THE CENTER FOR REPRODUCTIVE HEALTH
THE CENTER FOR ASSISTED REPRODUCTIVE TECHNOLOGIES
2410 PATTERSON STREET, SUITE 401, NASHVILLE, TN 37203

Date __________________ **Referred By**

☐ Physician (Circle One) OB/GYN – PCP – Urologist - FP

Name: ___________________________

Address: __________________________

City, State: ___________________________

Zip: __________________________

Tel#: ___________________________

☐ Internet/Website

☐ Healthlink/Channel 5

☐ Yellow Pages

☐ Fertility Lifelines

☐ Parent Magazine

☐ Friend: ___________________

☐ Other: ____________________

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone#: ___________________________ Fax #: ___________________________

PATIENT'S NAME: __________________________________ SS# _________-_______-________

Address: ____ City _________________________
(If post office box, please list physical address as well)

State:___________ Zip: ____________ Home Phone: ( ) ___________-________________

Cell Number: __________________ DOB: __________ Sex: M / F Marital Status: M / S / W / D

Race: Caucasian / African American / Hispanic / Native American / Alaskan Native / Asian / Pacific Islander / Other (Required for state reporting).

Employer:____Occupation:______________________

Employer's Address: ____

State: _____________ Zip: _________ Work Phone: ( ) ________-__________ EXT _______

Spouse's Name: _______________________________________ SS# _______-_______-________

Address: ____ City: __________________________

State: ______________________ Zip: ______________ Home Phone: ( ) _________-______

Cell Number: ______________________________________ Sex: M / F DOB: _______________

Spouse's Employer: ______________________________ Occupation: ________________________

Employer's Address: ____

State: _____________ Zip: _________ Work Phone: ( ) ______-________ EXT _________

FEMALE INSURANCE INFORMATION

Primary

Primary Insurance Carrier _______________________________________ HMO/PPO
(If HMO Please provide us with the following information:) (circle one)

PCP __________________________________ Phone # ______________________________

Does your Insurance require a referral? Yes or No

Claims Address: ____

Phone # ____________________________ Policy Holder: ___________________________

Relationship To The Policy Holder: ____

Policy Holders Date of Birth: ________________ SS# _________-__________-__________

I.D. # ____________________________________ Group # __________________________

Effective Date of Coverage: _________________ Is this insurance through your

employer? _______ If yes, please provide the name of the company _________________

Secondary

Secondary Insurance Carrier ____ HMO/PPO
(If HMO Please provide us with the following information:) (circle one)

PCP __________________________________ Phone # ______________________________

Does your Insurance require a referral? Yes or No

Claims Address: ____

Phone # ____________________________ Policy Holder: ___________________________

Relationship To The Policy Holder: ____

Policy Holders Date of Birth: ________________ SS# _________-__________-__________

I.D. # ____________________________________ Group # __________________________

Effective Date of Coverage: _________________ Is this insurance through your

employer? _______ If yes, please provide the name of the company _________________

MALE INSURANCE INFORMATION

Primary

Primary Insurance Carrier ______________________________________ HMO/PPO
(If HMO Please provide us with the following information:) (circle one)

PCP _________________________________ Phone # _____________________________

Does your Insurance require a referral? Yes or No

Claims Address: ____

Phone # ___________________________ Policy Holder: __________________________

Relationship To The Policy Holder: ____

Policy Holders Date of Birth: _______________ SS# ________-_________-_________

I.D. # ___________________________________ Group # ________________________

Effective Date of Coverage: ________________ Is this insurance through your

employer? _______ If yes, please provide the name of the company ________________

Secondary

Secondary Insurance Carrier ____ HMO/PPO
(If HMO Please provide us with the following information:) (circle one)

PCP _________________________________ Phone # _____________________________

Does your Insurance require a referral? Yes or No

Claims Address: ____

Phone # ___________________________ Policy Holder: __________________________

Relationship To The Policy Holder: ____

Policy Holders Date of Birth: _______________ SS# ________-_________-_________

I.D. # ___________________________________ Group # ________________________

Effective Date of Coverage: ________________ Is this insurance through your

employer? _______ If yes, please provide the name of the company ________________

Does insurance require prior authorization, referrals from the primary care physician, pre-admission certification to hospital, or second surgical opinion? (circle those that apply)

EMERGENCY CONTACT

Name ________________________________ Phone # ____________________________

Relationship to the patient: ____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
AND
ASSIGNMENT OF BENEFITS

I hereby authorize the Center for Reproductive health, P.C. and/or the Center for Assisted Reproductive Technologies, LLC to release any and all medical information which the insurance company may require for processing my claims and/or proof of good health in applying for insurance.

I hereby assign benefits to which I and/or my dependents are entitled under my insurance plan to the Center for Reproductive Health, P.C. and/or the Center for Assisted Reproductive Technologies, LLC.

REQUESTING COPIES OF MEDICAL RECORDS

Requests for copies of patient records must be **in writing.** Telephone requests are not acceptable, but requests may be faxed to the office. You may obtain a medical records release form from a member of our staff.

CRH shall furnish copies within 10 days of receipt of the written request. Because of confidential nature of medical records, CRH shall not fax medical records to any location.

Cost of copying $0.50 per page up to 40 pages in length and $0.25 per page for each page copied after the first 40 pages plus postage.

Costs of copying must be paid prior to records being mailed.

REFUNDS

If you make a payment using a credit card and a refund is due, your credit card will be credited the amount due minus any applicable credit card fees.

____

Patient Signature Date

____

Patient Signature Date

PAYMENT AND COLLECTION POLICY

Please read carefully. Should you have any questions, please ask prior to signing this statement.

I agree to pay for services provided by The Center for Reproductive Health and/or the Center for Assisted Reproductive Technologies. I also acknowledge that I am fully responsible for the balance which my insurance company does not reimburse the Center's. ***I have been advised that verification of benefits and pre-certification is not a guarantee of payment.*** Final claim determination will be made based on but not limited to, eligibility at time of service, actual services rendered, and plan limitations. I am responsible for all Non-Covered services and agree to pay for all services. I understand that I should contact my insurance company if I have any concerns regarding insurance reimbursement. I understand if my insurance requires a referral, it is my responsibility to obtain the referral—the Center is not and will not be responsible for obtaining the referral for me. If I fail to obtain the referral, prior to services being rendered, the Center will not submit claims to my insurance company and I will be responsible for 100% of charges.

I further acknowledge that I will be liable for any collection fees and/or court costs and attorney fees, should my account become delinquent and be forwarded for collections. including charges of 25% to 33.33% of the outstanding balance. Once an unpaid account is placed in collections, all office visits are on a cash only basis.

I further acknowledge that I will be charged monthly 1.5% interest on any balance over 30 days old.

There is a separate $25.00 fee for all returned checks. The patient is responsible for payment of the check and this additional $25.00 fee upon notification of the returned check. This payment must be made by cash, credit card, cashier check or money order in the amount of the returned check plus the $25.00 fee.

I permit a copy of this authorization to be used in place of the original.

I have read and fully understand the above.

____

Signature of Patient Date

____

Signature of Patient Date

____

Witness Signature Date