Patient Registration Form

Center for Reproductive Biology of Indiana

Day Date Time

PATIENT INFORMATION

Last Name: First Name: Middle Initial:

Maiden Name: E-Mail Address:

Address: City: State: Zip Code:

Home Phone: Cell Phone: DOB: Age: Sex:

SS#: Marital Status:

PHYSICIAN INFORMATION

Referring M.D. Practice/Clinic:

Address: City: State:

Zip Code: Phone: Fax:

How did you learn about our medical practice?

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: DOB: 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:

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Financial Policy

Assignment of Benefits:

I hereby authorize payment to the Center for Reproductive Biology of Indiana, LLC (CRBI) of any medical benefits payable to me. I also understand that if my insurance plan requires referral authorization or precertification, it is my responsibility to obtain these prior to my lab procedure(s). I will be responsible for any and all fees for services rendered.

Initials: ______________________

I understand CRBI recommends contacting my insurance company to verify my benefits, but that I may request CRBI to submit a claim to my insurance company at any time. I understand that CRBI does not contract with insurance companies, and that all insurance billing will be applied as out-of-network benefits. Any services not authorized or charges not paid by my insurance company will become my financial responsibility. I understand that any unpaid balances will be my responsibility.

Initials: _______________________

I understand that CRBI will ask to collect lab fees prior to or at the time of service. CRBI accepts cash, check, credit card, and health savings accounts. I further understand that it is CRBI's policy to have any previous balances paid in full prior to beginning a new treatment cycle.

Initials: _______________________

Records Release:

I hereby authorize CRBI to release my records to my insurance company and 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 payer.

Initials: _______________________

Financial Agreement:

I understand the fees for all services rendered are the full responsibility of the patient. It is my 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 a copy of this policy can be provided to me at any time for my records.

X ____

Signature of Patient or Responsible Party Date