Fertility & Reproductive Endocrinology Specialists (FRES) d.b.a. Reproductive Health and Fertility Center (RHFC)
973 Featherstone Road, Suite 100 Rockford, IL 61107 and 900 Main Street, Suite 330 Peoria, IL 61602
Toll Free 877.373.7552

PLEASE PRINT CLEARLY – USE INK ONLY

Date ___________________

Patient *(first name, middle initial, last name)* ___________________ Date of Birth ___________________ SS# ___________________

Contact phone number(s): home ___________________ cell ___________________ work ___________________

Home Address ___________________ City, State, Zip Code ___________________

EMAIL Address (optional) ___________________

Occupation ___________________ Employer Name, Address & Phone ___________________

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Referring Physician (if applicable) ___________________

Address/Phone Number: ___________________

Spouse/Partner *(first name, middle initial, last name)* ___________________ **Spouse/Partner** Date of Birth ___________________

Spouse/Partner SS# ___________________ **Spouse/Partner** Phone # ___________________

Home Address (if different than above) ___________________ City, State, Zip ___________________

Spouse/Partner Occupation ___________________ Employer Name, Address & Phone ___________________

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Please provide the most up-to-date Insurance information below and present Insurance ID Card(s) to FRES Business Representative.
Failure to comply will prohibit FRES from submitting your insurance claim and payment in full will be required at each scheduled visit.

Primary Insurance ___________________ Policy ID# ___________________ Group# ___________________

Policy Holder ___________________ Employer Name/Group ___________________ Customer Service Ph# ___________________

Secondary Insurance ___________________ Policy ID# ___________________ Group# ___________________

Policy Holder ___________________ Employer Name/Group ___________________ Customer Service Ph# ___________________

Tertiary Insurance ___________________ Policy ID# ___________________ Group# ___________________

Policy Holder ___________________ Employer Name/Group ___________________ Customer Service Ph# ___________________

Please provide Emergency Contacts

#1 Name ___________________ Relationship to the Patient ___________________ Ph# ___________________

Home Address ___________________ City, State, Zip ___________________

#2 Name ___________________ Relationship to the Patient ___________________ Ph# ___________________

Home Address ___________________ City, State, Zip ___________________

RECEIPT of NOTICE OF FRES, SC. FINANCIAL DISCLOSURE

The information I have provided above is correct to the best of my knowledge and I am fully aware of my responsibility to update any and all contact details above as changes occur. I hereby acknowledge that I have received a copy of the ***Fertility & Reproductive Endocrinology Specialists (FRES) d.b.a. Reproductive Health and Fertility Center (RHFC)*** Notice of Financial Disclosure. This document fully describes my financial responsibilities as a patient and/or guarantor, in addition to rights of the ***Fertility & Reproductive Endocrinology Specialists (FRES) d.b.a. Reproductive Health and Fertility Center (RHFC).*** to uphold the financial policy.

Patient Signature ___________________ **Date** ___________________

RECEIPT of FRES, SC. NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the ***Fertility & Reproductive Endocrinology Specialists (FRES) d.b.a. Reproductive Health and Fertility Center (RHFC)*** Notice of Privacy Practices describing my rights as a patient and the ***Fertility & Reproductive Endocrinology Specialists (FRES) d.b.a. Reproductive Health and Fertility Center (RHFC)*** obligations regarding the use and disclosure of my health information.

Patient Signature ___________________ **Date** ___________________

For office use only: *To be completed if FRES, SC. Notice of Privacy Practice (NOPP) and/or Notice of FRES, SC Financial Disclosure is/are declined when provided:*
In my attempt to provide FRES' Notice of Financial Disclosure and FRES' Notice of Privacy Practices, ___________________ has declined to accept/receive a copy of:
(Please print Patient Name)

☐ FRES' Notice of Financial Disclosure ☐ FRES' Notice of Privacy Practices

___________________ ___________________ ***FRES Registration Received by:*** ___________________
FRES Representative Signature Date *(FRES Representative Initials & Date)*

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AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE

I , ____ authorize FRES, SC. d.b.a. RHFC to bill my insurance company(ies)
(please print name)
for all services that FRES, SC. d.b.a. RHFC has provided to me, unless otherwise identified by FRES, SC that the charge is a non-billable fee. I understand that my insurance card(s) provide proof of my insurance coverage and this information is required to be kept on file. I understand and agree that FRES, SC. d.b.a. RHFC will provide copies from my medical chart to my insurance company (ies) to assist in the review of benefit determination, claim review, and claim processing, in addition to any appeal initiated by FRES Business Office. I fully understand that my medical record may contain information pertaining to my psychiatric, mental health, developmental disabilities, alcohol and/or drug abuse information, and/or AQUIRED IMMUNE DEFICIENCY SYMDROME (AIDS)/HIV TEST RESULTS. I have the right to inspect and arrange for photocopies of the records that are to be disclosed.

I understand that my refusal to consent to the release of the above mentioned information will prevent the disclosure of this information. I understand that if this authorization is for the purpose of third party payment, the failure to release medical information for this purpose may adversely affect my entitlement to insurance benefits.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken. This authorization for release of information to my insurance company(ies) is valid for the duration of all services provided at FRES, SC. d.b.a. RHFC, unless I revoke it.

INSURANCE ASSIGNMENT

In consideration for all medical and billing services provided to me by the FRES, SC. d.b.a. RHFC, I assign and transfer to FRES, SC. d.b.a. RHFC all of my claims and rights to payment under any insurance policy(ies)by which I am covered, to the extent of charges incurred at FRES, SC. d.b.a. RHFC. By this assignment, I grant FRES, SC. d.b.a. RHFC, full power and authority to exercise my rights under said insurance policy (ies), to collect and to receive payments, to bring legal action to exercise said rights and to do all the things that I might do. I further promise to cooperate with FRES, SC. d.b.a. RHFC, in any action that it might become involved to enforce my rights to payment under any policy of insurance. I understand that this assignment shall remain in effect for all services provided by FRES, SC. d.b.a. RHFC, unless specifically revoked in writing by me, as the patient and guarantor of my account.

____	____
Patient Name (please print)	**Patient Signature**
____	____
Name of Parent/Legal Guardian (please print) ***if Patient is defined as a minor by age**	**Parent/Legal Guardian Signature**

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FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I am financially responsible to FRES, SC. d.b.a. RHFC, *for all charges incurred for services requested and provided to me and/or including payment that is not received by my insurance company (ies). I understand and agree that I am responsible for all charges that are considered by my insurance company (ies) to be non-covered, and/or for care that is, in the opinion of my insurance company (ies), determined to be not medically necessary and/or when usual and customary fees have been applied. I agree to pay all amounts that I owe and/or not paid by my insurance company (ies) to* FRES, SC. d.b.a. RHFC.

I understand and agree that any and all personal checks made payable to FRES, SC. d.b.a. RHFC, *will automatically be subject to* FRES, SC. d.b.a. RHFC*'s policies governing personal checks returned for non-sufficient funds. I acknowledge and agree for a third-party check collection agency to electronically debit from my account any and all dishonored personal checks (aka "insufficient funds") plus a processing fee with equitable taxes. I further understand and agree that any charges that* FRES, SC. d.b.a. RHFC, *incurs due to my dishonored check(s) is transferable to me and will become my financial responsibility and that I may incur additional charges from my own banking institution.*

I understand and agree that FRES, SC. d.b.a. RHFC, *may, upon my default of this agreement, take any necessary action against me to collect all sums due. I understand and agree that I will pay all costs of collection, including but not limited to agency fees and interest rates, attorney fees, court costs and reporter fees, and any and all other expenses which* FRES, SC d.b.a. RHFC *may incur. I also understand and agree that* FRES, SC. d.b.a. RHFC, *may charge me a service fee in addition to the balance that is being forwarded to the collection agency as appointed by* FRES, SC. d.b.a. RHFC *and any claim or dispute that may arise, directly or indirectly, as a result of receiving services from* Fertility & Reproductive Endocrinology Specialists (FRES, SC.) d.b.a. Reproductive Health and Fertility Center (RHFC) *MUST be resolved by a court located in Winnebago County, Illinois. You agree to submit to the personal jurisdiction of the courts located within Winnebago County, Illinois, for the purpose of litigating all such claims or disputes.*

By providing my signature below, I hereby state that I have read and understood the financial disclosure and agreement policies of FRES, SC. d.b.a. RHFC *and agree that I am identified as the guarantor and financially responsible party for all charges incurred and any said actions that may and will be taken against me by* FRES, SC. d.b.a. RHFC.

______________________________	______________________________
Patient Name (please print)	**Patient Signature**
______________________________	______________________________
Name of Parent/Legal Guardian (please print)	**Parent/Legal Guardian Signature**