



Welcome to ACRM!

Thank you for making an appointment for your Fertility Assessment. The tests you will receive will help evaluate your current fertility status so that you can make decisions about your future family building. This program is intended for women under the age of 40 who are not planning to conceive within the next 6 months. Please be advised this is not a complete exam, this is only a test of ovarian reserve.

We perform these tests at our Buckhead office. (1800 Howell Mill Rd, Suite 675, Atlanta 30318). The following pages outline what you'll need to know before your visit. The AMH test will be performed by Reprosourse, an outside lab. Reprosourse will file to your insurance and bill separately from ACRM.

We are happy that you have chosen Atlanta Center for Reproductive Medicine to perform these tests. Should you decide that Fertility Preservation is something you would like to pursue, we will schedule a new patient consultation at your convenience. We offer the full range of Assisted Reproductive Technologies (IVF, Donor Egg, Frozen Egg) and Genetic Screening. We have 4 locations, 7 physicians, 16 nurses, 4 embryologists and a whole team of support staff available to you. Our website provides more information about us (www.acrm.com).

We look forward to your visit!

Lisa Hasty, MD

Andre Denis, MPH, MD

Jim Toner, MD, PhD

Robin Fogle, MD

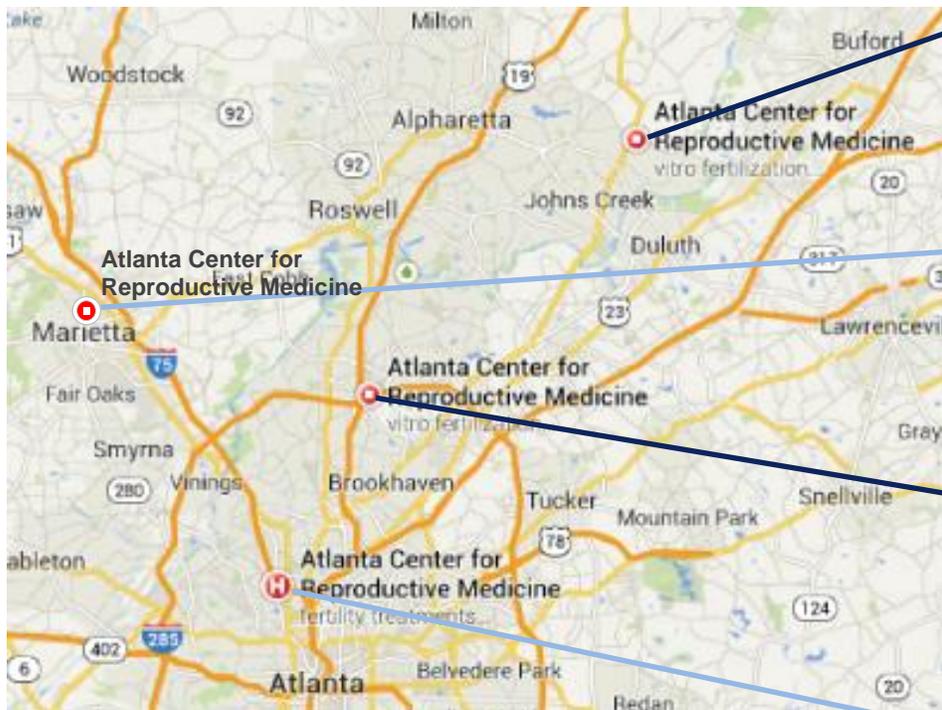
Sue Ellen Carpenter, MD

David Keenan, MD

Kathryn C. Calhoun, MD

Steven A. Voelkel, PhD, HCLD

Office Hours, Locations, & Emergency Contact



Johns Creek
6470 East Johns Crossing
Suite 200
Johns Creek, GA 30097

OPEN: Mon to Fri, 8 am to 4 pm

Marietta
711 Canton Road
Suite 410
Marietta, GA 30060

OPEN: Mon to Fri, 8 am to 4 pm

Perimeter (main)
5909 Peachtree Dunwoody Road
Suite 600
Atlanta, GA 30328

OPEN: Mon to Fri, 8 am to 4 pm
Sat, Sun, holidays, 8 am to

Buckhead
1800 Howell Mill Road
Suite 675
Atlanta, GA 30318

OPEN: Mon to Fri, 8 am to 4 pm

Note: We are open on weekends and most holidays until noon (only for certain appointment types)

Phone: (770) 928-2276 (for all offices)
Emergencies / After Hours: (770) 928-2276



For your visit...

Prior to your first visit with us, please:

- Fill out the **Patient Information Sheet**, and fax to (678) 303-0482 or email to: medicalrecords@acrm.com.
- Fill out the **Consents & Authorizations** and fax to (678) 303-0482 or email to: medicalrecords@acrm.com.

New Patient Information



Date: _____

You: Name: _____ Nickname: _____
 Date of Birth: _____ Age: _____
 Occupation: _____
 Home Phone#: _____ Cell Phone#: _____
 (Please put an * next to the preferred phone number to call.)
 Email: _____

Spouse / Partner (if applicable)

Name: _____ Nickname: _____
 Date of Birth: _____ Age: _____
 Occupation: _____
 Home Phone#: _____ Cell Phone#: _____
 (Please put an * next to the preferred phone number to call.)
 Email: _____

Your Address:

Street: _____
 City, State, and Zip: _____

Referred by:

Current doctor:

Practice Name: _____

Address: _____

Phone#: _____

Fax#: _____



Patient Consents & Authorizations

The following Consents and Authorizations need to be reviewed, completed, and returned by fax, email or in person before or at the first visit.

FAX to (678) 303-0482 or email to: medicalrecords@acrm.com

- Fertility Assessment Consent
- Consent to Communicate
- Consent to Receive Text Messages
- Consent to use Electronic Records
- Obligation to Pay
- Consent to Verify Insurance benefits
- Authorization to use Credit Card for billing

Name: _____ Date of birth: _____

Fertility Assessment Consent

Definitions:

The following defined terms are utilized throughout the following document:

Practice – Atlanta Center for Reproductive Medicine, LLC (ACRM) is referred to herein as the "Practice"

Lab – CCRM – Atlanta, LLC is referred to herein as the "Lab"

When the document refers to either the "Practice" or the "Lab" it is referring to the entities defined above.

I hereby consent to Fertility Assessment tests, consultation and other related services. This may include but is not limited to services rendered by Physician's Assistants, Nurse Practitioners, Nurses, Medical Assistants and Administrative Support Personnel. I may withdraw my permission at any time without fear of it compromising my decision to return for care at a later time (unless I have been discharged from the practice).

Signature: _____ Date: _____

Consent to Communicate

Definitions:

The following defined terms are utilized throughout the following document:

Practice – Atlanta Center for Reproductive Medicine, LLC (ACRM) is referred to herein as the "Practice"

Lab – CCRM – Atlanta, LLC is referred to herein as the "Lab"

When the document refers to either the "Practice" or the "Lab" it is referring to the entities defined above.

During the course of your Fertility Assessment at Atlanta Center for Reproductive Medicine, There may be reason for the practice or the lab to call with information regarding test results, future appointments or financial responsibility. I understand that I have the right to modify or rescind my authorization at any time. I certify that each number below is a private and direct number. I hereby grant my permission for ACRM staff to leave a voice mail message, which may include protected health information at the phone numbers I have provided in the event I cannot be reached.

I also grant permission for the Practice or the Lab to discuss information regarding my care and financial matters with my spouse or partner, if applicable.

Signature: _____ Date: _____

Phone Number: _____

Spouse or Partner's Name: _____

Consent to Receive Text Messages

On occasion, Atlanta Center for Reproductive Medicine will send appointment or account reminders via text messaging. Text messages will not be sent without your permission and your participation is not mandatory. You may revoke your consent and opt out of text messaging at any time. Normal rates and charges will be applied as per your agreement with your cell phone carrier.

I give my permission for text message appointment reminders to be sent to my cell phone.

Signature: _____ Date: _____

Mobile number capable of receiving text messages: _____

Name: _____ Date of birth: _____

Consent to use "Electronic Records"

Definitions:

The following defined terms are utilized throughout the following document:

Practice – Atlanta Center for Reproductive Medicine, LLC (ACRM) is referred to herein as the "Practice"

Lab – CCRM – Atlanta, LLC is referred to herein as the "Lab"

When the document refers to either the "Practice" or the "Lab" it is referring to the entities defined above.

I acknowledge and agree that the Practice or the Lab may convert some or all of my medical records into electronic format and thereafter maintain such medical records only in electronic format. I also acknowledge and agree that Consents (together with my signatures on all such Consents) that are obtained from me may be maintained in electronic format. For purposes of obtaining my consent (under O.C.G.A. §10-12-4), I hereby consent to being required to receive, recognize, accept, be bound by, and/or otherwise use electronic records and signatures as described herein. I hereby agree that such medical records and Consents and signatures of mine in electronic format are valid and will have the same validity as the hard paper copy thereof. Likewise, facsimiles or scanned images of any signed documents or consents shall have the same validity as the original. I acknowledge that I have carefully reviewed this Consent and understand its content.

Signature: _____ Date: _____

Obligation to Pay

Definitions:

The following defined terms are utilized throughout the following document:

Practice – Atlanta Center for Reproductive Medicine, LLC (ACRM) is referred to herein as the "Practice"

Lab – CCRM – Atlanta, LLC is referred to herein as the "Lab"

When the document refers to either the "Practice" or the "Lab" it is referring to the entities defined above.

I hereby make the assignment of all disability, surgical, medical, and major insurance benefits to the Practice and the Lab 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 or to my partner/spouse's account. I further agree that in the event of nonpayment by my insurer, to bear the cost of collection and/or court cost and reasonable legal fees should this be requested. I understand that I am responsible for services rendered and I agree to pay for services at the time of service. I hereby authorize the Practice or the Lab to release any information acquired in the course of my examination and treatment to my insurance company or to another physician. I direct my insurance carrier to issue payment directly to the Practice or the Lab. I understand that I am financially responsible to the Practice or the Lab for any balance on my account or my partner/spouse's account not covered by my insurance carrier. In the event a patient credit is created on my account, I agree that a refund will not be granted until final adjudication has been determined by all 3rd party payers. The cost of collection (35%) will be added to all delinquent accounts at the time they are placed with a collection agency. I/We understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the Practice or the Lab may add one and one half percent (1 ½%) per month to any balance owed, and in the event of default to pay collection charges and/or attorney fees. I also understand that it is my responsibility to notify the Practice or the lab if I become no longer responsible for future balances incurred on my partner/spouse's account due to separation or divorce.

Signature: _____ Date: _____

Name: _____ Date of birth: _____

Consent to Verify Insurance Benefits and Bill Insurance

I hereby give my permission to ACRM and CCRM Atlanta (or a third party company who it designates) to obtain from my past, present or future health insurance and prescription benefits companies full and complete health insurance and medication coverage information, including, but not limited to coverage related to infertility (if applicable).

The health insurance and medication benefits verification are offered as a courtesy and without charge. I agree to hold harmless ACRM, CCRM Atlanta, or the third party company performing the verification of insurance benefits and these companies or the third party company performing the verification of insurance benefits and these companies shall have no liability should the information obtained from my insurance company and communicated to me is different from the coverage applied by my insurance company to any claims subsequently filed.

Patients are encouraged to confirm all insurance or reimbursement coverage determinations directly with their insurance carrier or other reimbursement source.

HEALTH INSURANCE CARD:

Insurance Company: _____
ID number: _____ Group number/name: _____
Insured's Employer: _____ Policy number: _____
Phone number for benefits determination: _____

Signature: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Your partner's / spouse's name: _____

HEALTH INSURANCE CARD:

Insurance Company: _____
ID number: _____ Group number/name: _____
Insured's Employer: _____ Policy number: _____
Phone number for benefits determination: _____

Signature: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Attention All Aetna Patients - You may be required to register with Aetna's Infertility Hotline. If a patient is required by Aetna to register with the Aetna Infertility Hotline but fails to do so, Aetna will not consider paying for any services, and all services rendered will be your responsibility. Call 1.800.575.5999 to obtain your registration number, and complete the below:

My Aetna Registration No. is: _____ OR _____ I called Aetna and was informed that I am not required to register.

Name: _____ Date of birth: _____

Consent to use Credit Card for billing

As part of our effort to control the cost of health care for our patients and streamline our administrative processes, we have established an automated credit or debit card system for your convenience. This will simplify payment of your potential co-pays, deductibles, or any 'non-covered' services. This system is similar to what car rental agencies and hotels do worldwide. Our system will securely hold your card information until your health insurance processes your claims and mails you their "Explanation of Benefits" which outlines your financial obligation. Your card will only be charged once your insurance company specifies your exact responsibility. It is the intent of this policy to save you time and simplify the billing process. Your card information will be stored in a confidential and secure setting. Once your card information has been entered, this document will be shredded.

This authorizes ACRM to charge your card (listed below) for any balances due on your account for services provided by either ACRM or CCRM Atlanta. You will always be advised via a printed statement of any charge made to your card via this authorization. If the balance is less than \$500, we will charge your card and mail your receipt. For balances above \$500, we will contact you by email or phone regarding the balance due, then charge your card if we have not heard back from you by the close of the next business day.

You: Signature: _____ Date: _____

Name imprinted on card: _____

Card Type: VISA MasterCard [others currently not accepted]

Credit Card number: _____

Expiration date: _____

Billing Address: _____ (street)

_____ (city, state, zip)

Partner/Spouse: Signature: _____ Date: _____

Name imprinted on card: _____

Card Type: VISA MasterCard [others currently not accepted]

Credit Card number: _____

Expiration date: _____

Billing Address: _____ (street)

_____ (city, state, zip)