The Fertility Center of Charleston

Dear Prospective Patient,

Welcome! We are grateful that you have chosen The Fertility Center of Charleston to help grow your family!

Our dedicated team understands the importance of this decision and we will make every effort to guide, encourage, and support you on the journey from evaluation to treatment and pregnancy. Some of the treatment options available are ovulation induction (OI) with intrauterine insemination (IUI), in vitro fertilization (IVF), egg freezing, pre-implantation genetic testing (PGS), and donor eggs.

We are well aware of the emotional strain this process can bring to a family, so please know that our staff will make every effort to make each step as comfortable and easy for you as possible. You are in competent and caring hands and we promise to provide the best possible care to help you achieve success.

We also understand that fertility treatments can be financially challenging. We participate in and offer many unique programs and financing options which can aid in offsetting the costs of treatment.

In the following pages, we have provided some additional details about The Fertility Center of Charleston and your new patient visit.

Again, thank you so much for choosing The Fertility Center of Charleston. We look forward to meeting you at your new patient visit!

Sincerely,

Stephanie D. Singleton, MD

Dr. Stephanie Singleton and the staff of The Fertility Center of Charleston

THE FERTILITY CENTER
of Charleston

WHAT TO EXPECT DURING YOUR FIRST VISIT

Welcome to The Fertility Center of Charleston. We hope your first visit here will enable you to get a chance to meet our staff and see our facility. To make the most out of your first visit, we feel it is important that we receive any fertility-related medical records that you may have from your current or past physicians or your partner's physicians.

We request that you arrive fifteen (15) minutes prior to your initial consultation so that you can complete and finalize any remaining paper work. A member of our staff will check your blood pressure, height, and weight, and record allergies and current medications. You will then start with a one hour evaluation with Dr. Singleton. She will conduct a comprehensive medical history to identify possible causes of infertility and will discuss the possible etiologies of your infertility and the tests we use to establish a diagnosis. She may also discuss treatment options, along with the advantages and disadvantages of each treatment. The next step is typically a transvaginal ultrasound of the uterus and ovaries. This is the first step in determining if there is an abnormality of the reproductive tract.

Please remember that 20% of all couples have more than one cause of infertility and therefore, even if you are currently suspicious about or know a current cause of your infertility, a thorough evaluation is necessary to identify other causes. It is also important to remember that approximately 40% of all cases of infertility are from a male factor cause. The evaluation for male factor infertility starts with a semen analysis and we therefore strongly recommend that this test be performed during your initial visit so we can discuss the presence or absence of a male factor component.

Following this consultation, you will meet with one of our nurse coordinators who will help to coordinate your care. She will be in charge of scheduling your diagnostic tests and starting your treatment plan. After your nursing visit you will then have an opportunity to meet with our financial coordinator to discuss your insurance coverage, typical cost associated with your evaluation and treatment plan, and financial programs we have in place.

Please be reassured that you will receive all of the information and guidance necessary to make informed and appropriate treatment decisions together with our clinical team. Your satisfaction is very important to us. We look forward to seeing you soon!

THE FERTILITY CENTER
of Charleston

TREATMENT OPTIONS

The Fertility Center of Charleston provides a wide range of treatment options, from basic to state of the art. We have a very specialized team of infertility professionals focused on providing you with all the information and guidance needed to make informed and appropriate treatment decisions.

After your initial consultation and completion of your infertility evaluation your treatment plan will be tailored and customized according to your needs and cause of your infertility. Here are some of the treatment options we are able to offer.

OVULATION INDUCTION AND INTRAUTERINE INSEMINATION (IUI)

Fertility medications are used to stimulate the ovaries to produce 1-3 mature eggs and enhance the pregnancy rates per cycle. Blood tests and ultrasounds are used to monitor the progress of follicular growth and eventually determine the best time to perform the insemination. Semen is then processed to maximize the number of healthy motile sperm available to fertilize the mature egg(s). A catheter is used to deposit the processed sperm past the cervix and into the uterus. The concentration of sperm available to fertilize the egg(s) is of greater magnitude with IUI than would be found after intercourse, thus increasing the chance that fertilization will occur. This is a painless, in-office procedure.

Candidates for IUI include patients with infertility related to cervical factors, slight male factor infertility, and unexplained infertility. Success rates vary and depend on the age and diagnosis of the patient.

IN-VITRO FERTILIZATION (IVF)

In-Vitro fertilization is an option for those in which other basic treatment options (like IUI) are not an option. It is a more aggressive and involved treatment but yields the highest success rates. This treatment utilizes fertility medications to stimulate the ovaries to produce multiple mature eggs per treatment cycle. Several blood tests and ultrasounds are used to monitor the progress of the cycle and egg growth. At the optimal time the eggs are then retrieved from the ovary and fertilized in the embryology laboratory. After 5 days of incubation in the IVF laboratory, quality embryo(s) will be frozen. In a subsequent cycle, the uterus is prepared, using hormones, for optimal implantation. When ultrasound evalution shows that the uterine lining is optimal, an embryo will be transferred into the uterus

Candidates for IVF treatment are patients with failed tubal-reversal or tubal blockage, moderate to severe male factor infertility, failed treatment with ovulation induction and IUI, endometriosis, recurrent pregnancy loss, and those wishing genetic screening of embryos to prevent inheritable diseases.

PREIMPLANTATION GENETIC DIAGNOSIS (PGD)

Preimplantation Genetic Diagnosis is a test developed to help couples with a family history of genetically transmitted diseases to prevent this disease in their child. It is a procedure used in conjunction with in vitro fertilization (IVF) to screen embryos for a known chromosomal abnormality and a specific genetic disorder. Using PGD we can then transfer only chromosomally unaffected embryos (without the genetic disorder) into the uterus.

PREIMPLANTATION GENETIC SCREENING

Preimplantation Genetic Screening is a similar test to PGD but is not used to detect specific diseases. This test is a more general evaluation of the chromosomes of embryos to select chromosomally normal embryos for transfer. In standard IVF, we select embryos based on their level of appropriate development and appearance. This test actually allows us to determine which embryos are chromosomally normal. It can increase pregnancy rates and live births per transfer and help to reduce recurrent pregnancy loss.

DONOR EGGS

We provide donor egg services through the use of frozen donor oocytes available from My Egg Bank®. The use of a donor egg bank allows potential recipients a wider selection of donor oocytes ready for immediate use. After patient selection of a donor, the frozen eggs are shipped to our laboratory and then, when the patient's uterine lining is appropriate, they are thawed and fertilized creating embryos which are then transferred into the patient's uterus. If more embryos are available than selected for transfer, they may be cryopreserved for future use if the recipient so desires.

Candidates for the use of donor eggs are those patients who are not able to use their own eggs due to age, diminished ovarian reserve, or genetic disease.

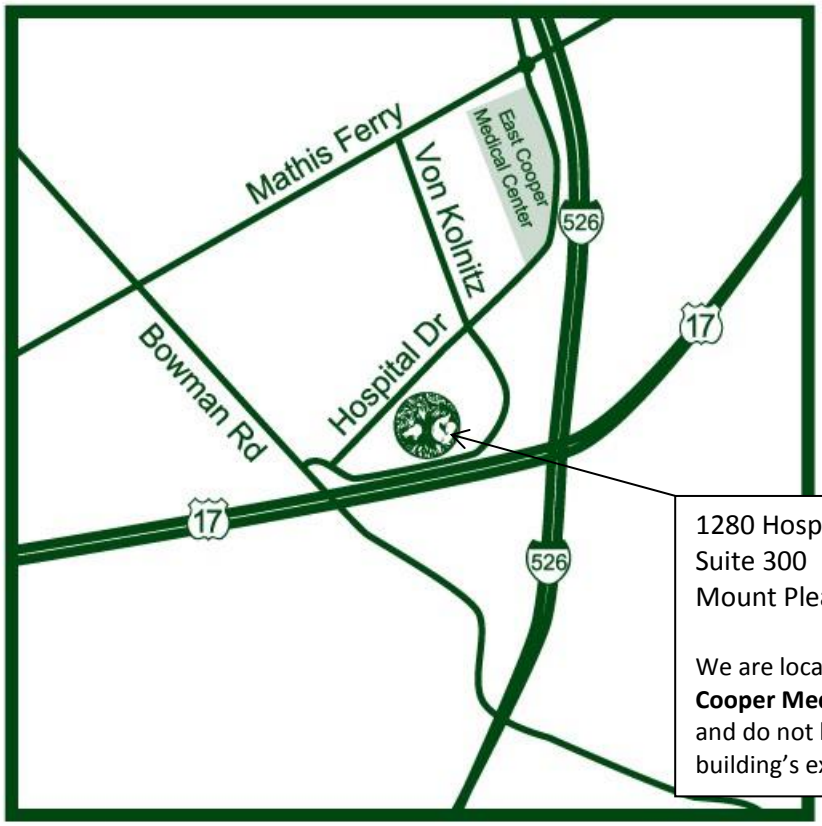
EGG FREEZING

Improvements in freezing technologies have allowed those who wish to freeze eggs for fertility preservation or other reasons to do so. Ultra-rapid freezing, called vitrification, is used after eggs are obtained from stimulated ovaries similar to an IVF cycle, without having to be fertilized.

Candidates for egg freezing are those who wish to delay pregnancy but want to preserve or bank their best quality eggs while they are young. Other candidates are those who may need treatments that could potentially affect future fertility, like chemotherapy or removal of the ovaries. Egg freezing success rates depend on the age and diagnosis of the patient.

THE FERTILITY CENTER
of Charleston

Mount Pleasant Office



1280 Hospital Drive
Suite 300
Mount Pleasant, SC, 29464

We are located in the **East Cooper Medical Arts Building** and do not have a sign on the building's exterior.

THE FERTILITY CENTER
of Charleston

Savannah Office

SAVANNAH

5354 Reynolds St, #416
Savannah, GA 31405

We are located on the 4th floor of the Candler Professional Office Building, which is on the campus of Candler Hospital.

THE FERTILITY CENTER of Charleston

Please print and return this form as soon as possible. All information will remain confidential. Thank you!

Patient Name _____
(Last) (First) (Middle) (Maiden) (Name Called)

_____
Home address to Include Apt #, City, State, and Zip Home Phone Cell Phone

_____
SSN DOB Age Marital Status Race

May we contact you via email? □ YES □ NO If so, email address:_____

Have you or your spouse been here before? □ YES □ NO Physician Who Referred You?_____

Physician's Address_____
At least City/State Phone Number

Employer_____ Occupation_____

Employer's Address_____City_____State_____Zipcode_____

Work Telephone_____ Are We Able To Contact You There?_____ **WE DO NOT SAY THE NAME OF OUR FACILITY**

How did you hear about our practice? □ Doctor □ Friend □ Print Advertisement □ Radio □ Telephone Book
□ Internet □ Our Web Site □ Fertility Network □ Other

Emergency Contact: Name_____
(Last) (First) (Relationship)

_____
Home Address Home Phone Cell Phone

Partner's Name_____
(Last) (First) (Middle) (Name Called)

_____
SSN DOB AGE Marital Status Race

_____
Employed By Work Number Cell Phone

Insurance Coverage(Primary)
Name of Insurance_____
City_____ State____ Zip_____
Telephone_____
Policy#_____
Group#_____
Policy Holder_____
Partner Covered □ YES □ NO

Insurance Coverage(Spouse/Partner)
Name of Insurance_____
City_____ State_____ Zip_____
Telephone _____
Policy#_____
Group#_____
Policy Holder_____
Partner Covered □ YES □ NO

I HEREBY MAKE ASSIGNMENT OF ALL SURGICAL, MEDICAL AND MAJOR MEDICAL INSURANCE BENEFITS TO STEPHANIE D. SINGLETON, MD, AND TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO EXECUTE AN ASSIGNMENT OF BENEFITS. I UNDERSTAND THAT REGARDLESS OF ANY INSURANCE COVERAGE I MIGHT HAVE, I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES TO THIS ACCOUNT. I FURTHER AGREE IN THE EVENT OF NON PAYMENT TO BEAR THE COST OF COLLECTION AND/OR COURT COSTS AND REASONABLE LEGAL FEES SHOULD THIS BE REQUESTED.

Signature_____ Date_____ Partner Signature_____ Date_____

THE FERTILITY CENTER of Charleston

QUESTIONNAIRE FOR FEMALE PATIENT

Name_____ Partner's Name_____
Length of time attempting pregnancy_____ Length of time not using contraceptives_____

MENSTRUAL HISTORY

Age at first period_____ Date of first day of last period_____ Usual duration of bleeding_____
Shortest number of days from beginning of one period to the beginning of the next _____
Longest number of days from the beginning of one period to the beginning of the next_____
Amount of flow □ Light □ Moderate □ Heavy Any cramping with period? □ Yes □ No

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OBSTETRICAL HISTORY

Children? □ Yes □ No Ages_____
How long to conceive_____
Any difficulty becoming pregnant previously? □Yes □ No
Number of previous pregnancies _____
Number of deliveries at term(40 weeks)_____
# of premature deliveries(less than 37 weeks)_____
Number of miscarriages_____
How many weeks along_____
Number of living children_____
Number of therapeutic abortions _____
How many weeks _____

Number of Vaginal Deliveries (include date, sex of baby, and weight):_____
_____
_____
Number of C-Section (include date, sex of baby, and weight)_____
_____
_____
Were there complications with previous pregnancies? □ Yes □ No
If yes, Explain complications, including dates_____
_____
_____
_____

PREVIOUS INFERTILITY TESTING

	Yes	No	Year	Results (if known)
Ovulation Testing	□	□	_____	_____
Hysterosalpingogram	□	□	_____	_____
Hysteroscopy	□	□	_____	_____
Laparoscopy	□	□	_____	_____
Semen Analysis	□	□	_____	_____
Hormone Studies	□	□	_____	_____

PREVIOUS INFERTILITY TREATMENT

	Yes	No	Date	Type
Procedures on Cervix/Uterus/Tubes	□	□	_____	_____
Procedures on Ovaries	□	□	_____	_____
Procedures for Adhesions	□	□	_____	_____
Treatment for Endometriosis	□	□	_____	_____
Pelvic Inflammatory Disease	□	□	_____	_____
Treatment with Medication	□	□	_____	_____
Artificial Insemination	□	□	_____	_____
Other Treatment	□	□	_____	_____

THE FERTILITY CENTER of Charleston

MEDICAL –SURGICAL HISTORY

	Yes	No	Date	Comments
Elevated Blood Pressure	□	□	_____	_____
Heart Murmur	□	□	_____	_____
Diabetes	□	□	_____	_____
Lung Disease	□	□	_____	_____
Liver or Gall Bladder Disease	□	□	_____	_____
Jaundice	□	□	_____	_____
Urinary Tract Abnormalities	□	□	_____	_____
Thyroid Disease	□	□	_____	_____
Arthritis	□	□	_____	_____
Autoimmune Disease(i.e Lupus)	□	□	_____	_____
Other Serious or Chronic Disease	□	□	_____	_____
Any Surgery	□	□	_____	_____
Syphilis	□	□	_____	_____
Gonorrhea	□	□	_____	_____
Chlamydia	□	□	_____	_____
Genital Warts	□	□	_____	_____
Hepatitis B or C	□	□	_____	_____
HIV 1 or 2	□	□	_____	_____
HSV (Herpes)	□	□	_____	_____
History of X-ray or Cancer treatment	□	□	_____	_____

List any allergies to medications:_____
_____
_____

List medications you are taking now:_____
_____
_____

List medications you have taken in the past:_____
_____
_____

Did your mother take any medications while pregnant with you?

□ Yes □ No If yes, please list_____
_____
_____

THE FERTILITY CENTER of Charleston

PARTNER QUESTIONNAIRE

Name_____Date_____
Occupation_____
Height_____ Weight_____ Partner's Name_____

MEDICAL –SURGICAL HISTORY

	Yes	No	Date	Comments
Elevated Blood Pressure	□	□	_____	_____
Heart Murmur	□	□	_____	_____
Diabetes	□	□	_____	_____
Lung Disease	□	□	_____	_____
Liver or Gall Bladder Disease	□	□	_____	_____
Jaundice	□	□	_____	_____
Urinary Tract Abnormalities	□	□	_____	_____
Thyroid Disease	□	□	_____	_____
Arthritis	□	□	_____	_____
Autoimmune Disease(i.e Lupus)	□	□	_____	_____
Other Serious or Chronic Disease	□	□	_____	_____
Any Surgery	□	□	_____	_____
Syphilis	□	□	_____	_____
Gonorrhea	□	□	_____	_____
Chlamydia	□	□	_____	_____
Genital Warts	□	□	_____	_____
Hepatitis B or C	□	□	_____	_____ ____
HIV 1 or 2	□	□	_____	_____
HSV (Herpes)	□	□	_____	_____
History of X-ray or Cancer treatment	□	□	_____	_____

List any allergies to medications:_____
_____
_____
List medications you are taking now:_____
_____
_____
List medications you have taken in the past:_____
_____
_____
Did your mother take any medications while pregnant with you?
□ Yes □ No If yes, please list_____
_____
_____
_____

For Male Partner Only to Complete

	Yes	No	Comments
Have you ever fathered a child	□	□	_____
Have you ever been told you are infertile	□	□	_____
Are you circumcised	□	□	_____
If no, does the foreskin retract easily	□	□	_____
Has there been any change in libido or sexl drive	□	□	_____
Is there any difficulty maintaining an erection	□	□	_____
Do you ejaculate into the vagina without difficulty	□	□	_____

THE FERTILITY CENTER of Charleston

For Male Partner Only (Continued)

	Yes	No	Comments
Any pain or burning with urination or ejaculation	□	□	_____
Any discharge from the penis	□	□	_____
Has a semen analysis ever been performed	□	□	_____
Do you have a history of undescended testes	□	□	_____
Do you have an injury to the testes	□	□	_____
Have you had surgery on the testes	□	□	_____
Have you had a hernia repair	□	□	_____
Any history of treatment to improve fertility	□	□	_____
Have you been treated for infection of testicles	□	□	_____
Been treated for infection of seminal vesicles	□	□	_____

For Female Partner Only to Complete

Menstrual History

Age at first period_____ Date of first day of last period_____ Usual duration of bleeding_____
Shortest number of days from beginning of one period to the beginning of the next _____
Longest number of days from the beginning of one period to the beginning of the next_____
Amount of flow □ Light □ Moderate □ Heavy Any cramping with period? □ Yes □ No

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For Female Partner Only to Complete

Obstetrical History

Children? □ Yes □ No Ages_____
How long to conceive_____
Any difficulty becoming pregnant previously? □Yes □ No
Number of previous pregnancies _____
Number of deliveries at term(40 weeks)_____
# of premature deliveries(less than 37 weeks)_____
Number of miscarriages_____
How many weeks along_____
Number of living children_____
Number of therapeutic abortions _____
How many weeks _____

Number of Vaginal Deliveries (include date, sex of baby, and weight):_____
_____
_____
Number of C-Section (include date, sex of baby, and weight)_____
_____
_____
Were there complications with previous pregnancies? □ Yes □ No
If yes, Explain complications, including dates_____
_____
_____
_____

THE FERTILITY CENTER
of Charleston

ZIKA Questionnaire

The CDC and ASRM continue to update information and recommendations regarding the risk of ZIKA and pregnancy. Please answer the following questions so that we can take these risks into consideration when providing care.

YES	NO	
☐	☐	Have you or your partner been diagnosed with ZIKA infection in the last 6 months?
☐	☐	Have you had sexual intercourse in the last 6 months with a male who is known to have either been diagnosed with ZIKA or traveled to one of the areas with active ZIKA transmission (listed below) within the last 6 months?

Please indicate any areas which you or your spouse have visited during the last 6 months or plan to visit during your treatment or pregnancy.

The Caribbean:	☐Anguilla;	☐Antigua and Barbuda;		☐Aruba;
	☐The Bahamas;	☐ Barbados;	☐Bonaire;	☐British Virgin Islands;
	☐Cayman Islands;	☐Cuba;	☐Curacao;	☐Dominica;
	☐Dominican Republic;	☐Grenada;	☐Guadeloupe;	☐Haiti;
	☐Jamaica;	☐Martinique;	☐Montserrat;	☐Commonwealth of Puerto Rico;
	☐Saba;	☐Saint Barthelemey;		☐Saint Kitts and Nevis;
	☐Saint Lucia;	☐Saint Martin;		☐Saint Vincent & the Grenadines;
	☐Saint Eustatius;	☐Saint Maarten;		☐Trinidad and Tobago;
	☐Turks and Caicos Islands;	☐US Virgin Islands		

□ **Mexico**

Central America:	☐Belize;	☐Costa Rica;	☐EI Salvador;	☐Guatemala;
	☐Honduras;	☐Nicaragua;	☐Panama	
South America:	☐Argentina;	☐Bolivia;	☐Brazil;	☐Colombia;
	☐Ecuador;	☐French Guiana;	☐Guyana;	☐Paraguay;
	☐Peru;	☐Suriname;	☐Venezuela	

□ **Singapore**

The Pacific Islands:	☐American Samoa;	☐Fiji;	☐Marshall Islands;	☐Micronesia;
	☐New Caledonia;	☐Palau;	☐Papua New Guinea;	
	☐Samoa;	☐Tonga		

□ **Cape Verde**

THE FERTILITY CENTER
of Charleston

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This form needs to be sent to your Physician(s) so that The Fertility Center of Charleston may obtain your medical records. Please send this form to any physicians (OB/GYN, Urologist, Infertility Specialist, etc) who have participated in your fertility related care ASAP.

Patient Name:_____
(First) (Middle/Maiden) (Last)

SSN#_____ DOB:_____

INFORMATION RELEASED FROM :	**INFORMATION RELEASED TO:**
PRACTICE NAME:	THE FERTILITY CENTER OF CHARLESTON
PHYSICIAN NAME:	**ATTN: NEW PATIENT COORDINATOR**
ADDRESS:	1280 HOSPITAL DRIVE, SUITE 300
	MOUNT PLEASANT, SC 29464
PHONE:	PHONE: 843-881-7400
FAX:	FAX: 843-881-7444

Dear Dr. _____

I am considering treatment at The Fertility Center of Charleston. Please forward a summary letter, this sheet and the below listed information to The Fertility Center of Charleston. All records need to be submitted prior to appointment date: _____

Please include the following if applicable:

- All semen analysis
- Hysterosalpingogram(HSG) reports and films
- Any operative notes and pathology
- All lab results
- Any other pertinent records related to infertility including notes on IUI or IVF

I request and authorize the above named physician or health care provider to release information to The Fertility Center of Charleston . I certify this request has been made voluntarily and that the information given above is accurate. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Copies of medical records may be mailed or faxed to the above address.

A copy of this authorization with my signature thereon may be utilized with the same effectiveness as the original.
Thank you for your assistance.
Sincerely,

_____ _____
Signature of Patient Date

PLEASE ENCLOSE THIS LETTER WITH THE RECORDS

THE FERTILITY CENTER
of Charleston

CONSENT AND AUTHORIZATION FOR ELECTRONIC COMMUNICATION (EMAIL)

E-mail and communication provides for a fast and easy way to communicate with your healthcare provider for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider relationship; rather is can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- E-mail communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard e-mail services, such as Gmail, AOL, Yahoo and Hotmail are not secure. This means that the e-mail messages are not encrypted and can be intercepted and read by unauthorized individuals.
- Transmitting e-mail that contains protected health information through an email system that is not encrypted does not meet the security guidelines as required by the Health Information Protection and Accountability Act(HIPPA).
- Your e-mail address will not be used for external marketing purposes without your permission. You may receive a group mailing from the practice, however, the recipients e-mail addresses will be hidden.

Provider Responsibilities

- The provider will attempt to electronically confirm your e-mail address by requesting a return response to all email messages.
- Your provider may route your e-mail messages to other members of the staff for informational purposes or for expediting a response.
- Designated staff may receive and read your e-mail.
- The provider will make every attempt to respond to your e-mail message within 2 business days. If you do not receive a response from the provider within 2 business days, please contact the office.
- Copies of e-mails sent and received from and to you will be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.
- All e-mail communication with patients is sent via a **SECURE** e-mail messaging system.

Patient Responsibilities

- E-mail messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should contact 911. For emergent or time sensitive situations, you should contact your healthcare provider through the office.
- Email messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via e-mail.
- Please key in your full name and the topic, i.e, medication question, in the subject line. This will serve to identify you as the sender of the e-mail.
- Please acknowledge that you received and read the provider's message by return e-mail to the provider.

I have read and understood the above description of the risks and responsibilities associated with the electronic communication with my healthcare provider.

I

THE FERTILITY CENTER of Charleston

acknowledge that commonly used e-mail services are not secure and fail outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

I have been given the opportunity to discuss electronic communication with my healthcare provider and have had all my questions answered.

In consideration of my desire to use electronic communication as a supplement to in-person office visits with my provider, I hereby consent to electronic communication via secure e-mail services.

I understand that I may revoke my consent to communicate electronically at any time by notifying The Fertility Center of Charleston in writing, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance on my consent.

I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a secured network.

I further agree to be held accountable for the patient responsibilities as outlined above.

PATIENT_____

Patient Authorized E-mail Address_____

Patient Signature_____ Date_____

PARTNER (if applicable)_____

Partner Authorized E-mail Address_____

Partner Signature_____ Date_____

THE FERTILITY CENTER
of Charleston

Patient Financial Policy

1. The Fertility Center of Charleston (TFCOC) is not a Medicare or Medicaid provider. Patient Initials_____ Partner Initials____

2. I am ultimately responsible for the payment of all medical services. Patient Initials_____ Partner Initials_____

3. I understand that it is my responsibility to supply TFCOC with any current insurance information and/or any referral authorization forms (pre-authorization forms). Patient Initials_____ Partner Initials_____

4. I understand I am (or guarantors) responsible for payment of co-pays, co-insurance, deductibles, supplemental fees, and all other fees not covered by my insurance plans and that payment must be made at the time services are rendered.
Patient Initials_____ Partner Initials_____

5. **Private Insurance Authorization for Assignment of Benefits/Information Release:** I authorize that the payment of medical benefits be made on my behalf directly to The Fertility Center of Charleston for any services furnished me by the physician (s). I understand that I am financially responsible for any amount not covered by my contract. I authorize the release to my insurance company information concerning health care, advice and/or treatment provided to me necessary for processing of insurance claims.
Patient Initials_____ Partner Initials_____

   I hereby assign all medical and surgical benefits to which I am entitled (assignment of benefits) to TFCOC. I authorize and direct my insurance carrier(s) to issue payment check(s) directly to TFCOC for rendered services. If I receive payment check(s) from my insurance carriers, I will promptly forward them to TFCOC. Patient Initials_____ Partner Initials_____

6. **Insurance Coverage:** TFCOC will bill my insurance plans if the patient provides the required insurance information and signs and Assignment of Benefits statement. TFCOC may submit claims for covered services to non-contracted insurance plans as a courtesy; however, the services must be paid in full at the time services are rendered. If the patient has dual coverage and we do not participate with the primary insurer, services must be paid in full at the time services are rendered. Patients with a contracted insurance plan that covers only a portion of the services must pay the difference between the charges and the anticipated insurance payment at the time the services are rendered. All patients receiving medical services are required to prove their social security number prior to services being rendered. A pre-treatment deposit is required to initiating certain services. Patient Initials_____ Partner Initials_____

   - We will file a claim for services rendered with the insurance carrier and allow 45 days for a payment in full. If payment is not received within 45 days, the balance due will become the obligation of the patient or guarantor(responsible party) and must be paid within 45 days. Patient Initials_____ Partner Initials_____

   - Fertility services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventative, pre-existing, or non-covered, you will be responsible for your balance. Patient Initials_____ Partner Initials_____

7. If you do not have insurance or we are non-participating providers with your insurance carrier, payment is expected at the time services are rendered. Patients receiving services at our Savannah monitoring facility may be required to pre-pay for all services to be rendered.
Patient Initials_____ Partner Initials_____

THE FERTILITY CENTER of Charleston

8. I understand payments may be made by cash, check , cashier check or credit card (Visa, MasterCard, Discover, or American Express) . No personal checks over $2,500. Returned checks will be handled in accordance with the Patient Financial Services Department NSF procedures. A $35.00 administration fee will be assessed for each returned check. Patient Initials_____ Partner Initials_____

9. **Phone Consults**: Our office does offer follow up phone consultations for out of town patients, however the cost is $120.00 and is not covered by insurance. Our no show /no contact policy does apply. Patient Initials_____ Partner Initials _____

10. **No show/Cancellation Policy**: I understand if I cannot keep my appointment, I will contact the office at least 48 hours in advance to cancel or reschedule my appointment. If I do not cancel or reschedule 48 hours in advance, I will be charged a no show/cancellation fee of $60.00. Patient Initials_____ Partner Initials_____

11. **Cryopreservation and Storage:** Our frozen storage system at TFCOC was established to provide our patients with a safe and convenient method to store frozen specimens for use in future treatments. Storage fees not paid upon receipt of statement within 90 days are subject to a collection process that may result in reporting the storage debt to an outside collections agency and may jeopardize the patient's credit rating. The patient will continue to accrue a yearly storage fee without notice until legal documentation is received releasing TFCOC as legal custodian. Cryopreservation fees that become delinquent will enter the same collection process as above.
Patient Initials_____ Partner Initials_____

12. **Cancellation of Cycle:** I understand if a cycle is cancelled for any reason, I will be charged for the actual procedures performed according to the standard fee schedule utilized by TFCOC. If I am undergoing an IVF cycle and convert to an IUI cycle, I will only be charged for the actual procedures performed. Any difference between cost of the actual procedures performed and the deposit amount will be refunded to me/guarantor once I have been released from care and any insurance payments due have been received.
Patient Initials_____ Partner Initials_____

13. **Refunds:** Overpayments of credit balances greater than $10.00 will be refunded to the appropriate party after review of the account. Patient refunds will not be processed until the patient is released from care and any insurance payments due have been received.
Patient Initials_____ Partner Initials_____

14. **Collections:** I agree to reimburse TFCOC for the fees of any collection agency, which may be based on the percentage of the debt at a minimum of 30% to a maximum of 50%, and of all cost and expenses, including reasonable attorneys' fees, TFCOC incurred in such collection efforts.
Patient Initials_____ Partner Initials_____

15. **Additional Information requests:** I understand there is a $25.00 charge per request for additional forms other than standard HFCA 1500 billing forms and any additional dictated letters required by Dr. Singleton. Ten (10) business days are allowed for these forms to be completed. Payment for these will be made in advance. Patient Initials_____ Partner Initials_____

16. I understand that his authorization will remain on file for future rendered services. Patient Initials_____ Partner Initials_____

I UNDERSTAND THE ABOVE FINANCIAL RESPONSIBILITIES AND AGREE TO THEIR TERMS. I ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS INSURANCE CLAIMS.

_____ _____
Signature of Patient Date

_____ _____
Signature of Partner Date

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Additional Authorizations

HIPPA Notice of Privacy Practices Acknowledgement

I have been made aware of The Fertility Center of Charleston's Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of TFCOC. 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions. **Patient initials_____ Partner initials_____**

Authorization to Release and/or Obtain Medical Records

I hereby authorize my primary care physician, my referring physician, and TFCOC physicians, the release, use, and disclosure of my entire medical record by mail, phone, and fax, to carry out my treatment, payment, and healthcare operations.

Patient initials_____ Partner initials_____

Authorized Methods of Communication (Please check all that apply)

1. Permission is given to leave call back phone number only: □ **Home** □ **Cell** □ **Work**

2. Permission is given to leave detailed message on answering machine/voice mail: □ **Home** □ **Cell** □ **Work**

3. Permission is given to discuss my healthcare treatment with: □ **Spouse** □ **Family Member** □ **Friend** □**Other**

Patient initials_____ Partner initials_____

This authorization will remain on file for future rendered services.

_____ _____
Signature of Patient Date

_____ _____
Signature of Partner Date