The Reproductive Medicine Group
The Prelude Network®

Pt initials: _____
Date:_____

Patient Out of Town Monitoring Agreement

Referring Physician Information:

Facility Name: _____ Contact Name: _____
Physician Name: _____ Contact Phone #: _____
Address _____ Fax #: _____

Patient Information

Patient Name: _____ SSN#: _____
Phone #: _____ D.O.B.: _____

I am currently receiving fertility care from _____ in the state of _____. For my convenience, I am requesting that The Reproductive Medicine Group (RMG) provide laboratory and/or ultrasound services for monitoring purposes as part of my ongoing fertility plan of treatment.

Consultation with one of our physicians:

I understand that if I have more than one visit with The Reproductive Medicine Group, I will be required to have a consultation with an RMG physician.

Laboratory and Ultrasound Services:

1. I will need a written order from my physician listing the date and specific lab work and/or ultrasound needed each day of testing. The order should include the diagnosis code and physician's signature. I understand the written order must be available before my testing can be scheduled. I understand that the Out of Town Monitoring Order form is available on RMG's website at: https://www.floridafertility.com/patient-forms/
2. I understand that I will be required to schedule an appointment for any lab and/or ultrasound monitoring services provided at RMG. I also understand I will need to call the office where I am receiving services to schedule the appointment.
3. I understand that The Reproductive Medicine Group will only perform laboratory testing that can be processed at RMG which include:
    a. Estradiol (E2)
    b. FSH
    c. LH
    d. Progesterone (P4)
    e. Beta HCG, quantitative (BhCG)
    f. TSH
    g. Free T4
    h. Prolactin
    i. Rubella
4. I understand that all other requested testing will be sent to another laboratory and that the testing laboratory will bill separately for the services it performs.
5. I understand that if my facility orders any stat lab testing, I will be charged a stat processing fee.

6. I understand that The Reproductive Medicine Group offers the following ultrasound services:
    a. Ultrasound monitoring for Follicle Development and Endometrial Thickness and Pattern
    b. Saline Infusion sonogram
7. I understand that the results of my lab work and/or ultrasound will be faxed to the ordering physician's office and that the ordering physician will be responsible for getting the results to me and any other information that I need.
8. Since my medical care is being coordinated through a physician not associated with The Reproductive Medicine Group, I understand that the physicians and staff of The Reproductive Medicine Group will not be able to answer any of my questions or concerns regarding my medications, injection techniques, treatment plan, laboratory and/or ultrasound results. All my questions or concerns will need to be directed to my referring physician.

Financial Agreement:

1. All charges for services provided by The Reproductive Medicine Group must be paid in full at the time services are provided. I understand that if my facility is responsible for payment, my facility must complete a Credit Authorization form to keep on file for payment of services. I understand this form is available on RMG's website at: https://www.floridafertility.com/patient-forms/

2. In the event that I have insurance coverage for ART monitoring, I will be financially responsible to pay out of pocket the selfpay price to RMG and will submit the Itemized Ledger provided by RMG to my insurance company for reimbursement.

3. I understand that if an authorization from my insurance company is required for any or all of my requested services, I will be responsible to coordinate the authorization through my ordering physician's office.
4. Current price lists for services provided will be made available to me upon my request.

I have reviewed the laboratory/ultrasound services information and financial agreement. I understand that the above terms and conditions as outlined are in effect with The Reproductive Medicine Group and that I am fully responsible for obtaining all required orders and providing payment at time services are provided.

_____	_____	_____
Patient's Signature	Printed Name	Date

Account#: _____