SOUTHWEST FERTILITY CENTER

MAKING DREAMS COME TRUE SINCE 1980

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:_____

Email Address: _____ Marital Status: M / S / W / D

Name of Partner / 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:_____

Email Address:_____

Patient Insurance: _____ Primary Insured's Name: _____ Date of Birth:_____

Policy#:_____ Group/Acct: _____ Patient's relation to Primary Insured: Self /Spouse/Other

Insurance Address:_____City_____State_____Zip_____Ph:(_____)_____

Secondary Insurance: _____ Primary Insured's Name: _____ Date of Birth:_____

Policy#:_____ Group/Acct: _____ Patient's relation to Insured: Spouse/Other

Insurance Address:_____City_____State_____Zip_____Ph:(_____)_____

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

Disclaimer: 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 as necessary for my care and to insurance companies and/or government agencies to facilitate claim processing. Any other party will require a medical record release filled out when the records are requested. 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 and legal expenses incurred in collection of any unpaid balances. I/We understand and agree to pay a 50% (fifty percent) collection agency fee in addition to any outstanding balances over 90 days past due. 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_____

Responsible Party Signature: _____ Date_____

HOW DID YOU HEAR ABOUT US? Yelp / Google Search / Google + / Facebook / Friend Referral: _____

Doctor Referral: _____ Phone:_____Specialty:_____