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: ________