Atlanta Center for Reproductive Medicine

A CCRM NETWORK CLINIC

Welcome to ACRM!

Thanks for making an appointment for your x-ray test (HSG or Hysterosalpingogram). It will help your doctor evaluate whether there are problems with your fallopian tubes or uterine cavity. We will forward the result directly to your doctor after completing the study.

We perform this test at our main "Perimeter" office (5909 Peachtree Dunwoody Road, suite 600, Atlanta, 30328). The following pages outline what you'll need to know about doing this test.

Beyond basic medical care and the full range of Assisted Reproductive Technologies (IVF, Donor Egg, Frozen Egg), we also offer psychological support, in-house acupuncture, and nutrition services should you need them. To make things easier and more successful for you, we have 4 locations, 7 physicians, 14 nurses, 3 embryologists and 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

Atlanta Center for Reproductive Medicine
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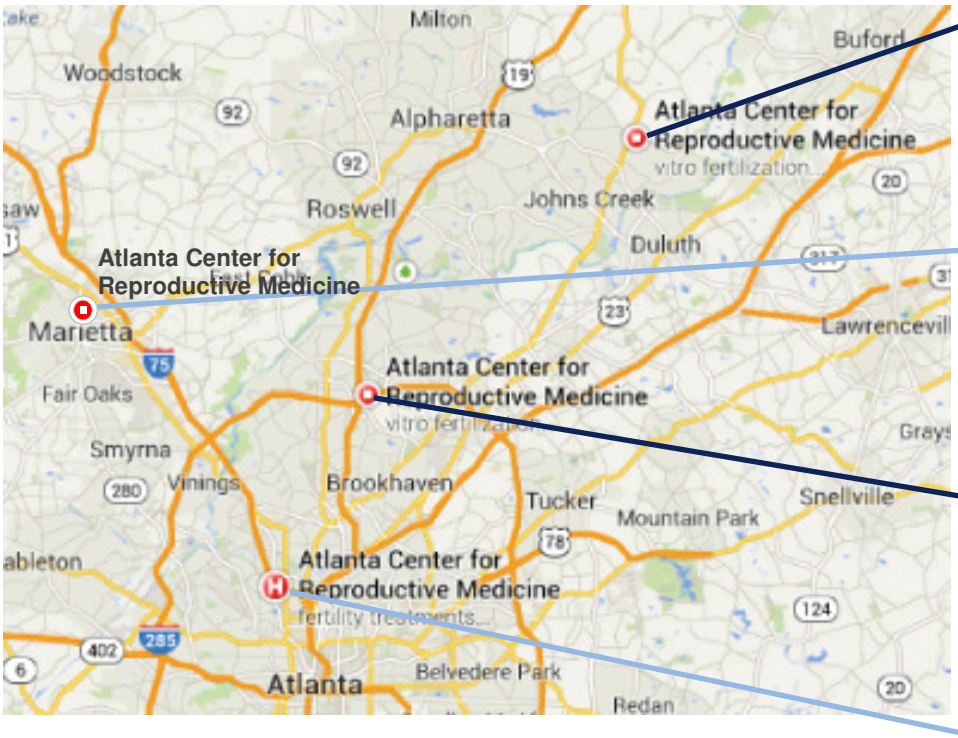

Johns Creek
6470 East Johns Crossing
Suite 200
Johns Creek, GA 30097

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…

Atlanta Center for Reproductive Medicine
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Prior to your first visit with us, please:

- ☐ Send **Medical Record Release** forms **to each** of your doctors.
- ☐ Fill out the **New Patient Questionnaire**, 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 Questionnaire

Atlanta Center for Reproductive Medicine
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Date: _____

You: *Name:* _____ *Nickname:* _____

Date of Birth: _____ *Age:* _____

Occupation: _____

Home Phone#: _____ *Cell Phone#:* _____
(Please put an * next to the preferred phone number to call.)

Pharmacy Name: _____ *Pharmacy Phone#:* _____

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.)

Pharmacy Name: _____ *Pharmacy Phone#:* _____

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

- Consent to Treat
- 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: _____

Consent to Treat

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 request care by the Practice and the lab, which includes but is not limited to physicians, nurses, counselors, laboratory staff, acupuncturists, and administrative support personnel. I may withdraw my permission at any time without fear of it compromising my decision to return to care at a later time (unless I have been discharged from the practice).

Signature: _____ Date: _____

Consent to Communicate

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

During the course of treatment at the Practice or the Lab, physicians, nurses, lab personnel, counselors, acupuncturists, nutritionists or administrative staff may have reason to call with information about test results and instructions regarding ongoing care, nutritionists as well as financial aspects of my treatment. 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 a 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.

Signature: _____ Date: _____

Spouse or Partner's Name: _____

Consent to Receive Text Messages

On occasion, Atlanta Center for Reproductive Medicine will send appointment 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:
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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 by the Practice or the Lab in electronic format. For purposes of obtaining my consent (under O.C.G.A. **§10-12-4),** I hereby consent to being required by the Practice or the Lab 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:
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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: _____

Spouse or Partner's Name: _____

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).

I also hereby give my permission to ACRM and CCRM Atlanta to forward certain medical information it deems necessary to an outside third party who it designates to determine my eligibility to participate in certain patient financial service programs that are made available through ACRM or CCRM Atlanta. Patients are in no way required to participate in these programs. I likewise give my permission to the third party company to forward to ACRM and CCRM Atlanta my prequalification status.

The health insurance and medication benefits verification and the financial services prequalification 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 shall have no liability should the information obtained from my insurance company and communicated to me is different form the coverage applied by my insurance company to any claims subsequently filed. I also agree to hold harmless ACRM and CCRM Atlanta and neither shall have any liability if the prequalification for a patient financial program is preliminarily granted but subsequently not granted.

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 ACRM 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)