Financial Policy

Reproductive Services of Indiana ***Michael A. Henry, M.D.***

Monitoring Patients Only

1. *Monitoring Patients*: You will be required to pay for services rendered on the day of your visit with the clinic. You will be required to pay for any additional fees generated during your visit._____(Initial)
2. *We do not take insurance for outside monitoring patients*. This program is run through our third party account Reproductive Services of Indiana. This account does not have any contracts with insurance companies. You may file your charges with your insurance if you have out of network coverage, but will be required to pay the difference in what is paid and what is charged to our office.

Please feel free to contact our Billing Manager to answer any questions you may have regarding financial issues. Call 317.817.1800 – opt. 2

I have read and fully understand the financial policy listed above. I understand that I will be given a copy of this policy for my records.

Patient's signature Date

Witness Date

Outside Monitoring Patient Registration Form

Reproductive Services of Indiana ***Michael A. Henry, M.D.***

Appointment Day Appointment Date Appointment Time

PATIENT INFORMATION: ** FEMALE PATIENT ONLY **

Last Name: First Name: Middle Initial:

Maiden Name: E-Mail Address:

Address: City: State: Zip Code:

Home Phone: Cell Phone: DOB: Age: Sex:

SS#: Ethnicity: Marital Status:

PHYSICIAN INFORMATION

Ordering Physician: Address:

City: State: Zip Code: Phone:

Referring Agency: Address:

City: State: Zip Code: Phone:

Contact at the Agency:

IN CASE OF EMERGENCY CONTACT: (OTHER THAN SPOUSE)

Name: Relationship:

Home Phone: Work Phone: Cell Phone:

Address:

Consent to Treat: I request and give consent to Reproductive Services of Indiana to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as considered necessary or beneficial by my ordering physician/agency for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial_____

Assignment and Release: I authorize Reproductive Services to release information from my medical record to the ordering physician and referring agency.

Initial_____

Financial Agreement: I understand the fees for all services rendered are the full responsibility of the patient or referring agency. All services are cash pay and due in full at the time of each appointment. Reproductive Services of Indiana does not accept any insurance payments for outside monitoring services. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initial_____

I understand the above and fully understand the terms thereof:

SIGNATURE OF MONITORED PATIENT OR RESPONSIBLE PARTY DATE

12/23

Outside Monitoring Protected Health Information Authorization

Reproductive Services of Indiana ***Michael A. Henry, M.D.***

I, _____

(Patient name) (Address)

_____

(City, state, zip code) (Date of birth)

request that the following options be followed for the disclosure of my Protected Health Information, (which would include your name, diagnosis, test results, and dates of service) as described in the Notice of Privacy Practices for Protected Health Information.

PLEASE LIST ALL THAT APPLY:

Reproductive Services of Indiana may disclose information to the following persons (you must list name, phone number and relationship).

Name	Phone Number	Relationship

_____

(Patient's Signature) (Date)

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the Office Manager at Henry Fertility.

201 Pennsylvania Parkway ♦ Suite 325 ♦ Indianapolis, Indiana ♦ 46280 ♦ Ph: 317.817.1800 ♦ Fax: 317.817.1810

Contract for Outside Monitoring Patients

Reproductive Services of Indianan ***Michael A. Henry, M.D.***

Monitoring Patients Only

1. As an outside monitoring patient, I understand that Dr. Henry is not my physician and the staff at Reproductive Services of Indiana is not responsible for answering questions or giving opinions on the services rendered or the treatment ordered.

2. I will be on time for my monitoring appointments and realize that there are situations in which the patients under the care of Dr. Henry and the Henry Fertility staff will come first. Although I am on time, I realize my appointment time could be subject to delay.

3. All questions relating to my care will be directed to the ordering physician and staff. The staff at Reproductive Services of Indiana's job as the clinic, is to facilitate the orders as sent by the ordering physician and report the results to them. If I have questions about the tests or results, I will direct my inquiry to my doctor's office.

I have read and fully understand the contract and understand the relationship with Reproductive Services of Indiana.

Patient's signature _____ Date _____

Witness _____ Date _____