Patient Registration Form

Center for Reproductive Biology of Indiana

Day Date Time

PATIENT INFORMATION

Last Name First Name Middle Initial

Address City State Zip Code

Home Phone Cell Phone DOB Age Sex

SS# Marital Status

PHYSICIAN INFORMATION

Referring M.D. Address

City State Zip Code Phone

EMPLOYMENT INFORMATION

Employer Business Phone

Street Address City State Zip Code

Occupation May we contact you at work? Hours

SPOUSE OR SIGNIFICANT OTHER INFORMATION

Name D.O.B. SS# Cell Phone

Employer Business Phone Occupation

Address City State Zip

IN CASE OF EMERGENCY CONTACT: (OTHER THAN SPOUSE)

Name Relationship

Home Phone Work Phone Cell Phone

Address

Patient Registration Form

FINANCIAL POLICY

Assignment of Benefits:

I hereby authorize direct payment to the Center for Reproductive Biology of Indiana, LLC of any medical benefits payable to me for the services provided at the Center for Reproductive Biology. I also understand that if my insurance plan requires a referral authorization or precertification for my procedures, it is my responsibility to obtain a referral prior to the procedure. I will be responsible for the unpaid balance due for any bills if this is not done.

Initials: _____

Any services not authorized by your insurance company may be denied and will become your financial responsibility. Please remember that prior authorization does not guarantee benefit payment. It is important that you contact your insurance company for verification of benefits.

Initials: _____

Co-payments, deductibles or fees for non-covered services will be collected at the time of service. We accept cash, check, Visa or MasterCard. We require that all patient-responsibility balances be paid in full prior to beginning a new cycle of treatment.

Initials: _____

Records Release:

I hereby authorize the Center for Reproductive Biology of Indiana, LLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

Initials: _____

Financial Agreement:

I understand the fees for all services rendered are the full responsibility of the patient. It is the patient's responsibility to make sure insurance payments are paid promptly to the laboratory. In the case of default payments, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

I have read and fully understand the financial policy listed above. I understand that I will be given a copy of this policy for my records.

X _____

Signature of Patient or Responsible Party Date