VIERAFERTILITY

Diran Chamoun, M.D.

3160 Alzante Circle, Melbourne, FL 32940
Phone: 321-751-4673 (HOPE) • **Fax**: 321-751-4567
Email: info@vierafertility.com • **vierafertility.com**

Billing Information

Contact Information

Name: _____ _____ _____ Date of Birth: _____/_____/_____
First Middle Last Month Day Year

Home Address: _____ _____ _____ _____
Street City State Zip/Postal Code

Marital Status: ☐ Single ☐ Married ☐ Common Law ☐ Prefer Not to Share SSN #:_____-_____-_____

Primary Phone: _____ ☐ Work ☐ Cell Alternate Phone:_____ ☐ Work ☐ Cell

Email:_____ Preferred Method of Contact: ☐ Phone ☐ Email

Employment Information

Responsible Party: Self Spouse/Partner Other: _____ Your Occupation: _____ ☐ Self-Employed

Employer Address: _____ _____ _____ _____
Street City State Zip/Postal Code

Responsible Party's Occupation: _____ ☐ Self-Employed Phone: _____

Responsible Party's Employer: _____ _____ _____
Name Address Phone

Insurance Information

Insurance Name: _____ Insurance ID #: _____ Group #: _____

Primary Care Physician: _____ _____ _____
Name Address Phone

INSURANCE AUTHORIZATION: I hereby authorize Viera Fertility to furnish information to my insurance carriers concerning my illness and treatment. I agree that if I fail to notify Viera Fertility of insurance change or obtain required referrals or preauthorization for services, I will be responsible for those charges.

ASSIGNMENT OF BENEFITS: I hereby assign Viera Fertility all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____
Signature of Authorized Person Date

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Insurance & Billing Authorization

Thank you for choosing Viera Fertility as your health care provider. We are committed to the success of your treatment. The following form is a statement of our Insurance and Billing Policy, which we require you to read, initial and sign prior to any treatment.

Viera Fertility will bill your insurance for covered charges incurred in our office. Your deductible and co-payment are due at the time of your visit. We accept cashier's checks, MasterCard, Visa, Discover and AMEX.

Viera Fertility verifies your insurance benefits with your insurance company prior to your appointment. Please be advised that it is only an estimation of benefits; it is not guaranteed by the insurance company and is subject to change by your insurance's approval. You will be responsible for all charges not paid by your insurance company. We will do everything in our power to appeal an unpaid charge; however, you are responsible for payment for your services rendered.

Some services provided by our office may be non-covered. If we have been informed that the service is not covered, you will be responsible for payment in full at the time of the visit. Otherwise, we will file the claim and bill you if it is denied.

It is important to note that many insurance policies do not cover infertility; therefore, your expenses at our office may or may not be covered. If your insurance coverage is terminated or you switch policies, it is your responsibility to let us know prior to receiving further services.

It is possible at some point your insurance company may request a copy of your records to determine if your treatment is for a non-covered or pre-existing condition. Unfortunately, this is a matter we have no control over. We cannot withhold or alter records.

For surgery, ovulation induction therapy and in vitro fertilization, we will bill your insurance; subject to verification of coverage and pre-payment of your expected out-of-pocket expenses. You will be billed for all charges not paid by your insurance. Patients with accounts sent to an outside collection agency are responsible for all collection costs and legal fees.

The medical personnel in our office are devoted exclusively to your medical care. Please direct all matters relating to fees, billing and insurance only to the business personnel.

I understand I am responsible for payment of all my services and agree to all of the above. _____
Initial

I hereby authorize the release of medical information to my insurance company and authorize the payment of benefits to Viera Fertility.

Print Patient Name: _____

Signature of Patient: _____ Date: _____

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Fee Policy

At Viera Fertility, we value transparency about your treatment program and included fees. Please review and sign below to acknowledge your understanding and acceptance of our fee policies.

Insurance

Viera Fertility will bill your insurance for coverage charges incurred in our office. Your deductible and co-payment are due at the time of your visit. Some services provided by our office may be non-covered. If we have been informed that the services is not covered, you will be responsible for payment in full at the time of the visit. Otherwise, we will file a claim and bill you if its denied. You will be held responsible for any charges not paid by the insurance company, regardless of the reason.

If your insurance coverage is terminated or if you switch policies, it's your responsibility to let us know this prior to undergoing further services.

It is possible that, at some point, your insurance company may request a copy of your file in order to determine whether your treatment is for a non-covered or pre-existing condition. This is a matter over which we have no control; we cannot withhold or alter records. There is a nominal handling fee for making those copies.

Payment Schedule

Payment is due at the time of service. If you wish to know the fee for any service in advance of scheduling, please feel free to ask the receptionist.

We accept cashier's checks, MasterCard, Visa, Discover or AMEX. We also offer our patients the option of applying for credit with a medical finance company.

☐ By checking this box and signing below, you agree to accept the terms of our fees policies.

Print Patient Name: _____

Signature of Patient: _____Date: _____

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Notification of Privacy Policy

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Introduction

At Viera Fertility, we are committed to treating you and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Viera Fertility, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed are actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Viera Fertility, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided for in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided for in 45 CFR 164.528
- Request communications of your health information by alternative means or locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

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Our Responsibilities

Viera Fertility is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain for you,
- Abide by terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

For More Information or to Report a Problem

For questions or more information, you may contact our clinic at info@vierafertility.com.

If you believe your privacy has been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint. The address for the OCR is:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment, and Health Operation

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other members of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team, who will then record the actions they took and their observations. In that way,
the physician will know how you respond to the treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from this practice.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

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We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department, anesthesiology, radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders by mail, answering machine messages, or your voicemail, or to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Public Health: We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability as required by law.

Worker compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following person(s) to obtain information about my care including laboratory results:

☐ Spouse Name: _____

☐ Other Name(s):_____

I have the right to change these restrictions and have the most recent authorization used.

Patient's Signature: _____ **Date:**_____

If not signed by the patient, please indicate your relationship to the patient (e.g. spouse).

Relationship: _____

Witnessed by (employee): _____

Privacy officer/designee signature: _____

Restriction accepted: ☐ Yes ☐ No

Patient notified of acceptance/denial: ☐ Yes ☐ No

For office use only:

If patient refuses to sign, indicate your attempt to obtain a signature below.

☐ Patient refused to sign this acknowledgement.

Reason: _____

_____

_____

Employee Name: _____ Date: _____ Time: _____

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Authorization for Disclosure of Confidential Information

Patient's Name: _____ Chart #: _____

Address: _____

Date of Birth: _____

I hereby authorize and request:

Doctor's Name:_____

Address: _____

Phone: _____ Fax: _____

To release the following information to:

Viera Fertility
3160 Alzante Circle
Melbourne, FL 32940

Check All That May be Released:

- ☐ Infertility notes & relevant studies only
- ☐ Other (Please specify): _____

Purpose of Disclosure:

- ☐ Infertility evaluation
- ☐ Other (Please specify): _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing any time prior to the expiration date.

Patient's Signature: _____ Date: _____

Witness: _____

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of any protected health information by Viera Fertility for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations. I understand that my diagnosis or treatment may be conditioned upon my consent as evidenced by my signature in this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations to the practice. Viera Fertility is not required to agree to the restrictions that I may request. I have the right to revoke this consent, in writing, at any time, except to the extent that Viera Fertility has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me or received by Dr. Chamoun through another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

I understand I have a right to review Viera Fertility's "Notice of Privacy Practices" prior to signing this document. Viera Fertility's "Notice of Privacy Practices" has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Viera Fertility. This Notice of Privacy Practices also describes my rights and Viera Fertility's duties with respect to my protected health information.

Viera Fertility reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Communication with Spouse / Family:

Health professionals, using their best judgment at your request, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to revoke your decision in writing at any time.

Print Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

Please initial where applicable:

____ OB/GYN ____ Family member ____ Psychologist ____ Attorney ____ Intended parents ____ Gestational carrier ____ Donor agency

_____ _____

Signature of Patient Date

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Patient Informed Consent for Pelvic Examination

Patient Name:_____ DOB: _____/_____/_____

I, _____, hereby authorize Dr. Diran Chamoun or any other provider and whomever he/she may designate as his/her assistants to perform upon a pelvic examination, which is defined as: a series of tasks that comprise of an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, external pelvic tissue or organs using any combination of modalities, which may include, but are not limited to, the healthcare provider's gloved hand, instrumentation including catheter insertion, and vaginal sonography. The procedure is used to diagnose and/or treat conditions that involve the pelvis.

The procedure listed above has been explained to me by the physician and I completely understand the nature and consequences of the procedure. In addition, he/she has informed me of the possible benefits, alternative methods of treatment, the risks involved, and the possibilities that complications may arise, which may include anxiety, fear, bleeding, infection, and unplanned injuries such as inadvertent puncture or laceration.

I understand I am responsible for informing the physician of any allergies and medical conditions before the procedure(s). I understand that I can terminate the procedure at any time. I understand I am responsible for informing the provider of any discomfort or unusual symptoms occuring during the procedure.

I understand that this Patient Consent for Pelvic Examination is required by F.S. 456.51. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examination(s) today and in the future and I have read and understand the above. I may revoke this consent in writing by hand delivering a copy of the revocation to my physician or any personnel at Viera Fertility Center.

_____ _____/_____/_____
Signature of Patient Date

☐ Patient is unable to give consent because: ☐ the patient is a minor ☐ other:_____

_____ _____/_____/_____
Signature of Legal Representative (if above box is checked) Date

The patient (and her representative) has been informed and counseled by me and others at Viera Fertility Center regarding pelvic examination(s) and the alterative options. The patient (and her representative) appears to be capable of understanding the information presented.

_____ _____/_____/_____
Diran Chamoun, MD Date