DATE: _____/_____/_____

PATIENT REGISTRATION FORM

ENTERED BY: _____

ACCOUNT # : _____

(PLEASE PRINT CLEARLY)

EMAIL:		
PATIENT'S FIRST NAME:	PATIENT'S LAST NAME:	SOCIAL SECURITY #: _ _

ADDRESS:	GENDER: AGE: DATE OF BIRTH: _ M _ F Month: Day: Yr:
CITY: STATE: ZIP CODE:	MARITAL STATUS: _ Single _ Married
HOME PHONE:	REFERRED BY:
WORK:	ADDRESS:
EMPLOYER:	CITY: STATE: ZIP CODE:
WORK ADDRESS:	TELEPHONE #:
CITY: STATE: ZIP CODE:	OB/GYN: PHONE#:

Please give us all information regarding your insurance plan(s). Please show all numbers on your card(s). If your benefits depend on pre-authorization or referral, it is your responsibility to inform us.

PRIMARY INSURANCE:	INSURED NAME:
ADDRESS:	INSURED'S DOB: GENDER: Month: Day: Yr: _ M _ F
CITY: STATE: ZIP CODE:	PATIENT RELATIONSHIP TO INSURED _ SELF _ SPOUSE _ OTHER
PHONE:	INSURED'S EMPLOYER:
POLICY#:	ADDRESS:
GROUP#:	CITY: STATE: ZIP CODE:
POLICY EFFECTIVE DATE:	TELEPHONE #:
SECONDARY INSURANCE:	INSURED NAME:
ADDRESS:	INSURED'S DOB: GENDER: Month: Day: Yr: _ M _ F
CITY: STATE: ZIP CODE:	PATIENT RELATIONSHIP TO INSURED _ SELF _ SPOUSE _ OTHER
PHONE:	INSURED'S EMPLOYER:
POLICY#:	ADDRESS:
GROUP#:	CITY: STATE: ZIP CODE:
POLICY EFFECTIVE DATE:	TELEPHONE #:

PARTNER'S NAME:	SOCIAL SECURITY #: _ _
ADDRESS:	GENDER: AGE: DATE OF BIRTH: _ M _ F Month: Day: Yr:
CITY: STATE: ZIP CODE:	RELATIONSHIP TO PATIENT: _ SPOUSE _ OTHER
PHONE #:	EMPLOYER:
PARTNER'S INSURANCE:	ADDRESS:
POLICY #:	CITY: STATE: ZIP CODE:
EFFECTIVE DATE:	PHONE #:
EMERGENCY CONTACT:	**PHONE#:**

THE CENTER FOR HUMAN REPRODUCTION ™
CLINICAL CARE • RESEARCH • EDUCATION
21 EAST 69TH STREET • NEW YORK, NEW YORK 10021

Authorization for Access by Others to Your Medical Records

Patient Name: _____
Last First Middle

Home Address: _____
Street Address City State Zip Code

Home Phone: _____ Date of Birth: _____

Please check off all situations below where you would grant the individuals listed below access to your medical records:

[ ] Confirmation of appointment details (including preparation for exam information)
[ ] Pick-up medical documentation (films, reports)

Last 4 digits of your SSN (this will be the pass code for access to you Medical Record) _____

Please list Individuals for whom you authorize access to your Medical record:

Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Other: _____
Name: _____ Other: _____

Acknowledgement: By submitting this form, I hereby permit the office to disclose my Medical Record to the individual(s) above. I understand that each individual I have listed will be required to provide the pass code I have indicated here in order for the office to release my Medical Record to them. In addition, the authorized individual(s) must present identification as proof that they are who they claim to be. I also understand that the office reserves the right to deny access if deemed necessary.

Signature: _____ Date of Authorization: _____

The Center for Human Reproduction

CLINICAL CARE ● RESEARCH ● EDUCATION

www.CenterForHumanReprod.com

Authorization of Disclosure to Insurance Providers and Acknowledgment of Financial Responsibilities

I, _____, hereby authorize CHR to release information concerning the treatment and the cost of said treatment to my insurance company and/or other third party administrator which may be responsible for payment of my treatment. I understand that CHR staff member will verify insurance coverage and obtain preauthorization for procedures CHR considers necessary.

I authorize payment to CHR for the healthcare benefits, and agree that, in the event that the cost of treatment is not fully covered or reimbursed by my insurance company and/or third party payer, it shall be my personal responsibility to pay to CHR the full cost of the services rendered. I also agree that I am responsible for my percentage of benefits that the insurance company deems my responsibility.

I agree that if I do not have insurance coverage, the cost of my treatment will be my personal financial responsibility. Payment must be made at the time of service, and CHR will provide a receipt which will be acceptable for insurance submission by me. I further understand and agree that I am responsible for all costs of collecting amounts due for services rendered, including but not limited to, attorney's fees and legal expenses.

Patient Signature	Patient Name	Date

Previously used insurance benefits

It is important for both you and CHR to understand what portion of your treatment will be covered by your insurance benefits and what portion you will be responsible for. Depending on the type of treatment that you need, we may need to clarify with your insurance provider what portion of the benefit their records show you have used. We also need to clarify with you what infertility services you have used but have not yet been charged to your insurance provider. Our financial department will work with you to develop a plan based on your available insurance benefits. Please complete the section below to help us calculate your deposit estimate.

I have had any treatment in the last 12 months (Please circle one): Yes / No
Describe the treatments received:
Insurance provider: