Overlake Reproductive Health, Inc., P.S.

Welcome to Overlake Reproductive Health!

Thank you for entrusting your care to us.

Overlake Reproductive Health is a private medical practice specializing in the diagnosis and treatment of female reproductive disorders as well as male infertility. Our clinic is staffed by practitioners who have specialized in reproductive endocrinology and infertility. We provide a team approach to your care.

ORH's aim is to provide the most comprehensive and current diagnostic procedures and methods of treatment. While we cannot always promise success, we do strive to be supportive and professional in every case. Above all, our staff is interested in your well-being. We hope that your care here will be a positive and successful experience.

Please find enclosed in your new patient packet:

- Registration forms
- Medical history questionnaire for you and your partner (separate download)
- Insurance verification form

The downloadable new patient packet as well as any appropriate health history forms can be found on our website. Please fill the forms out completely. The health history as well as all pertinent medical records must be received at least **7 days prior** to your appointment. Otherwise, your appointment is subject to cancellation and rescheduling.

If you have any trouble returning these forms please let us know so we can assist you.

Your first visit will take approximately 90 minutes. If you cannot keep this appointment, please call the scheduling desk at (425) 646-4700 at least 48 hours in advance so that another couple may be given your appointment time; failure to follow this policy will incur a $50 charge.

We appreciate your interest in our clinic and look forward to meeting you in person.

Sincerely,

Kevin M. Johnson, M.D.
Khurram Rehman, M.D.
Jo Overhouse Gray, ARNP
Michele Ingram, ARNP

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Driving Directions

Southbound:
Take exit 13B off I-405 for NE 8th St W, turn right onto 112th Ave NE, Turn Right onto NE 15th St. We are on the Left.

Northbound:
Take exit 13B off I-405 for NE 8th St W, Turn right onto 112th Ave Ne, Turn right onto NE 15th St. We are on the Left.

From the Airport:
Take WA-518 E to I-405 northbound then follow instructions for northbound above

From Seattle:
Depending on where you are coming from either take the I-90 to I-405 North and then follow the northbound directions above; or take the SR520 to I-405 South and then follow the southbound directions above.

Overlake Reproductive Health
11232 NE 15th St, 2nd Floor
Bellevue, WA 98004
(425) 646-4700

www.fertileweb.com

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PATIENT ACCOUNTS AND INSURANCE POLICY

To help you understand and anticipate any difficulties in insurance benefits you may encounter, please review this document.

Insurance coverage in this area of medicine is not as straightforward as in most other areas. For example,

- Many times there is coverage for testing to determine why you are infertile, but no coverage for treatment.
- Many times payment depends on why the service was performed. For instance, if we do an ultrasound of your ovaries to ensure that an ovarian cyst is shrinking, it will be paid, but if we do the ultrasound to track your response to fertility medications, it will often not be paid.
- May times the information we get from your insurer over the phone is incorrect or incomplete.

To best serve you, we have developed this approach:

DETERMINATION OF INSURANCE BENEFITS

When you become a patient at ORH, we contact your insurance company to obtain information regarding the coverage you have for infertility care. We have developed a list of questions that we ask to get a picture of the nature and extent of your coverage. We will provide you a copy of this summary. In order to help understand your fertility benefits we would like you to contact your insurance company. At the end of this packet we have enclosed an insurance verification form to help you ask the right questions. Please compare the information you receive with the summary we provide. If there are discrepancies between the two summaries please call your insurance company directly for clarification.

Unfortunately, this 'verification' of benefits does not oblige insurers to pay. Insurance companies protect themselves by stating that verification of your insurance coverage by them is:

- Not a guarantee of payment, and is
- Not a guarantee of what is actually covered and not covered.

Because of this disclaimer, even when they have told you or us that a service is covered, there is no obligation for them to pay. The true determination as to whether a service is covered is made at the time the claim is received by the insurance company. Whether insurance will pay is dependent on whether:

- The service you received is covered by your plan
- The reason for the service (the diagnosis) is covered by your plan
- The appropriate deductibles and co-pays have been met
- "pre-existing condition" exclusions apply

Further complicating payment is that some plans require that:

- You have experienced infertility for a specified amount of time before services will be covered, or
- The infertility is not due to prior elective sterilization, or
- Certain treatment steps should be taken before other treatment steps will be covered. This may not always be consistent with the course of treatment that we think is best for you. For instance, some companies will pay for IVF treatment, but only after 3 tries of gonadotropin cycles have failed.

There may be occurrences where your insurance company denies payment and deems that a service "is not consistent with the diagnosis" assigned to you.

CLAIMS FILING

For insurance companies/networks with which we are contracted

- We will be happy to file a claim for coverage of rendered services with your insurance company provided

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that you have insurance with a company with which we participate, if your plan provides benefits for the service provided for the reason it was provided, and if there are no other restrictions on covered services of which we are aware. We will collect any required co-payment at the time of your visit.

- If you have insurance with an insurer with which we participate, but your plan does not provide benefits for your diagnosis or for the procedures, then full payment for services rendered is required at each visit. We expect all balances to be settled on the day it occurs.
- Overlake Reproductive Health and Overlake Reproductive Health Laboratory are <u>two separate companies</u> with different insurance participation.
- It is possible that your individual insurance plan from one of the insurance companies listed below is not in-network. Please check with your insurance to verify that your particular plan is in-network with our providers, Dr. Johnson and Dr. Rehman, and our lab.

Overlake Reproductive Health Clinic currently participates in these networks:

- Aetna
- BC/BS
- Cigna
- First Choice
- Multi-plan
- Premera
- Regence Blue shield
- United Health Care

Overlake Reproductive Health Laboratory (Embryology/Andrology Services) is in-network with:

- Premera
- UHC

For insurance companies/networks with which we are not contracted

If you have health insurance with an insurer with which we do not participate, then full payment for all services rendered is required at the time of your visit. As noted above, we require that each patient's balance be settled on the day it occurs. We will provide you with a statement that can be submitted to your insurance company for reimbursement directly to you.

OTHER ITEMS

- Fees for all IVF cycles (IVF, Frozen embryo transfers, egg Recipient/Donor cycles, etc.) are collected in advance of the start of the cycle.
- If you are having surgery, we will calculate an estimate of the charges you would be responsible to pay based on your "in" or "out" of network status and based on the information the insurance company provides to us. This payment is required prior to the surgery. We will also file the claim with our insurance company. If you are "in" network, you are responsible for any patient balance after insurance adjustments have been taken. If you are "out" of network, you are responsible for the difference between what we charge and what insurance pays.
- Occasionally, when the doctors review lab results, they determine that another test is needed to make a complete evaluation. When this occurs, the charges for the additional test will be posted to your account at the time test is ordered.
- Occasionally, our audits detect that services were incorrectly posted to your account, resulting in overcharges or undercharges. When we identify such errors, we will correct your account, resulting in a credit or balance.
- Consultations with the doctors, including new patient appointment, and reconferences are billed by the amount of face time with the doctor when billing insurance. Some insurance statements may state extended time after 1st 30 minutes.

SETTLING BALANCES

As discussed prior, there are times when insurance companies process a claim in a manner different than expected. In these cases,

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- A claim may be completely denied as not covered, with no payment being made, thereby making you entirely responsible for the charge, or
- A claim may pay differently than was anticipated, also thereby making you responsible for a larger portion of the charge than expected.
- even though your insurance company communicated to us and we in turn communicated to you that a given service or set of services is covered, this Is NOT A GUARANTEE BY US of your insurance company's coverage for that service or set of services. If your insurance company denies coverage for any reason, you are responsible for full payment of the services billed. Because the insurance company states that the verbal information they provide is not a guarantee of payment nor can it be relied on as a guarantee of coverage, we are not responsible for any statement made by your insurance company, nor any statement made by us to you based on information given to us by your insurance company. It is very important for you to understand that the only TRUE representation of whether a given service is covered is when your insurance company actually processes the claim.

When this occurs, we will first try to understand why: Was the claim processed correctly? Were the appropriate diagnoses used? Were benefits incorrectly stated to us at verification? Typically an insurance company will send an EOB ("explanation of Benefits") that outlines what they paid and didn't pay and why. If we believe there are errors in the claim, we will resubmit. If you receive an EOB that processed your claim differently than you expected, please call your insurance company to clarify. If the insurance company states that they processed the claim incorrectly, please obtain the name of the person you spoke with, and call us with that information so we can note this in your account. If your insurance company reprocesses the claim, when you receive the corrected EOB showing payment was made to us, please call us to issue a refund to you.

If however there are no errors, we will make the corresponding adjustments to your account, determine the portion of the charge you are responsible for, and post this portion to your account.

As stated previously, there are times when an insurance company states that the test or procedure performed is not consistent with the diagnosis assigned to you. The practitioners at ORH perform or order services to be performed when they determine that they are important in the diagnosis and treatment of the patient for the particular circumstances of the patient. When your insurance company denies payment and renders the decision that the services are "not consistent with the diagnosis," it has decided otherwise.

When services have been performed by/ordered by an ORH practitioner, and your insurance deems the services to be "inconsistent with the diagnosis," your practitioner has deemed them to be important in your diagnosis and treatment and for your particular circumstances. Your signature below acknowledges your agreement that you will be responsible for the payment for these services, should your insurance company deny payment and state that these services are "inconsistent with the diagnosis" assigned to you.

Paying Your Bill Online

You may pay your bill via our website at fertileweb.com/paymybill. Please include the patient name and account number found on the invoice you are going to pay. After you submit the information on our portal you will be taken to a secure payment portal where you can enter the payment information.

Credit Card Authorizations

There are instances of charges being generated or recognized on days when there is no office visit scheduled. With the very busy lives of our patients, it is difficult to reach patients to come in and settle balances as they arise. Therefore, it is our offices' policy to require a credit card authorization be maintained on file so that your balances can be settled as they occur. Our patients find this convenient.

When these cases arise:

- We will mail you a copy of your credit card receipt and your statement on the day the charge is made.

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- An authorization form will be supplied to you and your spouse for your signatures.
- If you choose not to leave a CC on file we require a $500 deposit

Outside Laboratories

We utilize outside labs for some of the necessary testing. We will send your samples to the following outside labs: LabCorp, Pathology Inc., RIA, Reprosource, Counsyl, and Integrated Genetics. You will receive a statement from that lab which you will be responsible for paying. It is your responsibility to let us know if your insurance company is or is not contracted with these labs. We will make every effort to use the lab preferred by your insurance if you tell us which lab to use, although it may not be possible in all cases as not every lab can run all the tests we require. We are not responsible in the case that the lab has to outsource the test to another lab that is not covered by your insurance.

Insurance company Look Back Periods

Insurance companies often perform audits of paid claims. These audits can be performed for up to two years from the latter of the following (a) the date of service, (b) the receipt of the claim, (c) the payment of the claim, or (d) the receipt of an appeal. When an insurance company performs an audit and determines that claims were paid in error and should not have been, the insurance company contacts us for a refund of the monies they paid. They then direct us to collect for these services from the patient. Unfortunately this may mean that for a period of up to two years after any one of the above listed events your insurance company may reverse their decision. If this should occur we will than contact you for payment of these services.

Interest on Unpaid Balances

Should you have an outstanding balance on your account that is your responsibility and that is greater than 30 days old, we reserve the right to assess simple interest on the unpaid balance at the rate of 1.5%/month. This represents an annual interest rate of 18%

Administrative Billing when your Co-Pay, Co-Insurance or Patient Responsibility Balance is not paid at the Time of Service.

When your co-pay, or outstanding balance for the day's visit is not paid at the time of service delivery, we will assess a $25.00 administrative billing fee and subsequently bill you for the unpaid amount.

Account Representative

We understand that infertility is a challenging problem. Unfortunately, managing insurance benefits is often troublesome in this area. We have Patient Account Representatives who are trained to help you navigate these often troubled waters. For help with any billing issues please email billing@fertileweb.com or call us at (425) 646-4700 ext 311.

PATIENTS ATTESTATION:

I fully understand Overlake Reproductive Health's Patient Accounts and Insurance Policy described above. I understand that I am responsible for any balance not covered by or paid by insurance for any reason.

Patient Signature:____ Date: ____

Partner/Spouse Signature:______________________________________ Date: ____

Witness Signature: ____ Date: ____

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Overlake Reproductive Health

Billing Authorization Form

I would like to pay for this and future visits with Visa/Mastercard/American Express, please keep this information on file. I give permission for Overlake Reproductive Health, Inc. PS and Laboratory, LLC to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

Patient Name:	Partner Name:
(Office only) Patient Account Number:	

SELECT PAYMENT METHOD

VISA	Mastercard	American Express	Debit (Visa or MC)
Name on Card:		Exp Date:	
Billing Address:			
Billing ZIP Code:			
Card Number:			
Key Code:			

- We will call you before making any charges to a card, if the charge is an excess of $500.
- We will mail you a copy of your credit card receipt and your statement

I authorize and request Overlake Reproductive Health, Inc PS (ORH) & Overlake Reproductive Health Laboratory LLC to process my payments through my credit card noted above. I also understand I may discontinue this authorization at any time by giving written notice to ORH.

Signature: ______________________________________ Date: _____________________

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Overlake Reproductive Health

PATIENT REGISTRATION FORM

Dates Reviewed & Updated: __________ __________ __________ __________ __________ __________

Please Print

PATIENT INFORMATION

NAME ____ M___ F___ DOB___________ AGE ______________

Last First MI SS# ____

DRIVERS LICENSE # ______________________________ MARITAL STATUS ______________________________

ADDRESS ______________________________ OCCUPATION ______________________________

CITY/STATE ______________________ ZIP ________ EMPLOYER ______________________________

HOME PHONE (____) ______________________________ WORK PHONE (____) ______________________________

PARTNER NAME ______________________ DOB ________ CELL PHONE (____)______________________________

PRIMARY LANGUAGE SPOKEN ______________________________ PRIMARY CARE DOCTOR: ______________________________

I CONSENT TO RECEIVE EMAIL COMMUNICATIONS FROM ORH (PLEASE INITIAL) ______________________

PREFERRED EMAIL ADDRESS ____

REFERRED BY: please be as specific as possible. ____

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________________ SECONDARY INSURANCE ______________________________

INSURED ______________________ DOB ________ INSURED______________________ DOB ______________

EMPLOYER______________________________ EMPLOYER ______________________________

RELATIONSHIP TO PATIENT ______________________________ RELATIONSHIP TO PATIENT ______________________________

INSURED ID No. ______________________________ INSURED ID No.______________________________

GROUP No. ______________________________ GROUP No. ______________________________

Does your insurance require preauthorization before hospitalization or procedures? YES NO

If YES, phone number to call: ______________________________

The responsible party for billing purposes is: ____

EMERGENCY INFORMATION: Person to contact in case of emergency, not living at the above address.

Name ______________________________ Relation to Patient ______________________________

ADDRESS ______________________________ PHONE ______________________________

CITY/STATE ______________________ ZIP ________

Please read the following statement carefully before signing

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize all benefits to which my dependents or I are entitled to under my health insurance plan. In addition, I will not withhold or delay payment if my insurance denies payment of any of my charges. I have also been informed of the $35.00 fee (per RCW 62A.3-515&520) on checks returned from my bank NSF. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established with 1% interest per month (per RCW 19.52) on the unpaid balance.

PATIENT SIGNATURE ______________________________ DATE ______________________

PARTNER SIGNATURE ______________________________ DATE ______________________

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Overlake Reproductive Health

PARTNER/SPOUSE REGISTRATION FORM

Dates Reviewed & Updated: ___________ ___________ ___________ ___________ ___________ ___________

Please Print

PARTNER INFORMATION

NAME ____ M___ F___ DOB___________ AGE ______________

Last First MI SS# ______________________________________

DRIVERS LICENSE # ________________________________ MARITAL STATUS ____________________________

ADDRESS ____ OCCUPATION ________________________________

CITY/STATE ___________________________ ZIP ________ EMPLOYER __________________________________

HOME PHONE (___) ________________________________ WORK PHONE (___) ___________________________

PARTNER NAME _______________________ DOB _______ CELL PHONE (___)____________________________

REFERRED BY PRIMARY CARE DOCTOR:

I CONSENT TO RECEIVE EMAIL COMMUNICATIONS FROM ORH (PLEASE INITIAL) ____________________________

PREFERRED EMAIL ADDRESS ____

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________________ SECONDARY INSURANCE _______________________

INSURED ____________________________ DOB _______ INSURED____________________ DOB ____________

EMPLOYER_______________________________________ EMPLOYER __________________________________

RELATIONSHIP TO PATIENT _________________________ RELATIONSHIP TO PATIENT ____________________

INSURED ID No. __________________________________ INSURED ID No.______________________________

GROUP No. ______________________________________ GROUP No. _________________________________

Does your insurance require preauthorization before hospitalization or procedures? YES NO

If YES, phone number to call: _________________________

The responsible party for billing purposes is: ____

EMERGENCY INFORMATION: Person to contact in case of emergency, not living at the above address.

Name ____ Relation to Patient _________________________

ADDRESS ____ PHONE ____________________________________

CITY/STATE ___________________________ ZIP ________

Please read the following statement carefully before signing

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize all benefits to which my dependents or I are entitled to under my health insurance plan. In addition, I will not withhold or delay payment if my insurance denies payment of any of my charges. I have also been informed of the $35.00 fee (per RCW 62A.3-515&520) on checks returned from my bank NSF. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established with 1% interest per month (per RCW 19.52) on the unpaid balance.

PATIENT SIGNATURE ____________________________________ DATE _________________________

PARTNER SIGNATURE ___________________________________ DATE _________________________

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AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS AND INFORMATION

I, ____ Birthdate:_______/_____/_______Authorize

____

(Person/Facility)

____

Street Address City/State Zip

Release records to **OVERLAKE REPRODUCTIVE HEALTH, Inc., P.S.**
11232 NE 15th St. Suite 201
Bellevue, WA 98004
Phone: 425.646.4700 Fax: 425.646.1076

The following information:

Personal health records during the period of:____

_______All medical records Chart #: ________________
_______Lab results
_______X-ray results X-ray#: ________________
_______Original x-rays*

*any original X-rays so released will be promptly returned as soon as possible if necessary.

This consent______INCLUDES ______EXCLUDES Release of information pertaining to (check in each area):

______INCLUDES ______EXCLUDES Drug or alcohol abuse diagnosis or treatment

______INCLUDES ______EXCLUDES HIV (AIDS) testing/treatment

______INCLUDES ______EXCLUDES Psychiatric care/mental illness

______INCLUDES ______EXCLUDES Confirmed STD test results and/or treatment

I understand that records are protected under confidentiality regulations, and any records that contain information regarding drug and/or alcohol abuse that are created by an alcohol abuse or drug abuse prevention program are protected under federal confidentiality laws (42 CFR Part 2) and state law. I understand that said records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems cannot be disclosed without my written consent, and that those receiving this information are prohibited from re-disclosing these records unless expressly permitted by my written consent. I understand that any records that contain information regarding HIV and or confirmed STD tests or treatment are protected by state confidentiality laws (RCW 70.24). I understand that and HIV and/or confirmed STD tests or treatment records cannot be disclosed without my written consent unless permitted by State law, and that those receiving this information are prohibited from re-disclosing these records without my further written consent.

This consent may be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_______________________________ _______________________________

Signature Print Name

_______________________________ _______________________________

Witnessed Date

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Overlake Reproductive Health
PATIENT TELEPHONE CONSENT

I, ________________________________, give my permission for Overlake Reproductive Health to contact me with medical information at the following number(s).

Home: ____ Cell: __________________________________

☐ **I give permission** for Overlake Reproductive Health to leave a detailed message regardless of the nature of the information being shared with me. I understand that the clinic will leave only the minimum information necessary to convey the message and that a message will only be left if I am not available to answer the call. This information may include but is not limited to laboratory results and instructions. I understand that by giving my consent, I give permission to have normal test results, abnormal test results and next step follow-ups left on voice mail.

Please initial _____/_____

OR

☐ **I do not give my consent**, I understand that it will be **my responsibility** to call the clinic to obtain this information, if I am not available when called.

Please initial _____/_____

ORH EMAIL POLICY

Email can be a great way for you to keep in touch with us – there are many advantages, but to keep the use of email productive and in everyone's best interests we ask that you please bear in mind the following points:

- Urgent matters should never be communicated by email.
- Email is not 100% private or secure for confidential communications including medical advice or questions.
- Please limit emails to 2 or three brief questions per email, and generally to one to two emails per day.
- If your questions are time-sensitive and you do not get a response by the end of the next business day please call our office.
- Some matters require a face-to-face discussion with one of our providers. If we feel that your questions cannot be adequately addressed by email we will advise you of this.
- Conversely, if you feel that you would like a face-to-face discussion of points raised, or concerns, please schedule a visit with one of us.
- Email communications should follow the same standards of respect that would be expected for face-to-face communications.

I have read and understand this policy. Please initials _____/_____

My preferred email address is: ____

This consent is in effect until I advise Overlake Reproductive Health in writing of its discontinuance.

Signature ____ Date ______________________________

This notice will be maintained in the medical record

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Overlake Reproductive Health
PARTNER TELEPHONE CONSENT

I, _______________________________, give my permission for Overlake Reproductive Health to contact me with medical information at the following number(s).

Home: ______________________________________ Cell: _________________________________

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Please initial _____/_____

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Overlake Reproductive Health

PATIENT PRIVACY POLICIES

NOTICE OF PRIVACY POLICIES-& HIPAA ACKNOWLEDGMENT

We follow the federal HIPAA guidelines for protecting your privacy. You may ask to see our complete privacy policies at any time. We keep a medical record of the health care services we provide to you. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record, obtain a copy of it, or get more information about it by contacting our front desk staff.

Please Initial ________

AUTHORIZATION TO SHARE HEALTHCARE INFORMATION WITH FRIEND / FAMILY MEMBER

You may share the following health care information with:

Name: ____ Relationship: ______________________

Phone number: _____________________________________

Please check all that apply:

___ All healthcare information on record

___ Healthcare information related to following treatment: ____________________________________

___ Other information (appointments, test results, surgery planning, ect.)

___ Insurance and billing information

Please Initial ________

NOTICE OF ANNONYMOUS USE OF NON-MEDICAL PHOTOS

I authorize Overlake Reproductive Health (ORH) to anonymously use photos of myself and/or my child that we receive from you for any promotional materials regarding ORH facilities, or services. Such photos will not be sold to other parties. Promotional materials bearing these photos may be distributed for free to the public and posted on the ORH website. ORH reserves the right to use these materials until receiving, in writing, the request of participant, parent or legal guardian to discontinue use.

Select one option:

☐ I GIVE PERMISSION FOR ORH TO USE MY PHOTOS

☐ I DO NOT GIVE PERMISSION FOR ORH TO USE MY PHOTOS

I have read and acknowledge all the policies written above

Name: ____

Signature: ____ Date: ___________

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Overlake Reproductive Health

PARTNER PRIVACY POLICIES

NOTICE OF PRIVACY POLICIES-& HIPAA ACKNOWLEDGMENT

We follow the federal HIPAA guidelines for protecting your privacy. You may ask to see our complete privacy policies at any time. We keep a medical record of the health care services we provide to you. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record, obtain a copy of it, or get more information about it by contacting our front desk staff.

Please Initial ________

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You may share the following health care information with:

Name: ____ Relationship: ______________________

Phone number: _____________________________________

Please check all that apply:

___ All healthcare information on record

___ Healthcare information related to following treatment: ____________________________________

___ Other information (appointments, test results, surgery planning, ect.)

___ Insurance and billing information

Please Initial ________

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Select one option:

☐ I GIVE PERMISSION FOR ORH TO USE MY PHOTOS

☐ I DO NOT GIVE PERMISSION FOR ORH TO USE MY PHOTOS

I have read and acknowledge all the policies written above

Name: ____

Signature: ____ Date: ___________

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Insurance Benefit Questionnaire

As a new patient to Overlake Reproductive Health, we highly recommend that you contact your insurance company to obtain coverage information for the diagnosis and treatment of infertility. To help you with this task we have compiled a list of questions to ask your insurance provider. Please remember that any information your insurance company gives you is not a guarantee of coverage or payment.

1. Are Dr. Kevin Johnson and Dr. Khurram Rehman listed as participating providers? Y N
2. Is Overlake Reproductive Health Laboratory listed as a participating lab? Y N
3. Do I need a referral from my Primary care provider to be able to see Drs. Johnson or Rehman? Y N
4. Do I have any coverage for infertility? Y N
5. Do I have coverage for testing to diagnose the cause of infertility? Y N

   If yes, what is my co-pay for diagnostic office visits? ______________________________________
6. Do I owe anything above and beyond my copays for diagnostic coverage? ___________________________

   If no, please skip to question 10.
7. Do I have coverage for the Treatment of infertility? ____
8. Do I have coverage for sonograms related to infertility treatment? _________________________________
9. Do I have coverage for Artificial Insemination (IUI)? Y N
10. Do I have coverage for In Vitro Fertilization (IVF)? Y N

    If yes, what is my co-pay? _______________ My coinsurance? ______________
11. Do I have coverage for fertility medications? Y N

    If yes, do I need to go through a special pharmacy? Y N

    Pharmacy: _________________________________ Phone# ______________________________
12. Is pre-certification required for IVF? Y N
13. What is my lifetime Maximum benefit for infertility? ____
14. What is my annual deductible? ________________ How much is remaining? ______________________
    a. When does my annual deductible renew? ____
15. Is preauthorization required for the following?
    a. Treatment procedures performed in the office? Y N
    b. Oral/injectable Fertility Medications? Y N
    c. OB ultrasounds performed in the office? Y N
16. Is pre-certification required for out-patient surgery? Y N

Representative name: _________________ at (insurance) ______________ Phone #_____________________