ADVANCED REPRODUCTIVE MEDICINE & GYNECOLOGY
407 Uluniu Street Suite 312
Kailua HI 96734
808-262-0544

FERTILITY INSTITUTE OF HAWAII
1401 S. Beretania Street Suite 250
Honolulu HI 96814
(808) 545-2800

Date_____

Name: Last_____**First**_____**M.I.**_____ **Nickname**_____

Address_____ **City/State**_____**Zip**_____

Home Phone (_____)_____ **Work Phone (____)**_____**Cell Phone(____)**_____

Circle preferred number to reach you. Email address:_____

Birthdate_____ **Social Security #**_____-_____-_____ **Marital Status**_____

Employer_____**Occupation**_____

Spouse/Partner Name:_____ **Spouse/Partner DOB:**_____

In case of an emergency, we have your permission to contact:

Name _____**Phone**_____**Relationship**_____

ETHNICITY/RACE: Circle ONE OR MORE of the Following

American Indian or Alaska Native _____Asian _____Native Hawaiian _____ Other Pacific Islander_____

Black or African American ☐White_____Hispanic ☐Refuse to report_____Other Race_____

PRIMARY LANGUAGE:_____ **SECONDARY LANGUAGE**_____
Are you able to speak and understand English? Yes / No Do you require a translator: Yes / No

Primary Care Physician_____ **Referred by Primary care physician? Yes / No**

OB/GYN Physician_____ **Referred by OB/GYN physician? Yes / No**

How did you hear about our office? _____

GUARANTOR INFORMATION (person in charge of account if different from patient):

Guarantor Legal Name: Last_____**First**_____**M.I.**_____

Address: _____ **City/State**_____**Zip**_____

Birthdate_____ **Age**_____**Sex**_____ **Employer Name**_____

Home phone:_____ **Work phone:**_____ **Cell phone:**_____

Patient's Relationship to Guarantor: Spouse_____ Child _____ Legal Guardian_____ Other_____

INSURANCE INFORMATION

Primary Insurance Company _____ **Subscriber #** _____

Insured's Name_____ **Insured's Date of Birth:** _____**Relationship**_____

Secondary Insurance Company _____ **Subscriber #** _____

Insured's Name_____ **Insured's Date of Birth:** _____**Relationship**_____

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If we need to contact you regarding any future appointments or test results may we leave a message?

Yes or No (please circle) INITIAL:_____ Phone number you prefer us to call:_____

Would you like us to e-mail you patient education handouts rather than give you hard copies?

Yes or No (please circle) INITIAL:_____ E-mail address:_____

CONSENT FOR TREATMENT

INITIAL:_____ I, the undersigned, voluntarily agree to tests, procedures, and/or treatments, which the physician and I have discussed and deemed necessary.

PAR AND NON-PAR PAYMENT TERMS AND AGREEMENTS

I, the undersigned, in consideration for services rendered to the patient by Advanced Reproductive Medicine and Gynecology of Hawaii, Inc. and Fertility Institute of Hawaii, Inc. understand and agree to the following:

1. I understand that payment for charges is due on the date of service with the exception of insurance carriers for which we are under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment. I will be responsible for any co-payment, deductible or service not covered by my insurance provider. If I do not have insurance coverage for services rendered, I agree to pay all charges resulting from such services.
3. I understand that Advanced Reproductive Medicine and Gynecology of Hawaii, Inc. and Fertility Institute of Hawaii, Inc. IS NOT in contract with ALL insurance carriers and payment for charges is due on the date of service.
4. I hereby authorize if possible for Advanced Reproductive Medicine and Gynecology of Hawaii, Inc. and Fertility Institute of Hawaii, Inc. to file with my insurance on my behalf.
5. **I understand my insurance carrier may NOT fully cover all expenses paid at the time of service and that I am responsible for any differences unless my secondary insurance can be billed**. However, even with a secondary insurance, certain services may not be covered; therefore, I will be responsible for those expenses.
6. **I understand that if my primary insurance is a NON-PAR insurance and if I do have a secondary insurance, it is MY RESPONSIBILITY to bring in the Explanation of Benefits (EOB) to Advanced Reproductive Medicine and Gynecology of Hawaii, Inc. and Fertility Institute of Hawaii, Inc.** from my primary insurance to file with my secondary health insurance. I assign payment of my secondary medical benefits to Advanced Reproductive Medicine and Gynecology of Hawaii, Inc. and Fertility Institute of Hawaii, Inc. for services rendered.
7. I authorize release of all medical records and information necessary to process any claim generated by services I received in this office.

INITIAL:_____

My signature below indicates that I have read, understand and agree to all terms set above:

Signature:_____Date:_____