Virginia Fertility & IVF
4100 Olympia Circle, Suite 201
Charlottesville, VA 22911
434-220-6620 Fax 434-220-6621

PATIENT REGISTRATION

Name:_____ Employer:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Work Phone_____ Cell Phone:_____

Birthdate:_____ Social Security:_____ Sex:____

Email address:_____ Ethnicity:_____ Marital Status: S M W D Sep

Partner's Name:_____Partner's Birthdate:_____

Partner's Social Security:_____Home Phone:_____ Cell Phone:_____

Referring Physician:_____

How did you hear about us? ___doctor ___our website ___Locate-A-Doc ___magazine ___online telephone directory ___patient ___FaceBook __internet _____other

INSURANCE INFORMATION

Please present your card(s) for copying. If the patient is not the primary subscriber, please provide address, social security number, and date of birth of the subscriber. We will not be able to file to your insurance company without this information.

Primary Insurance:_____

Subscriber:_____ID #_____Group #_____

Address:_____City:_____State:_____Zip:_____

Social Security:_____ Birthdate:_____

Secondary Insurance:_____

Subscriber:_____ID #_____Group #_____

See reverse side please

RELEASE & ASSIGNMENT

I hereby consent to any necessary medical diagnosis and treatment for myself, child, or above-named individual for whom I am legally responsible. The release of medical information to any insurance carrier and direct payment to the practice for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

_____ _____

Signature Date

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship.

Virginia Fertility & IVF participates and accepts assignment of insurance benefits of most insurance organizations. Of course, you are still responsible for the timely payment of deductibles, co-insurance, and/or co-payments. Co-payments are due at the time of your visit.

If you have insurance with an organization that we do not participate with, provide us with adequate information, and we will bill your insurance company for you. However, we expect payment in full at the time of your appointment. In these cases, payment of your bill remains your responsibility, including any balance after your insurance company settles your claim.

I accept responsibility for payment of all charges incurred as well as all collection agency costs and/or attorney fees up to 33 1/3% should such collection action become necessary. I further attest that I have received, read, and understand this notice.

NOTICE OF PRIVACY PRACTICES

Virginia Fertility & IVF has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning our acknowledgment and consent.

ACKNOWLEDGEMENT & CONSENT

I have received the Notice of Privacy Practices for Virginia Fertility & IVF. Virginia Fertility &IVF is authorized to use and disclose health information about

_____

(Print patient name) Date of Birth

for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices, including discussions with family members (unless otherwise requested).