

## **ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

### **NOTICE OF PRIVACY PRACTICES:**

With this Form you have been provided with a copy of our Notice of Privacy Practices which provides a full description of how we will use and disclose your individually identifiable health information, including uses and disclosures for treatment, payment, and health care operation purposes. This Notice also explains important rights you have regarding your health information. Boston IVF Inc. and IVF New England (hereinafter referred to as the “Practice”) reserves the right to change its Privacy Notice at any time but you may always obtain a current copy upon request or by going to our website: [www.bostonivf.com](http://www.bostonivf.com).

### **USE AND DISCLOSURE OF INFORMATION:**

As described in our Notice of Privacy Practices, we will use and disclosure your individually identifiable health information for a variety of treatment, payment and health care operations purposes. As part of your treatment, we expect that you will want and allow us to share, without restriction, all of your health information related to the treatment of you and your partner. Unless you specify any restrictions in the space provided below, you are hereby consenting to such treatment-related disclosures to your reproductive partner while you are undergoing treatment by our Practice. The disclosure of your information may be made via mail, telephone, fax, e-mail, and/or Internet as may be necessary for the Practice to complete these purposes. If your health information contains any privileged or additionally protected information under State or Federal law you will be asked to sign a specific authorization for the release of this information.

### **ASSIGNMENT OF BENEFITS:**

In consideration for services and treatment rendered, I hereby assign, transfer, and set over onto the Practice all health insurance. I hereby direct my insurance company to make all payments for treatment and testing provided by Boston IVF Inc. and IVF New England to be sent directly to the Practice.

### **RESTRICTIONS ON USES AND DISCLOSURES:**

As explained in our Notice of Privacy Practices, you have the right to request how the Practice uses and discloses your health information for the purposes of treatment, payment and health care operations, and disclosures to family members or friends. You also have the right to ask us to send communications including your health information to an address of your choice or that we communicate with you in a certain way (e.g. do not leave messages on my home answering machine). While we are not required to grant any such request, you may indicate your desired restrictions or instructions:

---

**ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF  
HEALTH INFORMATION**

I hereby give consent to the Practice, and its professionals, employees and agents, to use and disclose my individually identifiable health information as described above. I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I understand that I can contact the Practice Privacy Officer at 781-434-6500 if I have further questions or any complaints. I hereby release Practice, its professionals, employees, and agents, from all liability arising from the use and disclosure of my health information for treatment, payment, and operations purposes. I understand that I may revoke this consent in writing except to the extent the Practice has already taken actions in reliance on it. I understand that if I revoke this consent, the Practice may refuse to provide me with further treatment. I also understand that this consent authorizes the Practice to use and disclose all past information documented in my medical record in accordance with its Privacy Notice.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Patient/Guardian Name (print)

\_\_\_\_\_  
Date

## **UNDERSTANDING YOUR INSURANCE BENEFITS**

Welcome to Boston IVF. We know that insurance and financial matters can be complicated. This document is designed to outline important insurance and financial information that you need to know while receiving services at Boston IVF. Please read this document carefully as your signature on this form indicates you have read and understand the information. This document will be valid during your entire time as a patient here at Boston IVF.

- Please contact your insurance company as it is **your** responsibility to obtain your infertility benefits. Your insurance company's customer service representatives, as well as your employer's benefits personnel will help you to understand your plan, **what it covers, and what it does not.**
- Your insurance company may require referrals from your primary care physician for your visits. It is your responsibility to obtain these referrals. If you are not able to obtain a referral from your primary care physician you will be charged for your visit(s).
- If your insurance plan imposes a dollar limit on your treatment, you are responsible for keeping track of the money paid by your insurance. Once you have met this dollar maximum, you will be responsible for the cost of services that are provided to you.
- Please notify us **immediately** of any changes to your insurance. If your coverage terminates while you are undergoing treatment, you will be financially responsible for charges incurred during your lapse in coverage. Due to the pre-authorization requirements of the insurance companies, if you change insurance plans while undergoing a treatment cycle, your cycle may be delayed or cancelled and you may be responsible for the cost of that treatment cycle. If you proceed with any treatment that has not been approved by your insurance company, you will be responsible for those charges.
- Many patients choose to freeze sperm and/or embryos at our facility. This may or may not be a covered benefit under your plan. Please check with your insurance company to determine if these services are a covered benefit for you.
- There are annual storage charges for frozen embryos as well as frozen sperm that are not covered by insurance. Contact your financial counselor for our current prices for these services.
- We require 48-hour notice if you are canceling your appointment. If you do not cancel your appointment with a **48 hour notice** or if you do not appear for your appointment you will be responsible for a late cancellation or no show fee of up to the full cost of the visit.
- All charges on your account are due prior to services being rendered. In the event your account becomes delinquent, you will be responsible for all collection costs including any attorney fees.

**CREDIT POLICY:** It is our policy that payment is required at the time of service. If you have insurance and your insurance plan provides coverage for infertility services, we will bill them for you. All deductibles, co-pays, or percentages of fees must be paid at the time of service. If insurance is denied, payment in full is required prior to commencement of any services

**UNDERSTANDING YOUR INSURANCE BENEFITS**

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize that payment of all insurance claims on my behalf be made directly to Boston IVF.

**RELEASE OF INFORMATION:** I hereby authorize Boston IVF to release to my insurance company, any medical information, including diagnosis and records of treatment, necessary to process my insurance claims.

**AGREEMENT OF FINANCIAL RESPONSIBILITY:** I understand that if I do not have insurance I am financially responsible to Boston IVF for any services I receive. I also understand that if I have insurance coverage, I will be financially responsible for any amount not covered by my insurance company. **During my treatment monitoring with ultrasounds and blood work may be required. I understand that if I use a monitoring site other than one of the Boston IVF and IVF New England centers I will be responsible for all charges incurred. I understand that I must provide Boston IVF and IVF New England with any changes to my personal and insurance information immediately and by signing below indicate that the information I reviewed on this form is correct.** Failure to provide this information will result in my account becoming my sole financial responsibility, payable immediately. In the event that this account becomes delinquent, I agree to pay all costs associated with collecting this debt, which may include reasonable collections and attorney's fees.

**MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED IN THIS DOCUMENT.**

---

Signature

---

Date

---

Print Name

# **Boston IVF, LLC**

## **NOTICE OF PATIENT RIGHTS**

### **EVERY PATIENT OF THIS HEALTH CENTER SHALL HAVE THE FOLLOWING RIGHTS:**

1. The right to ask the name and specialty, if any, of the physician(s) or other persons responsible for your care and the coordination of your care.
2. Confidentiality of all records and communications to the extent provided by law.
3. To have all reasonable requests responded to promptly and adequately within the capacity of the facility.
4. Upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or educational institution in so far as said relationship relates to his/her care of treatment.
5. Upon request, to receive, from a person designated by the facility, any information which the facility has available, relative to financial assistance.
6. Upon request, to inspect his/her medical records and to receive a copy of the medical records, the copying fee will be in accordance to that set by the federal government.
7. To refuse examination, observation, or treatment, by students, or any other facility staff, without jeopardizing access to psychiatric, psychological, or other medical care or attention.
8. To refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic.
9. To privacy during medical treatment or other rendering of care within the capacity of the facility.
10. To prompt life saving treatment in an emergency without discrimination due to economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment.
11. To informed consent to the extent provided by law.
12. To change providers upon request, if other qualified providers are available.
13. Upon request, patient has the right to receive a copy of an itemized bill or other statement of charges submitted to any third party, by the facility for their care, and to have a copy of said itemized bill or statement, sent to the attending physician of the patient or resident upon request.
14. To be free from any form of discrimination and to be free of all forms of abuse and/or harassment.
15. To file a formal patient complaint against a specific physician at the Surgery Center of Waltham. Physician complaints are filed with Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 or consumer line 1-800-377-0550.
16. Patient may speak with a Patient Advocate or Manager to lodge a complaint or grievance without fear of reprisal. If grievances are not resolved to your satisfaction, you have the right to contact the AAAHC (Accreditation Association of Ambulatory Surgery Centers) at 1-847-853-6060 or the Massachusetts Department of Public Health (DPH) directly at the following location: Commonwealth of Massachusetts, Department of Public Health, Division of Health Care Quality, Complaint Unit, 10 West Street, 5th Floor, Boston, MA 02111. Hotline: 1-800-462-5540.

# Boston IVF, LLC

## NOTICE OF PATIENT RIGHTS

17. To report any Medicare beneficiary issues you may visit the Ombudsman's webpage at: [www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp)
18. The right to file an Advanced Directive, allowing you to appoint a health care proxy. (Mass. General Law, Chapter 210D). Forms are available upon request. Please note that under Massachusetts Law, your Advanced Directive will not be effective in the event of a medical emergency. **If you suffer a serious medical event while at the SCW, you will receive emergency medical care and your Advanced Directive will accompany you to the emergency receiving facility.**
19. If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient shall be exercised by the person appointed under State law to act on the patients' behalf. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.
20. Each patient has the right to receive a listing of Physician Shareholders providing patient care.

Current shareholders are listed below:

Dr. Michael Alper

### **YOUR RESPOSIBILITIES TO THIS HEALTH CENTER ARE:**

1. To provide accurate and complete information regarding medical history, hospitalizations, and current health concerns.
2. To participate and collaborate in your treatment, and to follow treatment plans recommended by physicians and other health professionals working under the attending physician's direction.
3. To provide accurate and complete financial information and work with the medical center to ensure that financial obligations related to your care are met.
4. To accept personal financial responsibility for any charges not covered by insurance.
5. To provide a responsible adult to provide transportation home, and to remain with you, as directed by the provider or as indicated on discharge instructions.
6. To behave respectfully toward all health care professionals and staff, as well as other patients and visitors. Disruptive, violent, or threatening behavior may result in termination of care.

If I am transferred to a Hospital or Emergency Room, I give a designated representative of Boston IVF permission to request information about my care. **Yes / No**

**I have read and reviewed the above information and had to opportunity to obtain more information and ask questions.**

---

**Patient Acknowledgement**

---

**Date**

**E-MAIL CORRESPONDENCE CONSENT (eIVF version)**

**APPROPRIATE PURPOSE FOR E-MAIL CORRESPONDENCE**

E-mail may be used to request information and ask non-urgent questions. **It is NOT to be used for emergencies or for time sensitive issues related to your medical care.** Please contact your physician by phone with questions or concerns that are time sensitive. E-mail correspondence is reviewed by Boston IVF and IVF New England during regular business office hours. Reply to e-mail may occur on the following business day. If you experience a sudden or severe change in your health, or otherwise need an immediate response, please contact 911 immediately.

**PATIENT RESPONSIBILITY**

Requests to change your e-mail address on record must be made to our Registration Department or your physician's Administrative Assistant. Changes made in regards to your e-mail correspondence will be documented in your medical record. You may revoke consent to use e-mail as a form of correspondence in writing at any time, except to the extent the practice has already made disclosures.

**PRIVACY RECOMMENDATIONS**

We cannot and do not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, your employer may view any e-mail sent on your employer's system.

**E-MAIL USE ACKNOWLEDGEMENT**

I have been informed of and understand the risks and requirements involved with using e-mail as a form of correspondence. I understand that the confidentiality of my individually identifiable health information may be compromised when sent through electronic transmission via e-mail. I agree to the terms listed above, and I hereby voluntarily accept e-mail as one form of communication with my physician and staff at Boston IVF / IVF New England.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth