Patient Registration

PLEASE PRINT. ALL INFORMATION WILL REMAIN CONFIDENTIAL. THANK YOU!

Scheduled Appointment date: ______________________ Have you or your partner ever been here before? ☐ Yes ☐ No

Patient Name ____
(Last) (First) (Middle)

Home Address ____

City ______________________ State ________ Zip ____________

Primary Phone ____________________ ☐ home ☐ cell ☐ Work DOB ______/______/______

Secondary Phone ____________________ ☐ home ☐ cell ☐ Work Age ________

SSN # ________-______-__________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Same Sex Couple
(The last 6 digits are required)

May we contact you via email? ☐ Yes ☐ No If Yes, email address: ______________________

Emergency Contact Name ____________________ Relationship __________ Phone ____________

Are you employed? ☐ Yes ☐ No If yes, your Employer ____________________ Occupation ____________

Employer's Address ____________________ City ____________ State ______ Zip ________

Work Phone ______________________ May we contact you there? ☐ Yes ☐ No

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Partner Name ____
(Last) (First) (Middle)

SSN # ________-______-__________ DOB ______/______/______ Age ______

Employed by ______________________ Occupation ______________________

Work Phone ______________________ Cell Phone ______________________

PATIENT INSURANCE COVERAGE

Name of Insurance ______________________
Address ______________________
City ______________ State ______ Zip ________
Telephone ______________________
Policy # ______________________
Group # ______________________
Policy Holder ______________________
Partner Covered Under this Policy? ☐ **Yes** ☐ **No**

SPOUSE/PARTNER INSURANCE COVERAGE

Name of Insurance ______________________
Address ______________________
City ______________ State ______ Zip ________
Telephone ______________________
Policy # ______________________
Group # ______________________
Policy Holder ______________________
Partner Covered Under this Policy? ☐ **Yes** ☐ **No**

***** Please be prepared to present your insurance card and valid government issued photo ID to the receptionist *****

REFERRED BY (MARK ALL THAT APPLY)

- ❒ DOCTOR (PLEASE LIST NAME) ____________________ ❒ MD ❒ DO
- ❒ FRIEND / WORD OF MOUTH (PLEASE LIST NAME) ____________________
  MAY WE CONTACT THIS PERSON FOR REFERRING YOU? ❒ YES ❒ NO, I PREFER TO BE DISCRETE
- ❒ INSURANCE CO. ____________________
- ❒ RMA OF MI EMPLOYEE ____________________
- ❒ RMA OF MI WEBSITE
- ❒ RMA OF MI SEMINAR
- ❒ RADIO
- ❒ PREMIER IVF
- ❒ INTERNET

I authorize payment of Medical Benefits to this facility/doctor. I authorize release of any medical information needed to process the claim. I hereby agree to pay for all services rendered to the above mentioned patient as incurred. I understand there is no guarantee any or all services will be covered by my insurance company. In the event of account default, I promise to pay collection costs and reasonable attorney fees as required effecting collection on the debt. I understand that should my account become delinquent or should I fail to pay as promise; RMA of Michigan reserves the right to deny further care to me either temporarily or permanently.

SIGNATURE ____________________ DATE ____________________

SHARED PROTECTED HEALTH INFORMATION

Name	Results / Medical Info	Bills / Account
	❒ Yes ❒ No	❒ Yes ❒ No
	❒ Yes ❒ No	❒ Yes ❒ No
	❒ Yes ❒ No	❒ Yes ❒ No

____
Please Print Patient / Guardian Name

____
If Guardian, Relationship to Patient

____
Signature of Patient / Guardian

____
Date

Brad T. Miller, M.D.
Lynda J. Wolf, M.D.

Patient Financial Agreement

General Financial Provisions:

The patient, or their legal guardian, is ultimately responsible for all services incurred at RMA of Michigan. Spouses cannot sign this Agreement on behalf of the patient. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. RMA will do its best to verify your insurance benefits. However, RMA is not responsible if your insurance company provides incorrect or false information which results in unexpected out-of-pocket expenses. We strongly suggest you attempt to verify your own insurance benefits and ensure all necessary pre-authorizations are in place prior to the date of service.

Financing Options:

RMA of Michigan has established relationships with several financing companies for those interested in obtaining a low-interest/no interest financing. **RMA does not carry balances or offer payment plans.** Our Financial Counselor is available to discuss these program details.

If We Participate With Your Insurance Company:

RMA of Michigan participates and submits claims to the following insurance carriers provided we have all required information and you have granted Assignment of Benefits so that payment is made to us:

- Aetna
- Blue Cross Blue Shield of Michigan (excluding Blue Choice)
- William Beaumont Employee Health Plan
- Cofinity
- United HealthCare
- HAP
- HealthPlus PPO

Patient must pay the difference between the charges and the anticipated insurance payment at the time the services are incurred. This includes all non-covered services, unpaid deductibles and co-pays. If your insurance company pays less than anticipated; we will bill you for the balance. You agree to clear that balance within 30 days. We are not able to offer payment plans.

RMA will make every attempt to resolve insurance claim issues with your insurance company.

Please inform us upon receipt of a new insurance card or any changes in coverage. This prevents delays in processing claims.

If We Do Not Participate With Your Insurance Company Or You Are Uninsured:

All services must be paid on the date services are rendered. We do not carry balances or offer payment plans. RMA of Michigan does not verify benefits or submit claims for insurance companies not listed above.

Payment Methods

The following payment methods are accepted: Money order, cashier check, Debit Card, Visa, MasterCard, and Discover, cash and personal check for payments not to exceed $700.00. IVF deposits may be paid by certified check or credit card and must be paid at least one week in advance of your cycle start.

NSF Check Policy
Returned checks will incur a $25.00 fee for each returned check. Once we receive a returned check, future payments must be made by credit card, money order, and cashier check. Cash can be used when payment does not exceed $700.00.

Cryopreservation and Storage Fees
If you have consented to freeze your embryos, oocyte, and/or sperm, a storage fee will occur. If storage fees are not paid within 30 days, the fee will be considered delinquent. Cryopreservation is not included in your cost estimate and is due within 5 days of the service being performed. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees. Additionally, RMA of Michigan reserves the right to consider unpaid cryopreserved items as unwanted or abandoned and has the right to discard after all internal attempts to obtain payment have been exhausted.

Cancellation of Cycle
If your cycle is cancelled for any reason, you will be charged for all services up to that point. Any cycle deposit money remaining after those services are paid can be refunded to you. Please notify the financial department when the cycle is cancelled so that your refund request can be processed timely. Refunds take approximately 2 weeks from the date of request.

If you are undergoing an IVF cycle and convert to an insemination cycle, you will only be charged for the actual procedures performed during both cycles. An excess amount paid in your cycle deposit will be refunded to the patient/guarantor once the patient has been released from care and all insurance dispositions received.

Medications
Your physician will provide you with the necessary prescriptions for your treatment cycle. You may have the prescriptions filled at your local pharmacy or we can recommend a specialty pharmacy that may offer a cost advantage if your fertility medications are not covered by insurance. Some insurance companies require prior authorization before they will cover the cost of the fertility medications. We will complete the paperwork necessary to obtain this authorization when necessary.

Anesthesia
Anesthesia Staffing Consultants, Inc. (a separate entity) provides our patients with anesthesia services. The anesthesia fee for egg retrieval is **$400.00** and will be **billed to you directly by Anesthesia Staffing Consultants, Inc. (ASC)**. Anesthesia payment is due at the same time your IVF payment is due. ASC accepts checks, Visa, MasterCard, Discover and American Express as method of payment. Any questions regarding your anesthesia charges and to make payment please contact them directly at (**248) 258-5058**.

Subsequent Cycles and Treatment
Your account must be reconciled prior to any new cycle start. This means that you must have a $0.00 balance on both your patient account and insurance account. If it is not, you will not be able to proceed with the start of further treatment until it is reconciled.

Requests for Medical Records
We will gladly provide you with copies of your medical records. For each request we must have a signed medical records release form which contains the name, address and fax number of the healthcare provider where you wish the records to be sent. This form is available on our website at www.rmami.com. Spouses cannot authorize record release for one another. Copying fees, based upon the Michigan Medical Records Access Act, Act 47 of 2004, are $23.00 per request for 2012 and can change on an annual basis. This fee may be waived when your medical records are for the purpose of sharing with your primary care doctor or your ob-gyn. We cannot copy your medical records that were provided to us from your other healthcare providers. You will need to contact those healthcare providers directly. Please allow five (5) days for us to respond to your copying request.

Refunds
Overpayments and credit balances will be refunded to the appropriate party after review of the account. Patient refunds will not be processed until all insurance dispositions are received, if applicable. Once a refund is requested, it may take up to 2 weeks to be processed.

Delinquent Accounts
All accounts that cannot be collected by RMA of Michigan will be referred to a collection agency or attorney for further collection action in accordance with established guidelines as deemed appropriate. Any fees assessed will be the responsibility of the debtor. Additionally, RMA will no longer be able to offer care to those whose accounts needed third-party assistance to collect on the debt.

Patient Acknowledgement and Guarantee
I have read, understand, and agree to the Patient Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility and I guarantee that my account with RMA will be paid per the terms of the Agreement.

____
Print Patient Name

____ _______________
Signature of Patient Date