Atlantic
Reproductive Medicine
Specialists

DATE:_____ **CHART #:**_____ **PROVIDER:** (circle one) Dr. Copland or Dr. Walmer

PATIENT INFORMATION

PATIENT FULL NAME:_____

DATE OF BIRTH:_____ **SEX:** (circle one) FEMALE or MALE

ADDRESS: _____

HOME PHONE:_____ **CELL PHONE:** _____

EMAIL:_____

MARITAL STATUS: (circle one) SINGLE MARRIED PARTNERSHIP DIVORCED OTHER

PRIMARY CARE PHYSICIAN:_____ **REFERRED BY:**_____

RESPONSIBLE PARTY INFORMATION

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

RESP. PARTY NAME:_____

DATE OF BIRTH:_____ **SEX:** (circle one) FEMALE or MALE

HOME PHONE:_____ **CELL PHONE:**_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:_____

PATIENT RELATIONSHIP TO THE SUBSRIBER: (circle one) SELF SPOUSE CHILD OTHER

SUBSCRIBERS NAME:_____ **DATE OF BIRTH:**_____

ID #:_____ **GROUP #:**_____ **COPAY AMOUNT:**_____

Please indicate below how you heard about Atlantic Reproductive Medicine Specialists:

Physician: _____ Specialty: _____

Friend or Relative: _____ May we thank them? Y N

Former or Current Patient: _____ May we thank them? Y N

___ I am a previous patient ___ Spouse/Partner is a patient ___ Internet ___ Radio (station_____)

___ Print Ad (source_____) ___ Social Media (source_____)

___ Seminar (location _____) ___Other(specify _____)

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PATIENT CONTACT INFORMATION

PATIENT FULL NAME:_____ **Date of Birth:**_____

It is important that we be able to communicate efficiently and frequently with you during your care. Please give us as many options as you can for reaching you and indicate beside the contact information if it is an acceptable form of contact to leave a personal message.

Email: _____ Acceptable to contact: ___ Yes ___ No

Mobile #: _____ Acceptable to contact: ___ Yes ___ No

Home #: _____ Acceptable to contact: ___ Yes ___ No

Work #: _____ Acceptable to contact: ___ Yes ___ No

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____

PATIENT PORTAL WEB CORRESPONDENCE

At Atlantic Reproductive Medicine Specialists, we want to make communication as simple as possible. One of the ways we do this is by giving you access to your medical records through our Patient Portal. The front office staff will give you your username and assign a temporary password so you can access this private information. The Patient Portal is the primary way for you to communicate with our very knowledgeable physician and nursing staff.

By logging into your portal you may…

- View test results
- Communicate directly with our care team about any question or concerns.
- View future appointments
- Request changes to your demographic information, etc. Please note that changes will not immediately reflect.

On business days

- Web correspondences sent before 3pm will be answered the same day.
- After 3pm, the response will be sent the next business day.

After hours, on weekends or holidays

- Non-urgent web correspondences will be responded to on the next business day.
- Urgent issues can be handles two ways.
  1. If an issue on the weekend needs a response within 24 hours, put "URGENT" in the subject line.
  2. If an issue needs immediate attention after 3pm on business days or during a weekend or holiday do not use electronic communication. One of our physicians can be reached 24 hours a day by calling 919-248-8777. After hours, you will be given an option to leave a message for the physician on call.

DISCLAIMER FOR EMERGENCY OR URGENT MEDICAL CONDITIONS DO NOT USE ELECTRONTIC FROMS OF COMMUNICATION. IN AN EMERGENCY, CALL 911.

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CONSENT FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ hereby authorize the use or disclosure of information as follows:

_____ All health and /or financial information pertaining to medical treatments, procedures and tests.

_____ All health and /or financial information pertaining to medical treatments, procedures and tests may only be discussed with me.

_____ Purpose of request use or disclosure: Continuation of Treatment.

_____ Notice of Rights and other information

_____ I will allow release of PHI and/or financial information to the person(s) listed below:

Name: _____ DOB: _____ Relationship to patient: _____

Name: _____ DOB: _____ Relationship to patient: _____

In addition, I request that you restrict my information in the following way:

_____

_____

_____

I understand that this consent form will be valid and remain in effect as long as I receive medical care/treatment at Atlantic Reproductive Medicine Specialists.

Patient Full Legal Name: _____ DOB: _____
(Please Print)

Patient Signature: _____ Date: _____

Atlantic
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Authorization Agreement For Assignment of Benefits & Information Release

Assignment of Benefits

I, the undersigned hereby authorized payment of medical benefits directly to Atlantic Reproductive Medicine Specialists for any service (inpatient or outpatient) furnished me by the physician(s). I authorize Atlantic Reproductive Medicine Specialists to release to my insurance company or their agent any information concerning healthcare, advice, treatment or supplies provided me by Atlantic Reproductive Medicine Specialists. This information will be used for the purpose of evaluating and administering claims of benefits. I agree to forward Atlantic Reproductive Medicine Specialists all health insurance payments, which I receive for services rendered by Atlantic Reproductive Medicine Specialists physician(s).

Beneficiary Agreement

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

I may refuse to sign this Authorization. Understanding that by doing so, Atlantic Reproductive Medicine Specialists will not be responsible for filing any claims to my insurance carrier on my behalf. I may revoke this authorization at any time. My revocation must be in writing, signed by me and delivered to the following address:

Atlantic Reproductive Medicine Specialists
10208 Cerny Street, Suite 306
Raleigh, NC 27617

My revocation will be effective upon receipt. I have a right to receive a copy of this authorization. Medical care or treatment will be conditioned on my providing or refusing to provide this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that this consent form will be valid and remain in effect as long as I receive medical care/treatment at Atlantic Reproductive Medicine Specialists.

Patient Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
We are legally required to protect the privacy of your health information. We call this "protected health information," or "PHI" for short. It includes information that can be used to identify you and that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. We reserve the right to change the terms of this notice and our privacy policies at any time. Any change will apply to the PHI we already have. Whenever we make any important changes to our policies, we will promptly change this notice and post the newly updated notice on our website at www.AtlanticReproductive.com under the Resource tab. You can also request a copy of this notice from the contact person listed in Section IV below at any time.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization. We may use and disclose your PHI without your authorization for the following reasons:

1. Treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate, or manage your health care or any related services, except where PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription, or to a laboratory to order a blood test.

2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. For example, we may disclose your demographic information to laboratory care providers for payment of their services.

3. For health care operations. We may disclose your PHI, as necessary, to operate this facility and provide quality care. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement. For example, we may disclose PHI when a law requires that we report information to the government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. For public health activities. For example, we may disclose PHI to report information about birth, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. For health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorize by law.

7. For organ donation. We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants.

8. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

9. To avoid harm. In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

B. Uses and Disclosures Where You to Have the Opportunity to Object:

1. Disclosures to family, friends, or others. We may disclose your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon authorization.

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

III. WHAT RIGHT YOU HAVE REGARDING YOUR PHI.
You have the following rights with respect to your PHI;

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement or restriction.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The Right to See and Get Electronic Copies of Your PHI. We will provide a copy of the requested PHI in electronic form and format requested by the individual. If the requested format is not readily producible, the practice will provide a readable electronic format that is agreed upon. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of the instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to our opening date of August 6, 2012. We will respond within 30 days of

receiving your written request. The list we will give you will include disclosures made since our opening date of August 6, 2012. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond to your request within 30 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all full future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you we've done it, and tell others that need to know about the change in your PHI.

IV. TO OBTAIN INFORMATION OR ISSUE COMPLAINT ABOUT OUR PRIVACY PRACTICES.
If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint please contact: ***Our Office @ 919-248-8777***

V. EFFECTIVE DATE OF THIS NOTICE
This notice is effective signature date of the patient on the Acknowledgement of Receipt of Notice of Privacy Practices form.

Atlantic
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Atlantic Reproductive Medicine Specialists Notice of Privacy Practices:

- It tells me how Atlantic Reproductive Medicine Specialists will use my health information for the purpose of my treatment, payment for my treatment and Atlantic Reproductive Medicine Specialists health care operation.
- The Notice explains in more detail how Atlantic Reproductive Medicine Specialists may use and share my health information for other treatment, payment and health care operations.
- Atlantic Reproductive Medicine Specialists will also use and share my health information as required/permitted by law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Atlantic Reproductive Medicine Specialists Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 919-248-8777.

☐ **I accept receipt of Notice of Privacy Practices.**

☐ **I DO NOT accept receipt of Notice of Privacy Practices.**

Patient Full Legal Name: _____ DOB: _____
(Please Print)

Patient Signature: _____ Date: _____

For Office Use Only

☐ Patient Refuses to Acknowledge Receipt of Notice of Privacy Practices.

_____ Date: _____
Signature of Privacy Officer

Atlantic
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FINANCIAL POLICY

Thank you for choosing Atlantic Reproductive Medicine Specialists as your fertility care provider. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. One of our very knowledgeable financial coordinator's would be more than happy to answer any financial questions about our fees, financial policies, or your insurance coverage.
CALL 919-248-8777, select option 4.

We are participating providers with the following insurance plans:

- **AETNA**
- **BCBS** – Except policies with the alpha prefix YPJW & YPVW.
- **CIGNA**
- **COVENTRY** – At this time only Dr. Susannah Copland participates.
- **TRICARE**
- **UNITED HEALTHCARE**

PLEASE READ EACH SECTION CAREFULLY AND INITIAL

CANCELLATION OF A NEW PATIENT CONSULTATION APPOINTMENT

In order to be respectful of the medical needs of other patients, please contact Atlantic Reproductive Medicine Specialists promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require 24-hour cancellation notice. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

Initial _____

NO SHOW/MISSED APPOINTMENTS

If you do not cancel your new patient consultation or established patient appointment at least 24 hours before, or if you no-show, we will assess you with a $60 missed appointment fee. This fee must be paid before another appointment will be scheduled. Please note that this fee will not be billed to your insurance.

Initial _____

PHONE CONSULTATION

During the course of your treatment at ARMS you may wish to have a phone consultation with your physician, the fee for a phone consultation for new patients is $160 and for an established patient it is $80. Phone consultations are not billed to insurance and will be the patient's responsibility to pay in full prior to the phone consultation.

Initial _____

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PAYMENT

At each visit payment is expected at the time of your visit. Payment will include any copay, unmet deductible, coinsurance, or non-covered charges from your insurance company. If you do not have insurance, payment in full for all services is expected at the time of your visit. All patient balances must be paid in full prior to beginning any treatment or treatment cycle. This also, includes spouse/partner accounts. When starting a treatment cycle the payment in full is always due by your baseline ultrasound.

We accept Cash, Checks, Visa, MasterCard, Discover and American Express credit cards. A $35 fee will be charged for any checks returned for insufficient funds. Regretfully we will not accept any further check payments and you will be asked to bring cash, certified funds or a money order for future payments.

Patient statements are billed monthly on any remaining balance. Payment in full is due upon receipt. For your convenience we accept online credit card payments. Visit our websites financial page at http://atlanticfertility.com/payments/ to make a secure online payment.

Initial _____

INSURANCE COVERAGE

As a courtesy we will verify your infertility benefits with your insurance company prior to your new patient consultation. It is your responsibility to keep us updated with your correct insurance information and of any changes in coverage. Your claim will process according to your particular benefit plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. A quote of benefits is not a guarantee of benefits or payment.

If your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Many insurance carriers cover services for the diagnosis and treatment of underlying cause of infertility only, meaning once treatment begins they will no longer cover services (monitoring follicular ultrasounds). Once treatment begins we will not bill your insurance for non-covered services.

Procedure and diagnosis coding for infertility treatment can easily be mistaken for diagnostic testing when claims are filed. Many times insurance companies will pay in error leading to patient believing they have coverage, even though the benefit for infertility treatment does not exist. Ultrasounds are sometimes paid by insurance without the carrier realizing the services are treatment related (rather than for diagnosis).

If your insurance plan requires registration by the member for infertility treatment and/or services or requires the member to use a preferred facility/provider for treatment it is the member's responsibility to abide by these plan provisions.

Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. We highly recommend you contact your insurance member benefits department and check into your coverage for infertility prior to your appointment.

Initial _____

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ADMINISTRATIVE FEE

A non-refundable administrative fee will be charged for each treatment cycle. This fee covers the coordination of the treatment cycle, medication training, paperwork and medication management. Please note that this fee is not covered by insurance and will not be billed to your insurance.

Initial _____

PREAUTHORIZATIONS AND PREDETERMINATION OF BENEFITS

Every effort will be made by the office to have all services and procedures preauthorized prior to treatment. The best way to ensure your insurance coverage for infertility treatments is valid is to get a written commitment for coverage prior to beginning infertility treatment. This is called a predetermination of benefits. When your insurance does not require an authorization for treatment, we will send a written request to your insurance company for a determination of your coverage. We will submit to them every possible code you may have during your treatment. We do this to help eliminate any surprised once the claim is processed. If you choose to move forward with treatment before the insurance authorizes your services or we receive the predetermination of benefits, you understand if any service is not approved or covered you are financially responsible for the complete charge.

Initial _____

REFERRALS

If your insurance plan requires a referral from your primary care physician for specialist visits, it is your responsibility to obtain the referral prior to your specialist appointment. If you fail to obtain a referral and your insurance denies your claims, you understand that you are financially responsible for any amount not covered.

Initial _____

MEDICATION COVERAGE

Please be aware that due to the large variety of medications offered we are unable to verify coverage for prescriptions, as we are a medical services provider not a pharmacy. You may contact your insurance plan to obtain benefit coverage for medications.

Initial _____

ANESTHESIA SERVICES

Our anesthesia services are provided by certified registered nurse anesthetists (CRNAs), who are independent contractors that are not employed by Atlantic Reproductive Medicine Specialists. Therefore, we are unable to bill your insurance for their services. The fee for anesthesia performed in our office is $450 and is due at the time of service.

Initial _____

REFUNDS & OVERPAYMENTS

Patient or insurance payments for services resulting in overpayment will receive a refund check during the next refund cycle, as long as the patient and spouse/partner does not have any other patient responsibilities or pending insurance charges.

Initial _____

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MEDICAL RECORDS FEE

A $30 fee will be charges for copies of medical records given directly to the patient. Atlantic Reproductive Medicine Specialists will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and as long as the patient has signed the appropriate medical records release form. It is requested outstanding balances be paid in full prior to medical records being released.

Initial _____

CANCELLATION OF TREATMENT CYCLE

Should a cycle be cancelled for any reason the patient will be responsible for any costs incurred prior to the cycles cancellation. A financial coordinator will review your treatment services rendered up to that point. If proceeding with another cycle a credit will be issued for the difference between the original treatment cost and the costs incurred to the point of cancellation. Any credit balance can be used against future treatment costs or a refund can be requested.

Initial _____

CANCELLATION OF WINFERTILITY TREATMENT CYCLE

ARMS will complete and submit a Physician Treatment Outcome & Billing form to WINFertility. WINFertility will adjust the amount of the physician's payment based on the services rendered up to the point of cancellation and the patient will get the appropriate refund from WINFertility.

Initial _____

I hereby acknowledge I have read and have been given the opportunity to request clarification of any policies not fully understood. By signing below, I fully understand the financial policy and accept responsibility for any payment that becomes due as outlined previously.

Patient Signature: _____ Date: _____

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Terms & Conditions for Credit Card Payments & Electronic Communications

SEE IMPORTANT DEFINITIONS IN SECTION II BELOW

I. GENERAL

1. These terms and conditions apply to all credit card payments made (whether by telephone, in the office or in any other manner) to Atlantic Reproductive Medicine Specialists (hereinafter referred to as "ARMS").
2. These terms and conditions also apply to Electronic Communications (whether or not in connection with a credit card payment).
3. In addition to these terms and conditions, the ARMS Privacy Policies apply to your use of any ARMS website. Current copies of these privacy policies may be found at: http://www.atlanticfertility.com
4. By making a credit card payment to ARMS, or by requesting Electronic Communications, you accept these terms and conditions.
5. ARMS may amend these terms and conditions at any time by posting the amendment on its website at least 30 days prior to the effective date of change.

II. DEFINITIONS

As used in these terms and conditions:

1. "ARMS," "we," or "us" refers collectively to Atlantic Reproductive Medicine Specialists.
2. "You" means you, the patient.
3. "Service" means any service provided by ARMS, such as healthcare, advice, treatment or supplies provided to you.
4. "Electronic Communications" means any electronic billing and payment communications sent by ARMS to you or by you to ARMS, such as emails relating to billing or payment, disclosures, notices and other communications regarding your Service.
5. "Credit cards" includes both credit cards and debit cards (American Express, Discover, Master Card and Visa.

III. AUTHORIZATION

By supplying your credit card information:

1. You are stating that you are an authorized user of the credit card and that the associated information entered (account holder name, account number, billing address, etc.) is accurate.
2. You authorize ARMS to charge the agreed amount of patient responsibility to your credit card.
3. If you set up automatic payments, then you authorize ARMS to charge the amount due for the invoice being paid to the credit card.
4. You also authorize ARMS to return to your credit card any funds due to you by ARMS resulting from use of this Service. Credit back to credit card will only be done same day as transaction, all other credits will be issued a paper check refund. See Financial Policy.

IV. CHARGES

1. For each transaction, in addition to the charge you authorized, your credit card issuer and network may assess their customary transaction or handling charge, if any.
2. If a charge is declined or reversed by the credit card issuer or network, you agree to pay us a service charge in the amount of $25.00 and to reimburse us the entire reversed amount within 7 business days of the reversal by a new means of payment. Your credit card issuer may also assess its customary charge for such transactions.

V. CREDIT CARD REFUND POLICY

1. Services rendered will not be refunded or reduced and you will continue to be liable for the full payment of the price.
2. If an overpayment was made by the patient for services filed to insurance and patient responsibility was less than estimated a check refund will be issued to the patient during the next refund cycle, as long as the patient does not have any other responsibilities or pending charges.

VI. DISHONORED REQUESTS FOR PAYMENTS

If your credit card issuer or network does not honor an online payment transaction, then we have the right to charge the amount of any such transaction to your account or to collect the amount from you.

VII. CONFIRMATION OF PAYMENT

If you set up automatic payments, then you are consenting to having your credit card processed for the agreed monthly payment and receive a one-time confirmation of each payment electronically to the email address you have provided to us.

VIII. ELECTRONIC COMMUNICATIONS

If you have authorized "Electronic Only" communications, then the following additional terms apply:

1. You understand and agree that ARMS may provide you with all Electronic Communications exclusively online.
2. At your request, we will provide you with paper copies of Communications that we provide you electronically.
3. You may elect to withdraw your consent to receive Electronic Communications (other than confirmation of online credit card payments) at any time by doing one of the following: by emailing together@atlanticreproductive.com, by writing to ARMS at 10208 Cerny Street, Suite 306, Raleigh, NC 27617 or by calling ARMS at 919-248-8777
4. If you give or withdraw consent by writing to us or calling to us, there may be a delay in implementing your request.
5. You may also contact us to request a paper copy of any Electronic Communication or if you need to update any information relating to a change in your email address so that we can continue to contact you.

IX. EFFECTIVE DATE OF THIS NOTICE

This notice is effective upon charge authorization to ARMS.

I have read and understand the terms & conditions for credit card payments and electronic communications. By signing below, I agree with all the terms and conditions and accept responsibility for any payment that becomes due as outlined previously.

Patient Signature: _____ Date: _____