, M.D.

## Patient Financial Agreement

### General Financial Provisions:

The patient, or their legal guardian, is ultimately responsible for all services incurred. Spouses cannot sign this Agreement in behalf of the patient. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. RMA will do its best to verify your insurance benefits. However, RMA is not responsible if your insurance company provides incorrect or false information which results in unexpected out-of-pocket expenses. We strongly suggest you attempt to verify your own insurance benefits and ensure all necessary pre-authorizations are in place prior to the date of service. IVF is seldom a covered benefit.

### We Do Not Carry Balances

RMA requires that you keep a credit/debit card authorization on file. This is required for instances of charges being generated on a day you do not visit us or when a balance results after your insurance processes claims. With the very busy lives of our patients, it is difficult to reach patients to come in and settle balances as they arise. Therefore, we require a credit/debit card authorization be maintained on file so that your balances can be settled as they occur. Our patients like this strategy for convenience. We will mail to you a copy of your credit/debit card receipt and your statement on the day the charge is made.

### Financing Options:

RMA of Michigan has established relationships with several financing companies for those interested in obtaining a low-interest/no interest financing. RMA does not carry balances or offer payment plans. Please discuss with a Patient Services or Patient Account Specialist for details.

### If We Participate With Your Insurance Company:

RMA of Michigan participates and submits claims to the following insurance carriers provided we have all required information and you have granted Assignment of Benefits so that payment is made to us:

- Aetna
- Blue Cross Blue Shield of Michigan (excluding Blue Choice)
- Beaumont Insurance
- Cofinity
- United HealthCare

Patient must pay the difference between the charges and the anticipated insurance payment at the time the services are incurred. This includes all non-covered services, unpaid deductibles and co-pays. If your insurance company pays less than anticipated; we will bill you for the balance. You agree to clear that balance within 30 days. We are not able to offer payment plans.

RMA will make every attempt to resolve insurance claim issues with your insurance company. However, if your insurance company does not pay us within 60 days; we will seek payment from you.

Please inform us upon receipt of a new insurance card or any changes in coverage. This prevents delays in processing claims.

### Master Medical Policy Holders:

We require all services are paid in full as you go. As a courtesy, we will submit claims to Blue Cross Blue Shield for you. Blue Cross Blue Shield will send any payments directly to the insured; they do not pay us.

130 Town Center Drive, Suite 106 ▪ Troy, Michigan 48084  
Phone (248) 619-3100 ▪ Fax (248) 619-9031 ▪ [www.rmami.com](http://www.rmami.com)

**If We Do Not Participate With Your Insurance Company Or You Are Uninsured:**

All services must be paid in full prior to the services being incurred. We do not carry balances or offer payment plans. RMA of Michigan does not verify benefits or submit claims for insurance companies not listed above.

**Payment Methods**

The following payment methods are accepted: cash for payments not to exceed \$500.00, personal check, money order, cashier check, Debit Card, Visa, MasterCard, and Discover. IVF deposits may be paid by certified check or credit and must be paid at least one week in advance of your cycle start.

**NSF Check Policy**

Returned checks will incur a \$25.00 fee for each returned check. Once we receive a returned check, future payments must be made by credit card, money order, and cashier check. Cash can be used when payment does not exceed \$500.00.

**Cryopreservation and Storage Fees**

If you have consented to freeze your embryos, oocyte, and/or sperm, a storage fee will occur. If storage fees are not paid within 30 days, the fee will be considered delinquent. Cryopreservation is not included in your cost estimate and is due within 5 days of the service being performed. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees. Additionally, RMA of Michigan reserves the right to consider unpaid cryopreserved items as unwanted or abandoned and has the right to discard after all internal attempts to obtain payment have been exhausted.

**Cancellation of Cycle**

If your cycle is cancelled for any reason, you will be charged for all services up to that point. Any cycle deposit money remaining after those services are paid can be refunded to you. Please notify the financial department when the cycle is cancelled so that your refund request can be processed timely. Refunds take approximately 2 weeks from the date of request.

If you are undergoing an IVF cycle and convert to an insemination cycle, you will only be charged for the actual procedures performed during both cycles. An excess amount paid in your cycle deposit will be refunded to the patient/guarantor once the patient has been released from care and all insurance dispositions received.

**Medications**

Your physician or nurse coordinator will provide you with the necessary prescriptions for your treatment cycle. You can take your prescriptions to your pharmacy and deal with them as you would any other prescription. You can also use one of the mail order pharmacies that we work with such as Schraft's, Freedom Drug, or Ferring Direct. If you have a prescription plan that requires insurance authorization, please advise your nurse immediately so that any necessary authorizations are obtained. Failure to do so may cause a delay in picking up your medications as most insurance companies take several days to process these requests.

**Anesthesia**

Anesthesia Staffing Consultants, Inc. (a separate entity) provides our patients with anesthesia services. The anesthesia fee for egg retrieval is **\$350.00** and will be **billed to you directly by Anesthesia Staffing Consultants, Inc. (ASC)**. Anesthesia payment is due at the same time your IVF payment is due. ASC accepts checks, Visa, MasterCard, Discover and American Express as method of payment. Any questions regarding your anesthesia charges and to make payment please contact them directly at **(248) 258-5058**.

**Subsequent Cycles and Treatment**

Your account must be reconciled prior to any new cycle start. This means that you must have a \$0.00 balance on both your patient account and insurance account. If it is not, you will not be able to proceed with the start of further treatment until it is reconciled.

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**Requests for Medical Records**

We will gladly provide you with copies of your medical records. For each request we must have a signed medical records release form which contains the name, address and fax number of the healthcare provider where you wish the records to be sent. This form is available on our website at [www.rmami.com](http://www.rmami.com). Spouses cannot authorize record release for each other. Each individual must sign a form regarding their own records. For each request, there is a minimum fee \$5.00 for 5 pages or less and \$25.00 for 6 pages and up. The amount due will be pre-calculated and must be prepaid before the medical records are copied. This fee may be waived when your medical records are for the purpose of sharing with your primary care doctor or your ob-gyn. We cannot copy your medical records that were provided to us from your other healthcare providers. You will need to contact those healthcare providers directly. Please allow at least ten (10) days for us to respond to your copying request. We can accommodate your requests with shorter notice but an additional \$25.00 may apply.

**Refunds**

Overpayments and credit balances will be refunded to the appropriate party after review of the account. Patient refunds will not be processed until all insurance dispositions are received, if applicable. Once a refund is requested, it may take up to 2 weeks to be processed. If payment was made by credit card; we are required to process the refund to that card.

**Delinquent Accounts**

All accounts that cannot be collected by RMA of Michigan will be referred to a collection agency or attorney for further collection action in accordance with established guidelines as deemed appropriate. Any fees assessed will be the responsibility of the debtor. Additionally, RMA will no longer be able to offer care to those whose accounts needed third-party assistance to collect on the debt.

**Patient Acknowledgement and Guarantee**

I have read, understand, and agree to the Patient Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility and I guarantee that my account with RMA will be paid per the terms of the Agreement.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date