!! ITEMS IN RED MUST BE COMPLETED AFTER PRINTING !!

The Center for Reproductive Medicine, P.C.

(251) 438-4200 • (251) 438-4211 *Chart No.* _____

Date *Email* ☐ *YES* ☐ *NO*

Patient's Name _____

First *Middle* *Last*

Street Address _____

City *State* *Zip* _____ *Age* _____ *Birth Date* _____

***Patient's** Social Security No.* _____

Home Phone: _____ *Cell Phone:* _____

Circle One: ○ *Single* ○ *Married* ○ *Widowed* ○ *Divorced*

Insurance Information

Primary Insurance _____ ***Secondary Insurance*** _____

Contract No. *Contract No.* _____

Group No. _____ *Group No.*

Subscriber ○ *Self or* ○ *Spouse* ***(PLEASE CIRCLE ONE)*** *Subscriber* ○ *Self or* ○ *Spouse* ***(PLEASE CIRCLE ONE)***

***Patient's** Employer / School*

Business Address

Occupation *Business Phone* ( )

Spouse's / Partner Name *Email*

Employer *Business Phone* ( )

Occupation *Cell Phone* (_____)

Birth Date _____ *Social Security No.*

Insurance Co. *Subscriber* Select *Contract #* *Group#*

(please select from dropdown)

I GIVE MY PERMISSION TO RELEASE ANY AND ALL OF MY TEST RESULTS TO MY SPOUSE/PARTNER AND OR PERSON LISTED BELOW.

SPOUSE/PARTNER

PARENT/OTHER _____

DECLINE INITIAL HERE IF YOU ONLY WANT US TO SPEAK WITH YOU

Pharmacy Name

Phone _____

*In case of emergency, contact (**OTHER THAN SPOUSE**):*

Phone: *Name/Relationship*

***How did you learn of our practice**? Circle one:* ○ *Referring Dr* ○ *Internet* ○ *Friend* ○ *Phone Book*

***Referring Doctor**:*

- OVER -

*We accept assignment on most insurance carriers but **YOU** are responsible for any services not covered by your insurance carrier. **YOU** are responsible for all charges incurred. You are responsible for any medical fees which your insurance companies denies for failure on your part to obtain referrals or prior authorizations. You are responsible for services rendered which are not paid for by your insurance at the time of service such as deductibles, co-pays and for services which are deemed necessary by our physicians, but are not covered by your insurance even if you fail to pay for services rendered, you agree to pay reasonable attorney's fees and all costs of collection including court costs if this matter is referred to an attorney.*

Medical Records Release and Assignment either by Fax or Copies

I hereby authorize my physician Dr. George T. Koulianos or Dr. George B. Inge to release any information acquired in the course of my examination or treatment by Dr. Koulianos or Dr. Inge to my health insurance carriers, referring physicians, and any other physicians or hospitals which might provide services to me while I am receiving services from Dr. George T. Koulianos or Dr. George B. Inge. I understand that this information is either transmitted through FAX transmission or copies made of the original document mailed via US Post Master.

I also give my permission to be contacted or for a message to be left in regards to any account balances, test results and/or any treatment and care by The Center for Reproductive Medicine.

PLEASE INITIAL:

_____ I AGREE **_____ I DO NOT AGREE**

to communicating via email with physicians, nurses, and other office staff regarding medical, insurance, and billing matters. I understand that while every effort will be made to keep my information secure and private, The Center for Reproductive Medicine cannot make any guarantees in this regard and that there are risks associated with unencrypted email transmissions including but not limited to the possibility of information being intercepted by a third party or improperly accessed during storage or transmission. I also understand that The Center for Reproductive Medicine has no control over the internet service provider that transmits the information.

I have read the above agreement and agree to all.

I would like to receive a copy of The Center for Reproductive Medicine's Privacy Practices

*I **DO NOT** wish to receive a copy of The Center for Reproductive Medicine's Privacy Practices*

_____

Signature *Date*