Male New Patient Information

Red Rock Fertility

Patient Information

First Name: _____ M.I. _____ Last Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H) _____ (C) _____ (W) _____

Employer: _____ Occupation: _____

Race: ❑ Black ❑ Caucasian ❑ Filipino ❑ Hispanic ❑ Indian ❑ Native American ❑ Other
(Please check one for reporting requirements)

Please check one: ❑ Married ❑ Divorced ❑ Single Who referred you to us? _____

Who is your OB/GYN? _____ Ph: _____

Who is your Primary Care Physician? _____ Ph: _____

Emergency Contact Name: _____ Ph: _____ Relationship: _____

Insurance Information (you may leave blank if you gave us your insurance card)

Primary Insurance: _____ Phone: _____

Insured: _____ ID#: _____ Group#: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Phone: _____

Insured: _____ ID#: _____ Group#: _____

Address: _____ City: _____ State: _____ Zip: _____

Partner Information

First Name: _____ M.I. _____ Last Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H) _____ (C) _____ (W) _____

Employer: _____ Occupation: _____

Race: ❑ Black ❑ Caucasian ❑ Filipino ❑ Hispanic ❑ Indian ❑ Native American ❑ Other
(Please check one for reporting requirements)

Partner Insurance Information (you may leave blank if you gave us your partner's insurance card)

Primary Insurance: _____ Phone: _____

Insured: _____ ID#: _____ Group#: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Phone: _____

Insured: _____ ID#: _____ Group#: _____

Address: _____ City: _____ State: _____ Zip: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Red Rock Fertility Center or insurance company to release any information required to process my claims.

Patient Signature: _____ **Date:** _____

Patient Contact Information and Consent

There are many instances that we will need to be calling you with test results, appointment, or billing information. We will identify ourselves by name and "from his or her Dr.'s office." We would like your permission to do the following:

Please circle your answer

May we call your home?	Yes	No	N/A
Home phone #:_____			
When we call you at home, may we leave a message?	Yes	No	N/A
May we call your mobile phone?	Yes	No	N/A
Mobile phone #:_____			
When we call you on your mobile phone, may we leave a message?	Yes	No	N/A
May we contact you via text message?	Yes	No	N/A
May we call you at work?	Yes	No	N/A
Work phone #:_____			
When we call you at work, may we leave a message?	Yes	No	N/A
May we contact you via email?	Yes	No	N/A

Email address:_____

If we need to fax or mail your medical records anywhere, we require a written records release form signed by you. A separate form is required for you and your spouse.

Due to HIPAA regulations, Red Rock Fertility Center cannot discuss any medical or financial information to anyone without your permission. Please list those individuals to whom we may release this information:

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Patient Signature:_____ **Date:**_____

Billing and Financial Policies

Your billing representative will do the following for you:

- Verify your benefits prior to your first appointment
- Get pre-authorization on any procedures that your insurance company requires
- Answer any questions regarding insurance on your account

Our office will verify your insurance prior to your first visit. The benefits quoted to Red Rock Fertility Center are not a guarantee of payment. Understand that ultimately it is the patient's responsibility to know his/her own insurance coverage. If you dispute your benefit coverage in any way, please contact your insurance company. If you receive different benefit information from your insurance, have your insurance company give your representative a call or request this in writing.

Initials:_____

Your billing representative will obtain all authorizations required by your insurance. Please be advised if your insurance requires our office to obtain authorization or referral before services are rendered, you need to give **at least** 72 hours to obtain this information for you. If there is a problem in obtaining this for you, you will be notified before the time of service. However, even though our office has obtained prior authorization for any services done in our office, this is not a guarantee of benefits or payment to our facility. Therefore, if you do not have the benefits for the services you will be responsible for all charges incurred on that date of service. If you do not have the benefits, our facility will make every possible effort to get the services paid for you.

Initials:_____

We must emphasize that payments are due **before** services are rendered, unless prior arrangements have been made with your billing representative. We realize that financial problems do arise. If this happens, please contact us promptly if you need assistance in the management of your account. Please be advised that a new treatment cycle cannot be started until any previous account balances have been paid in full. Therefore, payment is expected at the time of your visit. For your convenience, we do accept MasterCard, Visa, Discover, and American Express.

Initials:_____

Your billing representative will be happy to answer any of your questions or concerns. Due to the fact that we give personalized attention to each patient, there may be times you must leave a message. We will make every attempt to return your call promptly.

Initials:_____

Print Name:_____

Patient Signature:_____ **Date:**_____

Authorization to Pay Benefits and Financial Responsibility

Patient Name (please print):_____

I hereby authorize payment of medical benefits to Red Rock Fertility Center for services rendered. I also authorize the physicians to release any information in the course of my examination or treatment. The assignment will remain in effect, until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

Patient Signature (or responsible party):_____ **Date:**_____

I,_____, hereby agree to be financially responsible for all charges incurred, regardless of insurance coverage In the event my account is referred to a collection service due to non- payment, I agree to pay collection/legal fees that are incurred. I also understand that a $32.00 NSF fee will be charged for checks initially returned unpaid by my account. If the same check is returned unpaid for a second time, I understand it may be referred to a collection service for recovery.

Patient Signature (or responsible party):_____ **Date:**_____

I,_____, understand that although the doctors at Red Rock Fertility Center (RRFC) may order blood work or testing to be done at an outside lab or facility, I will receive a bill from the outside lab or facility, not from RRFC. I understand that I am fully responsible for the outside bills and if I have any questions or problems with the bills, I will contact the lab or facility directly.

Patient Signature (or responsible party):_____ **Date:**_____

Practice Privacy Notice

Your Information. Your Rights. Our Responsibilities.

This Privacy Notice is effective as of May 1, 2014.

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost---based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out---of---pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost---based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Contact Officer.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights Web: http://www.hhs.gov/ocr/privacy/hipaa/complaints/

Phone: 1-877-696-6775

- We will not retaliate against you for filing a complaint.

Privacy Contact Officer

- The Provider's Privacy Contact Officer's information is:

Lee A. Stickney, CDP
Red Rock Fertility Center
9120 W. Russell Rd, Ste 200
Las Vegas, NV 89148
Phone: 702--262--0079

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at anytime. Let us know in writing if you change your mind.**

For more information visit: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Practice Privacy Notice

Acknowledgements:

I hereby **acknowledge** that I have been presented this Privacy Practice Notice:

Print Name:_____ Date:_____

Patient Signature: _____ Date: _____

OR

Acknowledgement Refusal:

On this date, the patient listed below **refused** or **failed to acknowledge** receipt of this Privacy Practice Notice.

Print Name:_____ Date:_____

Patient Signature: _____ Date: _____

Provider Employee Signature:_____ Date: _____

Photography Release Form

I do hereby consent to the use of the photograph(s) (including holiday or other cards) or video of myself and/or my baby in association with any production, media, display, or news events for Red Rock Fertility Center.

I understand that Red Rock Fertility Center may use the photograph(s), video or stories in the office, publications, press materials, web sites, and print and television advertisements, etc. promoting the practice.

I hereby irrevocably consent to and authorize the use and reproduction by you, or anyone authorized by Red Rock Fertility Center, of any and all photographs which you have taken, without compensation to me. All photos shall constitute the property of Red Rock Fertility Center, solely and completely.

*I hereby **consent** to the use of my use of photograph(s) and/or video for the use of display and/or marketing purposes.*

Print Patient Name:_____ Date:_____

Patient Signature:_____ Date: _____

OR

*I hereby **refuse** the use of my photograph(s) and/or video for the use of display and/or marketing purposes.*

Print Patient Name:_____ Date:_____

Red Rock Fertility Center
9120 W. Russell Rd, Ste 200
Las Vegas, NV 89148

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After the arbitration hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages, which apply in court proceedings, also apply in arbitration.

Does arbitration prevent you from making a claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he will determine a damage award.

The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of the doctor is bound.

What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are substituting an arbitrator for a jury to resolve your claims. You can still call and question witnesses, present evidence, and have an attorney of your choice, at your expense. This agreement generally helps to lower litigation time and costs for both patients and physicians. Further, both parties are spared the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

Red Rock Fertility Center
9120 W. Russell Rd, Ste 200
Las Vegas, NV 89148

PHYSICIAN-/-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1---4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ **INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."**

By: _____
Physician or Duly Authorized Representative Signature

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

Littman Medical Services, PC D/B/A Red Rock Fertility Center
Print Name of Physician, Medical Group or Association Name

_____
Print Patients Name

By: _____ / _____
Signature of Translator (Date)

By: _____/_____
Patient's Representative Signature Date

_____
Print Name of Translator

_____
Print Name and Relationship to patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records