Instructions for Form Completion

Welcome to Reproductive Care of Indiana!

We are excited that you have chosen our team to assist you in pursuing your dreams of parenthood. We look forward to personally meeting you and assisting you in making your dreams a reality. Please read through the following instructions in order to complete the forms for your first visit.

Medical Questionnaire

Please fill this form out to completion.

Patient Registration Form

This form is informational for our office. Your demographics, contact numbers and insurance information are very important. Please be sure to fill out each section to completion.

Insurance Verification Form

This form is to be used as a questionnaire when calling your insurance company to verify your benefits. Call the number on the back of your insurance card and walk through these questions with the insurance representative. Be sure to sign the form at the bottom.
If this form is not completed, you will be considered a self pay patient.

Insurance Waiver

This form needs to be signed and dated if you are a self pay patient and do not have insurance coverage stating you will be responsible in full for charges incurred under our care.

Financial Policy

Please initial all areas marked and sign at the bottom of the form. An RCI representative is to witness the form once it has been returned to our office.

Release of Records Form

This form is to be filled out and signed. This form gives us permission to obtain your medical information from another doctor's office if necessary.

Protected Health Info Authorization

This form lets us know which persons we can disclose any and all medical information to and in what manner we can leave that information.

Disclosure of Financial Interest

We are required by law to inform you which surgery centers Dr. Henry has financial interest in. Please read through the form, fill out the top and sign the bottom.

Notice of Privacy Practices

Your signature on this form proves that you received a copy of our privacy practices and have retained it for your records. The notice of privacy practice information is the double sided stapled sheets following this form in your packet. ***Please retain for your records.***

201 Pennsylvania Parkway ♦ Suite 325 ♦ Indianapolis, Indiana ♦ 46280 ♦ Ph: 317.817.1800 ♦ Fax: 317.817.1810
www.henryfertility.com

Medical Questionnaire

Henry Fertility ***Michael A. Henry, MD***

Name: Age: Ht: Wt:

Chief Complaint/Reason for visit:

When was the first day of your last menstrual period:

How often do your periods come? Are they regular?

How much pain or cramping do you have with your periods? ☐ none ☐ mild ☐ moderate ☐ severe

What pain medicine do you use for your cramps?

Are you using birth control now?

- If "Yes", what? (circle all that apply) ☐ Pills ☐ Condoms ☐ Tubal ☐ Depoprovera ☐ other
- If "No", how long have you not been using birth control ______________________________

Do you experience excess facial hair?

Have you ever had Chlamydia, gonorrhea, pelvic inflammatory disease or PID? When?

How many times have you been pregnant?

	Year	Baby born alive?	End in Miscarriage?	Tubal pregnancy?	End in abortion?	How long to conceive?	Fertility treatment required?	Is current partner the father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

List any complications that you had with your pregnancies:

When was your last pap smear? Was it normal?

Have you had a mammogram? If so, when was your last one?

List the medicines you know that you are allergic to:

List your current medications (both prescription and over-the-counter):

List all surgeries that you have had (include C-sections and D&C's) :

List any medical problems that you have:

Do you smoke? How many packs per day?

How did you hear about Reproductive Care of Indiana?

Patient Registration Form

Henry Fertility ***Michael A. Henry, M.D.***

____ **Methodist Medical Plaza North**
201 Pennsylvania Parkway, Suite 325
Indianapolis, IN 46280
Office: (317) 817-1800 or Toll Free: (888) 305-6795
Fax: (317) 817-1810

____ **Professional Office Building, AP&S Clinic**
1429 N 6th Street - 2nd Floor
Terre Haute, IN 47807
Office: (888) 305-6795
Fax: (317) 817-1810

____ **Lafayette Women's Clinic**
3920 E. St. Francis Way, Ste. 219
Lafayette, IN 47904
Office: (888) 305-6795
Fax: (317) 817-1810

____ **Aegis Women's Clinic**
2920 McIntire Drive, Ste 250
Bloomington, IN 47403
Office: (888) 305-6795
Fax: (317) 817-1810

____ **Southern IN Physicians for Women**
1010 W 2nd Street
Bloomington, IN 47403
Office: (888) 305-6795
Fax: (317) 817-1810

Appointment Day ____ Appointment Date ____ Appointment Time ____

PATIENT INFORMATION: ** FEMALE PATIENT ONLY **

Last Name: ____ First Name: ____ Middle Initial: ____

Maiden Name: ____ E-Mail Address: ____

Address: ____ City: ____ State: ____ Zip Code: ____

Home Phone: ____ Cell Phone: ____ DOB: ____ Age: ____ Sex: ____

SS#: ____ Ethnicity: ____ Marital Status: ____

PHYSICIAN INFORMATION

Primary Care Physician: ____ Address: ____

City: ____ State: ____ Zip Code: ____ Phone: ____

Referring M.D. ____ Address ____

City: ____ State: ____ Zip Code: ____ Phone: ____

How did you learn about our medical practice? ____

EMPLOYMENT INFORMATION

Employer: ____ Business Phone: ____

Street Address: ____ City: ____ State: ____ Zip Code: ____

Occupation: ____ May we contact you at work? ____ Hours: ____

SPOUSE OR SIGNIFICANT OTHER INFORMATION **Gender: ____ Male ____ Female ____ Other ____________________**

Name: ____ DOB: ____ SS#: ____ Cell Phone: ____

Employer: ____ Business Phone: ____ Occupation: ____

Address: ____ City: ____ State: ____ Zip: ____

INSURANCE INFORMATION

Company ID#: ____ Group#: ____ Phone: ____

Insurance through (circle one): Patient Spouse Significant Other Parent Other

Please list social security number and date of birth of person who carries you on insurance if not already listed above:

SS#: ____ DOB: ____

Patient Registration Form

IN CASE OF EMERGENCY CONTACT: (OTHER THAN SPOUSE)

Name: Relationship:

Home Phone: Work Phone: Cell Phone:

Address:

PREFERRED METHOD OF CONTACT: ____ Email ____ home phone ____ cell phone

Our preferred method of contact is by email. If you prefer to be contacted by phone, check here _____

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial___________________________

Assignment and Release: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initial___________________________

Financial Agreement: I understand the fees for all services rendered are the full responsibility of the patient. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initial____________________________

I understand the above and fully understand the terms thereof:

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

201 Pennsylvania Parkway ♦ Suite 325 ♦ Indianapolis, Indiana ♦ 46280 ♦ Ph: 317.817.1800 ♦ Fax: 317.817.1810
www.henryfertility.com

Insurance Verification Form

Henry Fertility ***Michael A. Henry, M.D.***

Please complete this insurance verification form prior to your visit with the doctor.
Use this form as a questionnaire when calling the member services number on your insurance card.

**It is your responsibility to call your insurance company and/or your primary physician for referral authorization. Thereafter you are responsible to inform the office staff of referral updates, extensions and/or change of insurances.

Today's date:

Insurance Company: Effective Date of Policy:

Insurance phone number for verification:

Policy Deductible: Amount Met: Coinsurance:

Is there a Specialist Office Visit Co-Pay? YES / NO If YES, Amount?

Does your policy require a referral to see a Specialist? YES / NO

Do you have to go to certain labs, hospitals, pharmacies? If yes please list the names of the required facilities:

Hospital:

Labs:

Pharmacy:

** Please note if your insurance allows you to go anywhere, indicate so in the space provided*

*****Please contact your insurance company <u>prior to your appointment</u> and ask the following questions*****

If we are seeing you for infertility related services, does your policy cover infertility services?	Yes	No
If YES, does your policy require precertification or a pre-determination letter for these services?	Yes	No
Are ultrasounds and blood draws with an infertility diagnosis considered diagnostic CPT codes: 76857 (ultrasound) AND 82670 (blood test) with Diagnosis of N97.9 for example.	Yes	No
Is CPT code 58340 (Hysterosalpingogram or HSG) a covered service? Does it require prior authorization? ***This test is not for infertility treatment and will have a medical diagnosis. This is a diagnostic test.***	Yes Yes	No No

Notes:

I understand that this form must be competed accurately, which may require that I call my insurance company **PRIOR** to my first visit, and that it is part of my medical record. I also understand that if I do not fill out this form to completion, claims for infertility treatment will not be sent to my insurance as Henry Fertility will assume I do not have infertility benefits on my policy.

Patient Signature Date

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201 Pennsylvania Parkway ♦ Suite 325 ♦ Indianapolis, Indiana ♦ 46280 ♦ Ph: 317.817.1800 ♦ Fax: 317.817.1810
www.henryfertility.com

Financial Policy

1. If you **DO NOT** have insurance coverage and are a self-pay patient, or if your insurance does not cover these services you will be required to pay $220.00 on the day of your visit with the doctor. This is an estimate of the charge for your initial visit. You will be billed for any additional fees generated during your visit.__________(Initial)

2. Patients are responsible for obtaining prior authorizations or referrals from their Primary Care Physician (PCP) and/or insurance company. Please bring this authorization with you to your first visit or have your PCP office mail or fax it to us prior to your visit. If you do not have a referral on the date of service, you will be asked to sign a waiver or you will be given the option of rescheduling your appointment.__________(Initial)

3. Any services not authorized by your insurance company will be denied and will become your financial responsibility. **Remember that prior authorization does not guarantee benefit payment.** Contact your insurance company for verification of benefits.__________(Initial)

4. Co-payments or deductibles and fees for non-covered services will be collected at the time of service. We accept payment by cash, check, Visa, MasterCard or Discover.__________(Initial)

5. For patients undergoing fertility treatment, we require that all patient responsibility balances be paid in full prior to beginning a new cycle of treatment.__________(Initial)

Please feel free to contact our Billing Manager to answer any questions you may have regarding financial issues. Call 317.817.1800 – opt. 2

I have read and fully understand the financial policy listed above. I understand that I will be given a copy of this policy for my records.

Patient's signature ________________________________ Date ____________

Witness ________________________________ Date ____________

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Protected Health Information Authorization

Henry Fertility *Michael A. Henry, M.D.*

I, ____

(Patient name) (Address)

____

(City, state, zip code) (Date of birth)

request that the following options be followed for the disclosure of my Protected Health Information, (which would include your name, diagnosis, test results, and dates of service) as described in the Notice of Privacy Practices for Protected Health Information.

PLEASE LIST ALL THAT APPLY:

Henry Fertility may disclose information to the following persons (you must list name, phone number and relationship).

Name	Phone Number	Relationship

Email is our preferred method of contact.
If you prefer to be contacted by phone, please check here ____ Phone Number:________________

It is okay to contact and correspond via email at this address: ______________________________________

Henry Fertility may leave Protected Health Information on my answering machine/voicemail. Phone number (home, cell, work):

____

____

(Patient's Printed Name) (Social Security Number)

____

(Patient's Signature) (Date)

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the Office Manager at Reproductive Care of Indiana.

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Physician's Disclosure of Financial Interest

Henry Fertility *Michael A. Henry, M.D.*

Methodist Medical Plaza North
201 Pennsylvania Parkway, Suite 325
Indianapolis, IN 46280
Office: (317) 817-1800 or Toll Free: (888) 305-6795
Fax: (317) 817-1810

Professional Office Building, AP&S Clinic
1429 N 6th Street 2nd Floor
Terre Haute, IN 47807
Office: (888) 305-6795
Fax: (317) 817-1810

Lafayette Women's Clinic
3920 E. St. Francis Way Ste. 219
Lafayette, IN 47905
Office: (888) 305-6795
Fax: (317) 817-1810

Aegis Women's Clinic
2920 McIntire Drive, Suite 250
Bloomington, IN 47403
Office: (888) 305-6795
Fax: (317) 817-1810

Date: ______________________________

To: ______________________________
Patient Name

____
Address

Indiana law (I.C. 25-22.5-11) generally requires a physician to make certain disclosures to a patient when the physician refers the patient to a health care entity in which the physician has a financial interest. While you are a patient, I may refer you, or the named patient for whom you are legal representative, to one of the health care entities listed below in which I have a financial interest. In each case, you may choose to be referred to another health care entity.

Beltway Surgery Center
Clarian North Medical Center
Center for Reproductive Biology of Indiana

PATIENT ACKNOWLEDGEMENT

I, the above named patient, or legal representative of such patient, hereby acknowledge receipt of, on the date indicated above, a copy of the foregoing Physician's Disclosure of Financial Interest.

____
(Signature of Patient or Patient's Representative)

____
(Name Printed)

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Henry Fertilty
Notice of Privacy Practices for Protected Health Information

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 student 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 your 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 will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the other services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. 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.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object
We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of your protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Facility Directories: Unless you object, we will use and disclose in our facility directory you name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation.

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.

If you have any questions about this notice, please contact our Privacy Contact at (317) 817-1800.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment of health care operations 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/condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain both before and after the change. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

- You will be asked by your physician to sign this Notice of Privacy Practices. We will make a good faith effort to obtain a written acknowledgement that you received this Notice of Privacy Practices of Protected Health Information the first time we provide services to you or as soon as reasonable practicable under the circumstances. Your protected health information may be used and disclosed by your physician, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to obtain payment for your health care bills and to support the operation of the physician's practice.
- Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

- Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party that may need access to your protected health information. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating 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.
- In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
- Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. 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.
- Others Involved in Your Healthcare: Unless you object, we may disclose to a member of you family, a relative, a close friend or any other person you identify, your protected health information 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 such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals in your health care.
- Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your acknowledgement of our Privacy Practices as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your acknowledgement, but is unable, he or she may still use or disclose your protected health information for treatment, payment, and health care operations.
- Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain an acknowledgment of our Privacy Practices from you but is unable to do so due to sustainable communication barriers.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object:

- Required by Law
- Public Health
- Communicable Diseases
- Health Oversight
- Abuse and Neglect
- Legal Proceedings
- Law Enforcement
- Coroners, Funeral Directors and Organ Research
- Research
- Criminal Activity
- Food and Drug Administration
- Military Activity and National Securtiy
- Worker's Compensation
- Inmates
- Requires Uses and Disclosures

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice may use for making decisions about you.
- Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in a 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. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose and part of your protected health information for the purposes 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 a 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. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless is it is needed to provide emergency treatment. With this in mind, please discuss and restriction you wish to request with your physician. You may request a restriction by submitting a written request to our Privacy Contact.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable request. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

- You may have the right to have your physician amend your protected health information. This means you may request an amendment of protect health information about you in a designated record set for 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 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. Please contact our Privacy Contact if you have any questions about amending your medical record.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations and valid authorizations or incidental disclosures as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility director, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14th, 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 obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. 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.
- You may contact our Privacy Contact at 317-817-1800 for further information about the complaint process.

This notice was published and becomes effective on April 14th, 2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name ______________________________

Patient Signature ______________________________

Date ______________________________

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Medical Release Form

Henry Fertility *Michael A. Henry, M.D.*

Patient authorization for copy and release of medical records to Henry Fertility

I, ____
(Name of Patient)

____
(Address of Patient)

____
(Date of Birth) (SS #)

Hereby authorize Henry Fertility to **obtain copies of my health information from:**

____
(Name and complete address of healthcare provider)

____
(Phone and Fax Number)

Portion of protected health information record requested:

_____________ Complete medical record

_____________ Partial medical records- specific records requested include:

____

Please forward medical records to:
Michael A. Henry, MD
Henry Fertility
201 Pennsylvania Parkway, Suite 325
Indianapolis, IN 46280
317-817-1800
317-817-1810 FAX

Patient Signature: ______________________________ Date: ______________

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