Procreate Foundation
Financial Assistance Program

PATIENT APPLICATION

Phone: (757) 290-0069 Fax: (757) 842-6871

PATIENT INFORMATION Please remember that your program eligibility requires that you promptly notify Procreate Foundation by calling Denise Joyner at (757) 290-0069 if you become insured by any private or government insurance plan

FIRST NAME	LAST NAME	MI

DATE OF BIRTH	GENDER ☐ Male ☐ Female	By providing your e-mail address, you consent to receive additional mailings from Procreate Foundation. E-MAIL

HOME PHONE	MOBILE PHONE

MAILING ADDRESS	CITY	STATE	ZIP CODE

PREFERRED METHOD OF CONTACT ☐ Home phone ☐ Mobile phone ☐ Mail ☐ E-mail	COUNTRY

Please indicate if you or your partner are active, veteran or retired US Military: ☐ Yes (Indicate branch):____________________ ☐ No

Please indicate your dates of service. From ______________ Until_________________________ (Month/Day/Year)

FAX OR MAIL YOUR INCOME VERIFICATION FORM TO:
Fax: (757) 842-6871 Mail: Procreate Foundation • 700 Oak Grove Road • Chesapeake, VA 23320

We will need to know the annual adjusted income for the entire household. The following are acceptable income documents that we can use to validate your income:

- ☐ 1040 Form
- ☐ 1040A Form
- ☐ 1040EZ Form
- ☐ 1040 Form Married Filing Separately (MFS) (Need a form from both filers)
- ☐ 1040A Form (MFS)
- ☐ 1099 Form

How many people live in your household?

PATIENT SIGNATURE AND AUTHORIZATION:
Fax: (757) 842-6871 Mail: Procreate Foundation • 700 Oak Grove Road • Chesapeake, VA 23320

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to Use and Disclose Health and Other Personal Information form. If I am an active duty or retired military member, I commit to making the Procreate Foundation aware, if at any time, I gain private insurance coverage for infertility treatment. If I am not an active duty or retired military member, I commit to making the Procreate Foundation aware, if at any time, I gain any insurance coverage for infertility treatment. No units of product received under this program or any medical expenses related to my fertility treatment will be submitted for Medicare, Medicaid, TRICARE, the Department of Veterans Affairs, the Department of Defense, or any public or private third-party reimbursement, or returned for credit.

Please remember that, as discussed above, your program eligibility requires that you promptly notify the Procreate Foundation by calling Denise Joyner at (757) 290-0069 if you become insured by any private or government insurance plan.

PATIENT SIGNATURE	PATIENT NAME	DATE

ART CENTER CONTACT OR SITE NAME:

ART CENTER	CONTACT E-MAIL

For assistance or additional information, call (757) 290-0069 Monday to Friday, 8:30 AM to 4:00 PM EST

For Administrative Use:

Rec'd Date: Approval Date: Denial Date:

Authorization to Use and Disclose Health and Other Personal Information

Patient's Name ____

Address ____

Home Phone ______________________________ DOB ____/____/______

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to Procreate Foundation and its agents and representatives including any company that helps administer Procreate Foundation's Financial Assistance Program (collectively "Procreate Foundation") so that Procreate Foundation may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) contact me by mail, e-mail, and/or telephone to enroll me in, and administer Procreate Foundation's Financial Assistance Program;

(2) provide me with materials relating to Procreate Foundation's Financial Assistance Program;

(3) verify the accuracy of the information I provide and in my application for Procreate Foundation's Financial Assistance Program;

(4) conduct surveys to measure my satisfaction with Procreate Foundation's Financial Assistance Program.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to Procreate Foundation in order to assist Procreate Foundation in accomplishing the purposes described above. I understand that once my information is disclosed pursuant to this authorization, there is no guarantee that it will not be disclosed to another third party. However, I understand that Procreate Foundation will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative') separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive care at Procreate Fertility Center of Virginia or any other ART center, but it will limit my ability to participate in Procreate Foundation's Financial Assistance Program.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting Procreate Foundation or its representatives in writing by mail or fax at 700 Oak Grove Road, Chesapeake, VA 23320, fax (757) 842-6871. If I revoke this authorization, Procreate Foundation will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by Procreate Foundation that are described in this authorization can be changed at any time, without prior notification.

I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): ____

Signature of patient (or personal representative): ______________________ Date ____/____/______

Authority/relationship of personal representative (if applicable): ______________________

Signature of patient (or personal representative): ______________________ Date ____/____/______

Authority/relationship of personal representative (if applicable): ______________________

PATIENT MUST SIGN THIS FORM, THEN SEND OR FAX BOTH PAGES