

Virginia IVF & Andrology Center

9030 Stony Point Parkway, Suite 390 Richmond, VA 23235 (804) 323-9980

Date of Service: _____

Patient Information Form

New Patient: Complete all sections, sign in the last block

Repeat Patient: Complete bold sections marked with an *, update any information as needed, sign in the last block

***Patient Name (Male):** _____ *** Female Partner:** _____

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

***Birth Date:** _____ ***Soc. Sec. #:** _____ - _____ - _____ Marital Status: Married / Single / Other

Home Phone: (____) _____ Cell Phone : (____) _____ Work Phone : (____) _____

Please circle numbers on which we can leave a detailed message: home / cell / work / none

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: (____) _____ Relationship: _____

Primary Insurance Company Name: _____ Phone (____) _____

Name of Insured: _____ Relationship to Insured: Self / Spouse / Child / Other

Claims Filing Address: _____

Subscriber ID#: _____ Group #: _____

Secondary Insurance Company Name: _____ Phone (____) _____

Name of Insured: _____ Relationship to Insured: Self / Spouse / Child / Other

Claims Filing Address: _____

Subscriber ID#: _____ Group #: _____

If Insured on Primary or Secondary Policy is Other than Patient:

Insured's Birth Date: _____ Insured's Soc. Sec. #: _____ - _____ - _____

Insured's Home Phone: (____) _____ Insured's Work Phone: (____) _____

Insured's Employer or Occupation: _____ Plan or Program Name: _____

____ ***File a courtesy claim with my insurance carrier(s) (information as provided above). I understand that I am responsible to obtain any necessary referrals or authorization for treatment. I understand that Virginia IVF & Andrology Center is non-participating with all insurance plans and that I am responsible to pay all charges at the time of service, unless otherwise directed by Virginia IVF & Andrology Center.**

____ ***Do not file a courtesy claim with my insurance carrier.**

I understand that Virginia IVF & Andrology Center is a Virginia limited liability company owned and operated by the following individuals: Drs. Edelstein, Gianfortoni, Matt, Rosenberg, Steingold and Tidey. Dr. Matt is the Laboratory Director for Virginia IVF & Andrology Center. All other owners are physicians who provide treatment and procedures at the laboratory as an extension of their office practices. Other physicians may, on occasion, also perform procedures at the laboratory.

I hereby authorize Virginia IVF & Andrology Center to release information regarding services rendered to me to the insurance company(ies) named heron; and assign payment directly to Virginia IVF & Andrology Center. I understand that I am financially responsible for all charges incurred by me at Virginia IVF & Andrology Center. I agree that in the event that my account must be referred to an attorney for collection, I will be responsible for all attorney's fees, court costs, and interest.

***Signature:** _____

***Date:** _____

PHYSICIAN / VIRGINIA IVF & ANDROLOGY CENTER USE ONLY

Doctor's Name: _____ Signature: _____ Diagnosis Code (ICD-9): _____

Test(s) Requested:	_____ Semen Analysis	_____ Semen Wash	_____ Sperm Isolation
	_____ Semen Analysis, limited	_____ Sperm Swim-up	_____ 24hr. Motility
	_____ Cryostorage, 1st	_____ Cryostorage, Repeat	_____ Cryo, IUI Ready
	_____ Retrograde SA, urine	_____ Antisperm Antibodies D/ I	_____ Courier Fee
	_____ TESA/PESA Kit	_____ On-Site Assistance	_____ Other: _____
	_____ Release IUI Ready	_____ Thaw/Wash Frozen Sample	_____

Total Payment Collected: _____ **Check** **Cash** **Credit** **None, Agreement Signed** **Collected by:** _____