

The Muasher Center

For Fertility and IVF

*Where Experience
and Compassionate
Care Come Together*



Suheil J. Muasher, MD, FACOG

Board Certified
Reproductive Endocrinologist
Medical Director

Associate Professor of Gynecology
and Obstetrics
Johns Hopkins University
School of Medicine

Clinical Professor of Obstetrics
and Gynecology
George Washington University

Professor of Obstetrics
and Gynecology
Virginia Commonwealth University

Former Director of IVF
The Jones Institute for
Reproductive Medicine
(1988-2001)

Former Medical Director
The Jones Institute for
Reproductive Medicine
Northern Virginia /DC Center
(2001-2003)

ADMINISTRATION

Bassam A. Kawwass, FACHE
Chief Executive Officer

Lisa M. Williams
Office Manager

Alice Brown
Front Desk Receptionist

ANDROLOGY, EMBRYOLOGY and ENDOCRINOLOGY LABORATORIES

Jacob F. Mayer, PhD, HCLD
Director

Ashley L. Rettberg, BA
Embryology Supervisor

Abeer Ibrahim, B.Sc., M Phil
Embryologist

NURSING

**Jessica White, RNC, MSN,
WHNP**
Nurse Practitioner

Venecia Williams, RN, BSN
Infertility Nurse

Susan L. English, RN
Infertility Nurse

Prosperity Medical Center

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NOTICE OF PRACTICES ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.
- Disclose protected health information required by law

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization had the right to change its Notice of Privacy Practices at any time and that I may contact this organization at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions. But if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

Date: _____

MCFIVF Staff: _____

Reason: _____

The Muasher Center for Fertility and IVF
Dr. Suheil J. Muasher, MD, FCOG
Female Patient Registration

Name _____ Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip _____
Marital Status: S M D W SS# _____ Marriage Date _____
Phones: Home _____ Cell _____
Work _____ Pharmacy # _____ Email _____
Occupation _____ Employer _____
Primary Care Physician _____ Phone _____
How did you here about us? _____

Spouse/Partner Name _____ Date of Birth _____ Age _____
SS# _____ Phones: Cell _____
Employer _____ Work _____

Billing Information

Primary Insurance _____ Policy Holder _____
ID# _____ Group _____
Secondary Insurance _____ Policy Holder _____
ID# _____ Group _____

I, _____, hereby authorize **The Muasher Center for Fertility and IVF** to apply for benefits on my behalf for services rendered and request that the payments from my insurance company be made directly to the above physician. I authorize **MFC** and staff to disclose information concerning my medical findings and treatment until the date of the conclusion of such treatment, to those individuals who are required such information for the purpose of payment, medical quality assurance and peer review. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges not covered under my insurance plan.

X _____ Date _____