

THE FERTILITY INSTITUTE OF VIRGINIA, LTD.

10710 Midlothian Turnpike, Suite 331

Richmond, Virginia 23235

(804) 379-9000 Fax (804) 379-9031

PATIENT REGISTRATION FORM

PATIENT: LAST NAME: _____ FIRST: _____ MI: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (H) _____ (W) _____ (CP) _____

DATE OF BIRTH: ____ / ____ / ____ AGE: _____ SSN: _____ - _____ - _____

EMPLOYMENT: _____ ADDRESS: _____

SPOUSE/PARTNER: LAST NAME: _____ FIRST: _____

DATE OF BIRTH: ____ / ____ / ____ AGE: _____ SSN: _____ - _____ - _____

EMPLOYMENT: _____ ADDRESS: _____

PHONE: (W) _____ (CP) _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

PHONE: (H) _____ (W) _____ REL. TO PATIENT: _____

INSURANCE: *IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, PLEASE GIVE IT TO THE RECEPTION-IST AT THIS TIME. IF YOU DO NOT HAVE A REFERRAL, YOU WILL BE ASKED TO SIGN A WAIVER OR RESCHEDULE FOR ANOTHER DAY. IF YOU OWE A COPAY, IT IS DUE AT THE TIME OF YOUR VISIT.

PRIMARY INSURANCE: _____

MAILING ADDRESS TO SUBMIT CLAIMS: _____

SUBSCRIBER NAME: _____ POLICY ID: _____ GROUP: _____

SECONDARY INSURANCE: _____

MAILING ADDRESS TO SUBMIT CLAIMS: _____

SUBSCRIBER NAME: _____ POLICY ID: _____ GROUP: _____

REFERRING PHYSICIAN: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

I hereby authorize The Fertility Institute of Virginia, Ltd., to release my medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to The Fertility Institute of Virginia, Ltd. benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered valid as the original.

DATE: ____ / ____ / ____ PATIENT'/RESPONSIBLE PARTY'S SIGNATURE: _____

**Please advise if another insurance company covers spouse/partner. If so, please supply a copy of insurance card. Thank you.*

THE FERTILITY INSTITUTE OF VIRGINIA, LTD.

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

All professional services rendered are charged to the patient or their legal guardian. Payment for services is requested at the time of services unless other arrangements have been made in advance through our business office. The Fertility Institute of Virginia, Ltd. will file claims with your insurance company as a courtesy to you; we ask your understanding of and cooperation with our financial policies. I authorize payment of such insurance benefits to The Fertility Institute of Virginia, Ltd.

I understand that I am financially responsible for my deductible, copayments, and/or balance remaining after my insurance has paid. In addition, if my insurance carrier does not pay for my medical services, I am responsible for all charges for my medical care.

I understand that as a part of my health care, The Fertility Institute of Virginia, Ltd. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A basis for planning my care and treatment
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that The Fertility Institute of Virginia, Ltd. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section, 164.506 of the Code of Federal Regulations.

I further understand that The Fertility Institute of Virginia, Ltd. reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the practice change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use of disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsimile.

Signature of Patient: _____ Date: _____

HMO REFERRAL INFORMATION

I understand that my HMO plan will not pay for some services or supplies, which are experimental, and I agree to pay for such services or supplies.

Signature of Patient: _____ Date: _____