Michigan Center for
Fertility and
Women's Health

Welcome to Michigan Center!

Welcome to Michigan Center for Fertility and Women's Health, PLC! Your health is important, and we are proud you have trusted us with the opportunity to care for you. We look forward to helping meet your special health care needs and establishing a successful relationship with you.

Our entire staff is available to assist you. Dr. Carole Kowalczyk and Dr. Nicole Budrys are both board-certified Reproductive Endocrinologists / Infertility Specialists at Michigan Center for Fertility and Women's Health, offering care for the total woman. They are assisted by two very knowledgeable Physician Assistants, Alexa Karbowski and Mandi Johnson, and our highly qualified and compassionate staff. We have offices in Warren, Bloomfield Hills, and Plymouth and offer the following services:

- Consultations and New Patient Appointments
- Blood Monitoring
- Ultrasounds
- Sonohysterograms
- Semen Analysis
- Artificial Insemination (Warren and Bloomfield Hills locations only)
- Ovulation Induction Cycles
- Assisted Reproductive Procedures including In Vitro Fertilization and Embryo Transfer
- Preimplantation Genetic Testing for Aneuploidies (PGT-A) and/or Preimplantation Genetic Testing for Monogenic Disorders (PGT-M)
- Egg, Sperm & Embryo Cryopreservation
- Egg, Sperm & Embryo Donation

** In addition, we also have a close association with Male Infertility Specialists

In Harmony, LLC is also available at the Warren facility to provide massage therapy, healing touch, mindful meditation, fitness training, laser acupuncture, nutrition, and counseling services for infertility and stress management.

To help provide optimal care, please fill out the paperwork provided to you and bring it back to the office on your first visit. Please allow yourself at least 2 hours for your first appointment. Due to the nature of this specialty practice, some patients may require more time due to individual health needs. Please contact one of our offices if you have any questions before your visit.

We look forward to serving you.

Sincerely,

Carole Kowalczyk, MD
Nicole Budrys, MD
Michigan Center Staff

WARREN
4700 13 Mile Road
Warren, MI 48092
P: 586-576-0431 F: 586-576-0924

BLOOMFIELD HILLS
43494 Woodward Ave., Ste 110
Bloomfield Hills, MI 48302
P: 586-576-0431 F: 248-203-0902

PLYMOUTH
9365 Haggerty Rd
Plymouth, MI 48170
P: 586-576-0431 F: 734-667-3531

Michigan Center for
Fertility and
Women's Health

Dr. Carole Kowalczyk
Dr. Nicole Budrys
Alexa Karbowski, PA-C
Mandi Johnson, PA-C

PATIENT INFORMATION

Today's Date: _____

FIRST NAME _____ LAST NAME _____ MIDDLE _____ SEX _____

DATE OF BIRTH: _____ / _____ / _____ AGE: _____ S M D W MARITAL STATUS SS # _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BUS. PHONE _____ **EMAIL** _____

IS IT OK TO LEAVE A MESSAGE AT: HOME Y / N CELL Y / N BUSINESS Y / N EMAIL Y / N

EMPLOYER _____ POSITION _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE) _____ PHONE _____

RESPONSIBLE PARTY'S EMPLOYER _____ PHONE _____

I AUTHORIZE MY PARTNER TO RECEIVE MY MEDICAL INFO: Y / N _____ SIGNATURE

PHARMACY _____ PHONE _____

PATIENT INSURANCE & PAYMENT INFORMATION

INSURANCE CARRIER _____ CONTRACT / ID # _____ GROUP / POLICY # _____ _____ / _____ / _____ SUBSCRIBER'S DATE OF BIRTH

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PATIENT REFERRAL INFORMATION

REFERRED BY _____ PHONE _____

PHYSICIAN ADDRESS _____ CITY _____ STATE _____ ZIP _____

COPY OF RECORDS FROM REFERRING PHYSICIAN Y / N

DO YOU WANT A FOLLOW UP NOTE SENT TO YOUR REFERRING PHYSICIAN Y / N

PARTNER INFORMATION

FIRST NAME _____ LAST NAME _____ MIDDLE INT _____

DATE OF BIRTH: _____ / _____ / _____ AGE: _____ SEX: M F SS # _____

HOME ADDRESS (IF DIFFERENT FROM PATIENT) _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BUS. PHONE _____ **EMAIL** _____

IS IT OK TO LEAVE A MESSAGE AT: HOME Y / N CELL Y / N BUSINESS Y / N EMAIL Y / N

EMPLOYER _____ POSITION _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

I AUTHORIZE MY PARTNER TO RECEIVE MY MEDICAL INFO: Y / N

SIGNATURE _____

PARTNER INSURANCE & PAYMENT INFORMATION (if different from patient)

INSURANCE CARRIER _____ CONTRACT / ID # _____ GROUP / POLICY # _____ _____ / _____ / _____
SUBSCRIBER'S DATE OF BIRTH

Rev 09/22

Michigan Center for
Fertility and
Women's Health

H.I.P.P.A.
Health Insurance Portability and Accountability Act

Patient Name: _____ Date of Birth: _____

1. **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include diagnostic, radiology, and the laboratory procedures. Blood transfusions, anesthesia, therapeutic procedures, drugs, and medical, nursing, and laboratory care.
2. **Release of Information:** I authorize Michigan Center for Fertility & Women's Health to release pertinent information and/or copies of medical records for treatment, payment or health care operations purposes. I understand such information may include: Human Immunodeficiency Virus (HIV), AIDS Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS) Hepatitis, substance abuse, psychiatric/psychological service records, and social work records, if any. See notice of Privacy practices for further information.
3. **Human Immunodeficiency virus (HIV) and Hepatitis B (HBV) Testing:** I understand and agree that, in accordance with State law, and HIV and HBV test may be performed upon me in event a health care worker sustains a significant exposure to my blood or body fluids. The results of any tests will be treated confidentially.
4. **Testing and Disposal of Specimens and Tissues:** I authorize Michigan Center for Fertility and Women's Health to retain, preserve, or use for research, scientific or teaching purposes or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.
5. **Valuables:** I release (MCFWH) Michigan Center for Fertility and Women's Health from responsibility for all personal articles which I have during the time I am a patient at the office. I understand that (MCFWH) is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession or in the exam room, lab, or office at (MCFWH). I understand personal valuables must be kept with me at all times for their safekeeping.
6. **Payment:** I assign and authorize payment from insurance company directly to Michigan Center for Fertility and Women's Health for any and all services rendered. I agree to pay, at the time of service or an interim basis (agreed upon (MCFWH.), charges not covered by my insurance company. I understand that it is my primary responsibility to pay (MCFWH) all charges for services rendered irrespective and any disputes or disagreements between myself and insurance companies.
7. **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge no guarantees or promises have been made to me as to results of the care and treatment which I have here authorized.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

_____ _____
Date | Signature of Patient, Legal Guardian (if patient is a minor), Patient Advocate/Closest Relative (if patient is unable to consent

_____ _____
Witness Signature | Please indicate relationship to above, if not patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I received a copy of the Notice of Privacy Practices.

Acknowledgement of receipt of Notice of Privacy Practices was not obtained because _____

_____ _____ _____ _____
Patient or Representative Signature | Date | MCFWH Representative | Date

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Michigan Center for Fertility and Women's Health

Michigan Center IVF, PLLC
Fertility Storage, Inc.

Patient Authorization - Female

Please initial next to each statement:

_____ I authorize my insurance benefits to be paid directly to Michigan Center for Fertility and Women's Health, PLC, Michigan Center IVF PLLC, or Fertility Storage, Inc and authorize the release of pertinent medical information to my insurance carrier as required.

_____ I agree that I, and/or the third party (e.g. spouse, parent, or guardian) may have to pay for services that are rendered even though I may have insurance coverage. I, therefore, agree to pay all medical charges that my insurance carrier does not cover, including services that my insurance considers not medically necessary.

_____ I agree to keep my balance current. Anything over 31 days will be considered past due. I understand that non-payment may result in the inability to schedule appointments and/or my account going to collections.

_____ I agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely to secure reimbursement from the insurance carrier is inappropriate and is a fraudulent act. ****Please contact your insurance company regarding infertility benefit coverage. It is the responsibility of the patient to be familiar with their insurance coverage. The easiest way to obtain information from your insurance company is to call the number on your card.**

_____ I understand that Michigan Center for Fertility and Women's Health PLC, Michigan Center IVF, PLLC, and Fertility Storage, Inc., do not participate with Medicaid Insurance. I acknowledge that I do not participate with Medicaid Insurance.

_____ I understand there may be times that my ultrasound scan(s) may need to be sent to an outside facility for a second opinion. In this instance, I am aware that I may receive a bill from an outside radiologist for this service.

_____ I authorize Michigan Center for Fertility and Women's Health PLC, Michigan Center IVF, PLLC, and Fertility Storage, Inc to send medical information back to my referring physician.

_____ **I understand that if I participate in Ovulation Induction Therapy or the IVF program, my blood testing may need to be done at a Michigan Center for Fertility and Women's Health PLC facility due to the critical timing for results for appropriate medication dosing. My insurance may not cover this testing, and I agree to pay for this testing.**

_____ I understand that if I participate in Ovulation Induction Therapy or the IVF program and my insurance does not pay for certain procedure(s) or test(s); I agree to pay for the procedures(s) or test(s) not covered.

_____ If Michigan Center for Fertility and Women's Health, PLC needs to contact you with test results or otherwise, a message will be left only on phone numbers authorized by you. Please make sure to have voicemail set up on that phone number. If this is not acceptable please let us know how to contact you.

Patient Name _____

Patient Signature _____ Date _____

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Michigan Center for Fertility and Women's Health

Michigan Center IVF, PLLC
Fertility Storage, Inc.

Patient Authorization - Male

Please initial next to each statement:

_____ I authorize my insurance benefits to be paid directly to Michigan Center for Fertility and Women's Health, PLC, Michigan Center IVF PLLC, or Fertility Storage, Inc and authorize the release of pertinent medical information to my insurance carrier as required.

_____ I agree that I, and/or the third party (e.g. spouse, parent, or guardian) may have to pay for services that are rendered even though I may have insurance coverage. I, therefore, agree to pay all medical charges that my insurance carrier does not cover, including services that my insurance considers not medically necessary.

_____ I agree to keep my balance current. Anything over 31 days will be considered past due. I understand that non-payment may result in the inability to schedule appointments and/or my account going to collections.

_____ I agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely to secure reimbursement from the insurance carrier is inappropriate and is a fraudulent act. ****Please contact your insurance company regarding infertility benefit coverage. It is the responsibility of the patient to be familiar with their insurance coverage. The easiest way to obtain information from your insurance company is to call the number on your card.**

_____ I understand that Michigan Center for Fertility and Women's Health PLC, Michigan Center IVF, PLLC, and Fertility Storage, Inc., do not participate with Medicaid Insurance. I acknowledge that I do not participate with Medicaid Insurance.

_____ I authorize Michigan Center for Fertility and Women's Health PLC, Michigan Center IVF, PLLC, and Fertility Storage, Inc to send medical information back to my referring physician.

_____ If Michigan Center for Fertility and Women's Health, PLC needs to contact you with test results or otherwise, a message will be left only on phone numbers authorized by you. Please make sure to have voicemail set up on that phone number. If this is not acceptable please let us know how to contact you.

Patient Name _____

Patient Signature _____ Date _____

Rev 05/23

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Insurance and Payment Information and Acknowledgement

Insurance Information

Before you go to the doctor's office, be sure you understand what services your insurance plan will cover, as well as any costs you may pay for covered services.

We accept many different types of insurance and will be happy to assist you with any insurance questions. You need to understand your insurance benefits regarding your care and treatment. This will allow us to serve you most efficiently. If you have questions about your plan, the best and fastest way to get answers is to call the phone number on the back of your insurance card. We do not take Medicare or any forms of Medicaid.

You'll want to understand the following terms and how they apply to your plan:

Deductible: If your plan has a deductible, it means there is a set dollar amount you must pay for covered services, such as office visits.

Copayment and Coinsurance: These are fixed amounts or percentages that you must pay your health care provider for covered services, such as office visits.

If your insurance is a Managed Care or HMO and requires a referral or authorization, it is your responsibility to obtain them. If you do not have the required referral or authorization, you will be expected to pay for services rendered the day of your appointment or reschedule to another day.

Payment Information

All copays will be collected at the time of your appointment.

Patient balances cannot exceed $250.00 Non-payment may result in the inability to schedule appointments and/or the patient account going to collections.

We understand that there are certain times when an appointment cannot be kept. Please try to call our office to cancel at least 24 hours in advance. After two missed appointments, the patient will be billed a $25.00 fee for any appointment not cancelled within 24 hours.

Acknowledgement

I have reviewed and understand the above information regarding insurance and payment.

Patient Name _____

Patient Signature _____ Date _____

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