

SOUTHWEST FERTILITY CENTER, LTD

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Infertility, Reproductive Endocrinology, Gynecology

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Patient's Name: _____ Age : _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

May we leave confidential messages at your Home / Work / Cell / All phone numbers? Please circle all that apply.

SS#: _____ Employer: _____ Occupation: _____

Name of Spouse / Parent: _____ Age: _____ Date of Birth: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

May we leave confidential messages at your Home / Work / Cell / All phone numbers? Please circle all that apply

SS#: _____ Employer: _____ Occupation: _____

Patient Insurance: _____ Insured Person: _____

Policy#: _____ Group/Acct: _____ Insured Person: _____

Address: _____ City _____ State _____ Zip _____ Ph:(____) _____

Spouse Insurance: _____ Insured Person: _____

Policy#: _____ Group/Acct: _____ Insured Person: _____

Address: _____ City _____ State _____ Zip _____ Ph:(____) _____

How did you hear of us: Physician or / Insurance / Friend or / Our Website / Yellowpage Ad / Magazine Ad
Please circle all that apply Medical Office / List / Relative / Google / Yahoo / Other: _____

Name of Referring Physician/Other: _____ M.D. or D.O.

Address: _____ Phone: _____ Specialty: _____

In case of emergency notify: _____ Phone: (____) _____

I hereby give consent for diagnostic testing and treatment at SOUTHWEST FERTILITY CENTER, LTD. I authorize the release of my medical records to other medical providers and spouse as necessary for my care, and to insurance companies and/or government agencies to facilitate claim processing. I authorize assignment of insurance and/or government benefits directly to SOUTHWEST FERTILITY CENTER, LTD., or other healthcare providers required in your care.

I accept financial responsibility for my account. I understand that payment in full is expected the day services are rendered. Furthermore, I understand I will be responsible for any finance charges, all collection agency fees, and legal expenses incurred in collection of any unpaid balances. I understand that when my claims are submitted to insurance, that I am responsible for paying all deductibles, co-pay, or co-insurance amounts set forth in my insurance plan provisions. I understand that if my doctor does not participate with my insurance, I am responsible for paying when there is a difference, or if benefits are reduced for any reason. If the services rendered are not covered on my insurance policy, I am responsible for those charges in full. If my insurance denies coverage due to non-covered services, at any time, I am responsible for those charges in full.

SOUTHWEST FERTILITY CENTER, LTD., is compliant with Notice of Privacy Practices. If you would like to review our privacy practice policy, please contact our receptionist for a copy. I hereby acknowledge that I have available, at my request, a copy of Southwest Fertility Center's Notice of Privacy Practice Policy.

Patient's Signature: _____ Date _____

Parent/Spouse's Signature: _____ Date _____