Delaware Institute for Reproductive Medicine, P.A.
dreams, science, reality

Jeffrey B. Russell, MD, FACOG, Director
Board Certified Reproductive Endocrinology & Infertility
4745 Ogletown-Stanton Road • Suite 111 • Newark, DE 19713
Tel: 302-738-4600 • Fax: 302-738-3508
556 South DuPont Blvd. • Suite H • Milford, DE 19963
Tel: 302-424-6645 • Fax: 302-424-6647
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DEMOGRAPHICS & BILLING INFORMATION

Patient Name: _____ Date of Birth: _____ SS#: _____
Address: _____ Email: _____
City/State/Zip: _____ Home Phone: _____
Employer Name: _____ Work Phone: _____
Occupation: _____ Cell Phone: _____
Pharmacy Name: _____ Pharmacy Phone: _____
Referral Source: ❑Web Search ❑Social Media ❑Word of Mouth ❑Physician: _____
If previous patient, please provide name so that we may send a "Thank You" _____

Primary Insurance Carrier: _____
Address/City/State/Zip: _____
Insurance Phone: _____ Subscriber Name: _____
Group/Account Number: _____ Subscriber ID: _____

Secondary Insurance Carrier: _____
Address/City/State/Zip: _____
Insurance Phone: _____ Subscriber Name: _____
Group/Account Number: _____ Subscriber ID: _____

Partner Name: _____ Date of Birth: _____
Address: _____ SS #: _____
City/State/Zip: _____ Email: _____
Employer Name: _____ Home Phone: _____
Occupation: _____ Work Phone: _____
Primary Care Physician: _____ Cell Phone: _____

Primary Insurance Carrier: _____
Address/City/State/Zip: _____
Insurance Phone: _____ Subscriber Name: _____
Group/Account Number: _____ Subscriber ID: _____

Secondary Insurance Carrier: _____
Address/City/State/Zip: _____
Insurance Phone: _____ Subscriber Name: _____
Group/Account Number: _____ Subscriber ID: _____

I certify that the above is true and accurate to the best of my knowledge.

_____ _____
Patient Signature Date

_____ _____
Partner Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____
SS#: _____ *E-Mail: _____

I,_____, hereby authorize any hospital, physician, laboratory or medically related facility to disclose or furnish in writing a report of my diagnosis, treatment, prognosis and recommendations a well as any other data pertinent to my treatment to: *Jeffrey B. Russell, M.D. and the Delaware Institute for Reproductive Medicine, PA.* I also authorize the disclosure in writing of any or all information with respect to my present illness, medical history and treatment to any physician or medical facility at which I have been seen or that I am referred to for further opinion/treatment.

RELEASE OF INFORMATION TO PATIENT

Voicemail:

- ❑ A detailed voice mail message may be left at the following number: _____
- ❑ Do not leave a detailed voice mail message, I will call back for the details.

***Email:**

- ❑ I acknowledge that I have read and fully understand the Patient Consent for Electronic Mail document provided to me. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined therein. In addition, I agree to the instructions outlined therein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. I understand that I may withdraw my consent for email communication at any time by notifying my DIRM Provider in writing. Any questions I may have had were answered.

- ❑ I do not consent to electronic mail communication.

FOR FAMILY, FRIENDS OR SIGNIFICANT OTHERS

I,_____, authorize the following person(s) to share my medical information, including diagnosis, treatment plan, prognosis and care:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Or: ☐ I do not wish any of my information to be shared with anyone at this time.

EXPIRATION DATE OF AUTHORIZATION

This authorization is valid for 12 months from original signature date and may be changed or revoked at any time by the patient or the patient's personal representative by completing, signing and dating a new form.

_____ _____
Patient Signature Date

_____ _____
Partner Signature Date

FINANCIAL POLICY

Full payment for services is due at the time services are rendered, unless you are a member of an insurance carrier in which we participate. If you are a member of an insurance company in which we participate (Aetna, Blue Cross Blue Shield, Cigna, Coventry, Geisinger, Tricare, United Healthcare), full copayment, coinsurance and deductible is due at the time services are rendered. All medications dispensed from our offices must be paid for in full upon receipt of said medication. We accept cash, checks, MasterCard, VISA, Discover, and American Express. We will be happy to help you process your insurance claim form for reimbursement by your insurance carrier.

It is our policy to obtain social security numbers and credit card information from all patients. By asking us to file an insurance claim on your behalf and wait for payment, we are extending credit to you, and as such, a social security number is required. If you decline to provide us with a social security number and credit card, we require payment of patient and partner service(s), in full, prior to each visit. We will provide you with a receipt so that you may seek reimbursement from your insurance company.

Patients who begin a new cycle must have financial clearance from Patient Accounts at their baseline visit. Patients will be required to pay, in full, all patient and partner balances outstanding before they begin a new cycle.

We will gladly discuss your proposed treatment and answer any questions to the best of our ability. However, responsibility for knowing your benefits falls solely upon you and your insurance company. It is your responsibility to contact your insurance carrier directly prior to your appointment to become familiar with your benefits.

We must emphasize that as medical care providers, our relationship is with you and not your insurance carrier. While the filing of insurance claims is a courtesy that we extend our patients, all charges are your responsibility. We realize that temporary financial problems do arise, and we encourage you to contact us promptly for assistance in the management of your account. Overdue (>30 days) account balances will be assessed finance charges, currently at a rate of 25%. Accounts sent to collections will be assessed an additional finance charge of 25%.

As your insurance policy is a contract between you, your employer, and the insurance carrier, we are not party to this contract in any way. Therefore, it is your responsibility to follow up with the insurance carrier on all unpaid claims. If we have not received confirmation from the insurance carrier within 14 days of the billing date, we request your involvement in resolving these issues. Not all services are a covered benefit in all contracts. Some insurance companies select certain services that are excluded from coverage. When we do not participate with a carrier, we do not accept the “usual and customary” payment amount as payment in full for services rendered. You will be responsible for payment of any amounts not allowed by your plan. Payment in full is due immediately upon receipt of your statement.

I have read and understand the above statements. I have been given an opportunity to ask questions and any questions I may have had have been answered to my satisfaction. I hereby authorize Delaware Institute for Reproductive Medicine, P.A. (DIRM) to charge the following credit card for any copay, coinsurance/deductible/denial of services remaining after my insurance carrier has paid my claim(s). This authorization is valid for 12 months/1 year from signed date.

❑MasterCard ❑Visa ❑Discover ❑American Express

Last 4 Digits of Card Number	Expiration Date	CVV Code	Cardholder’s Signature & Date

Signature of Patient	Partner Signature
Printed Name – Patient	Printed Name - Partner

ASSIGNMENT OF BENEFITS & RECEIPT OF NOTICE OF PRIVACY PRACTICES

I (We), _____, hereby authorize the Delaware Institute for Reproductive Medicine, P.A. (DIRM) to release information concerning the care, treatment and cost of said care and treatment to my (our) insurance company(ies) and/or third party administrator(s) which may be responsible for payment of my (our) care and treatment.

I (We) authorize payment directly to DIRM for healthcare benefits and agree that if the cost of the treatment is not reimbursed by my (our) insurance company(ies) and/or a third-party administrator(s) that it shall be my (our) personal responsibility to pay DIRM for the full cost of services rendered. I (We) agree that I (we) am (are) responsible for my (our) percentage of benefits that the insurance company(ies) and/or third-party administrator(s) deems my (our) responsibility.

I (We) understand that the balance of my (our) account is due and payable in full upon receipt of my (our) statement.

Regardless of my (our) health insurance benefit status, I (we) understand and agree that the cost of care and treatment remains my (our) personal financial responsibility. I (We) also agree to pay all costs incurred in collecting amounts due for services rendered under this agreement, including but not limited to attorney's fees and legal expenses.

I (We) have received a copy of the Delaware Institute for Reproductive Medicine, P.A. Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Partner Signature Date

WEBSITE AND SOCIAL MEDIA RELEASE

I (We), _____, ❑do ❑do not hereby grant permission to Delaware Institute for Reproductive Medicine, PA (DIRM) to post my and/or my child's story, photo, or other item, hereinafter referred to as "Materials," I submit to and for DIRM's website, Instagram account, and Facebook account. I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors, from all claims and demands arising out of or in connection with any use of said "Materials", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights. I acknowledge and agree that no sums whatsoever will be due to me because of the use and/or exploitation of the "Materials" or any rights therein.

_____ _____

Patient Signature Date

_____ _____

Partner Signature Date

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I (We) hereby authorize release of my (our) medical records to Jeffrey B. Russell, M.D. and Delaware Institute for Reproductive Medicine, P.A. 4745 Ogletown-Stanton Road, Suite 111, Newark, Delaware 19713. **Please fax my medical records to (302)738-3508.** This authorization is valid for 12 months from original signature date.

PATIENT

Physician/Practice Name:	
Address:	
City/State/Zip:	
Patient Name (Print):	
Patient Date of Birth:	
Patient SS#:	

PARTNER

Physician/Practice Name:	
Address:	
City/State/Zip:	
Partner Name (Print):	
Partner Date of Birth:	
Partner SS#:	

I (We) understand my (our) records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released, except for the following:

□ HIV/AIDS diagnosis/treatment/testing □ Sexually transmitted disease
□Drug/Alcohol abuse/treatment/diagnosis □ Mental illness or psychiatric diagnosis/treatment

Patient Signature _____ Date _____

Partner Signature _____ Date _____

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