SINCE 2023

MUNA FERTILITY

COMPASSIONATE
INCLUSIVE
REPRODUCTIVE CARE

Outside Monitoring Patient Agreement

Facility Name_____

Contact Name_____ Physician Name_____

Office Phone Number_____ Fax Number_____

Patient Name_____ Date of Birth_____

Phone Number_____ Email_____

For my convenience, I would like to request that Muna Fertility provide laboratory and/or ultrasound services to support my ongoing fertility treatment plan with another provider.

Laboratory and Ultrasound Services:

To begin, I understand that I will need a written order from my physician, detailing the specific lab work and/or ultrasound services required for each day of testing. The order must include the diagnosis code and my physician's signature. I recognize that this written order must be submitted before my testing can be scheduled. I can find the **Referral Order Form** on Muna Fertility's website for this purpose.

I also understand that I will need to schedule an appointment for any lab and/or ultrasound monitoring services at Muna Fertility by contacting the office at 404-937-7844.

After my testing, I understand that my lab results and/or ultrasound reports will be sent directly to my ordering physician's office. My physician will be responsible for reviewing the results with me and providing any necessary medical guidance.

Since my care is being managed by a physician outside of Muna Fertility, I understand that the physicians and staff at Muna Fertility will not be able to address questions regarding my medications, treatment plan, or test results. I will reach out to my referring physician's office for clarification or guidance regarding these matters.

Financial Agreement:

I understand that I will need to pay Muna Fertility's self-pay rates at the time of service. This payment will be due regardless of any insurance coverage I may have.

In the event that I have insurance coverage for fertility services monitoring, I understand that I will be required to pay Muna Fertility's self-pay rates at the time of service. I can request an itemized ledger from Muna Fertility to submit to my insurance provider for reimbursement consideration.

I have carefully reviewed and fully understand the terms outlined above regarding laboratory and ultrasound services, as well as the associated financial responsibilities. I acknowledge my responsibility to provide the required orders and to make payment for services before they are rendered.

Patient Signature_____ Date_____

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Outside Monitoring Referral Order Form

Thank you for choosing Muna Fertility to assist in your patient's care. To ensure we can provide the necessary services or tests promptly and accurately, we kindly ask that you complete the referral and fax it to 404-905-5983 or email it to info@munafertility.com. If you have any questions or need assistance with this form, feel free to contact our team at (404) 937-7844. We're happy to help!

Patient Name (printed): _____ Date of Birth: _____

Facility Name:_____

Ordering Physician: _____

Fax Number: _____ Phone Number _____

Diagnosis to use for requested labs/procedure: _____

Preferred Date of Service: _____

Please check the boxes for the requested service(s):

Labs

☐ STAT
☐ Estradiol (E2)
☐ FSH
☐ Other Tests _____
☐ Progesterone (P4)
☐ Beta hCG, Quantitative
☐ LH

Ultrasound Monitoring

☐ Follicle Count and Size
☐ Endometrial Thickness and Pattern
☐ OB Ultrasound
☐ Other _____
☐ Identify Abnormalities (if any): _____

Additional Services

☐Semen Analysis
☐SIS
☐HSG
☐Mock Embryo Transfer (ET)
☐Endometrial Biopsy

Physician Signature_____ Date _____