AMERICAN REPRODUCTIVE CENTERS

Newport-Mesa Office
1640 Newport Blvd.
Suite 150, 460
Costa Mesa, CA 92627
Tel: 949-309-3330
Fax: 949-309-2578

Patient,

We would like to welcome you to American Reproductive Centers. We appreciate your choosing our Practice for your evaluation and treatment. The included information is to help facilitate our care for you. The registration information helps us get to know you.

Your appointment will be held at our Irvine office. We encourage that both partners attend the initial consult. The initial consult will further allow us to get to know you. A complete medical history will be taken on both partners. This initial consult is critical in assessing your diagnosis and possible treatment options.

Please bring with you the enclosed registration forms as well as identification and any insurance documents you may have. It would also expedite your care if you bring any medical records that you may possess. A medical release form is also included in this package to assist you in obtaining any medical records.

Please arrive 10-15 minutes prior to your appointment so as to start the registration process and prepare you for your visit. Payment or co-payment of services rendered will be collected at the time of your visit. If you have and HMO or EPO you will need a written authorization from your primary care physician.

If you cannot keep your scheduled appointment please notify the office as soon as you can.

Thank you for scheduling your appointment we hope to provide you with the best medical care possible.

Sincerely,

The Staff

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Insurance Benefits Confirmation:

Although American Reproductive Centers will assist you with determining insurance benefits for infertility testing or treatment, we recommend that patients become their own advocates. We recommend that all patients contact their Insurance carriers and determine the benefits available to them. We also recommend that you keep accurate documentation of any communication you have with your insurance.

Things to determine or ask:

1. Does my policy cover infertility treatment or testing?
2. Does my policy have out of network coverage?
3. Does my policy have limitations? (e.g. Waiting periods, exclusions, pre-existing condition limitation etc)
4. Does my policy have a deductible?
5. Does my policy have a special or different co-pay for specialists?
6. Does my policy require a referral from the primary care doctor?

If Testing is covered:

1. Does my policy cover office visits?
2. Does my policy cover lab testing?
3. Does my policy cover radiology testing?
4. Are there restrictions on the laboratory that must be used?
5.

If Treatment is covered:

1. Does my policy cover artificial insemination (AI)?
2. Does my policy cover In Vitro Fertilization (IVF)?
3. Does my policy cover Frozen Embryo Transfer (FET)?
4. Does my policy cover donor eggs or donor sperm?
5. Does my policy cover Surrogacy?
6. Does my policy cover any medications?
    a. Which Pharmacy can I use?
    b. Do I have a separate Pharmacy benefit?
        c. Are injectable medications covered
7. Does my policy cover any other fertility treatments not asked with above questions?

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Today's Date:	Primary Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐Mr. ☐Mrs.	☐Miss ☐Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐			
Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F	
Street address:	Social Security no.:	Home phone no.: ( )				
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Chose clinic because/referred to clinic by (Please check one box):	☐Dr.	☐ Insurance plan	☐Hospital			
☐Family	☐Friend	☐Close to home/work	☐Yellow Pages	☐Other		
Other family members seen here:						

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )			
Is this person a patient here? ☐Yes ☐No						
Occupation:	Employer:	Employer address:	Employer phone no.: ( )			
Is this patient covered by insurance? ☐Yes ☐No						
Please indicate primary insurance ☐						
☐				☐Other		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	☐Self	☐Spouse	☐Child	☐Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:			
Patient's relationship to subscriber:	☐Self	☐Spouse	☐Child	☐Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Patient/Guardian signature		Date	

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Today's Date:	Primary Physician:

PARTNER INFORMATION

Patient's last name: First: Middle:	☐Mr. ☐Mrs.	☐Miss ☐Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐		
Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:	Social Security no.:	Home phone no.: ( )			
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			
Chose clinic because/referred to clinic by (Please check one box):	☐Dr.	☐ Insurance plan	☐Hospital		
☐Family	☐Friend	☐Close to home/work	☐Yellow Pages	☐Other	
Other family members seen here:					

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ☐Yes ☐No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ☐Yes ☐No					
Please indicate primary insurance ☐					
			☐Other		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐Self	☐Spouse	☐Child	☐Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	☐Self	☐Spouse	☐Child	☐Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Patient/Guardian signature		Date	