

Reproductive Medicine and Surgery Center of Virginia, PLC
595 Peter Jefferson Parkway, Suite 390
Charlottesville, VA 22911
434-982-8520 Fax 434-982-8521

PATIENT REGISTRATION

Name: _____ Social Security: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone _____ Cell Phone: _____

Birthdate: _____ Sex: _____ Marital Status: S M W D Separated Ethnicity: _____

Employer's Name: _____

Partner's Name: _____ Partner's Birthdate: _____

Partner's Social Security: _____ Home Phone: _____ Work Phone: _____

Name of Primary Care Physician: _____

Referring Physician: _____

How did you hear about us? ___ doctor ___ internet ___ phone book ___ 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.

Reproductive Medicine and Surgery Center of Virginia, PLC 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. 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

Reproductive Medicine and Surgery Center of Virginia, PLC 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 Reproductive Medicine and Surgery Center of Virginia, PLC. Reproductive Medicine and Surgery Center of Virginia, PLC 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). Becoming pregnant is a couple's issue. For this reason I agree that RMSCVA has the authorization to discuss my test results and treatment plans with my spouse/intimate partner, whose name is-_____. I will notify RMSCVA if this authorization changes but understand there is no expiration.

Signature of Patient

Date