Virginia IVF & Andrology Center

9030 Stony Point Parkway, Suite 390 Richmond, VA 23235 (804) 323-9980 Fax (804) 323-9979

Patient Information Form

THANK YOU FOR PRINTING LEGIBLY

Patient Name_____ Partner Name_____
Full Legal Name – First MI Last Full Legal Name – First MI Last

Address_____ City_____ State_____ Zip_____

Birth Date_____/_____/_____ Social Security #_____-_____-_____ □M □F □Married □Single □Other

Home Phone (____)_____ Cell Phone (____)_____ Preferred Contact # □Home □Cell □Work

May we leave detailed phone messages that contain protected health information (PHI)? □Yes □No

Email_____ *By providing an email address, you agree that we may offer the option to electronically sign future documents and if you choose to electronically sign; we may legally rely upon that signature.*

Patient Employer_____ Occupation_____ Work Phone (___)_____ext____

Emergency Contact_____ Phone (____)_____ Relationship_____

What Physician Referred you to Virginia IVF? _____ Phone (____)_____

Are you an Egg Donor? □Yes □No Are you a Gestational Carrier? □Yes □No Are you a Sperm Donor? □Yes □No

If a Donor or Carrier, for what Patient? Name_____ Birth Date____/____/_____

□No Insurance □Insurance (prepay & file courtesy claim) □Shared IVF Success Program □Multicycle Program □WINFertility

Primary Insurance _____ Phone (____)_____ ID#_____ Group #_____

Address_____ City_____ State_____ Zip_____

Policyholders's Name_____ Patient's Relationship to Policyholder: Self / Spouse / Child / Other

Insured's Birth Date_____/_____/_____ Insured's Social Security #_____-_____-_____

Insured's Phone (____)_____ Insured's Employer_____ Work Phone (____)_____

Secondary Insurance _____ Phone (____)_____ ID#_____ Group #_____

Address_____ City_____ State_____ Zip_____

Policyholders's Name_____ Patient's Relationship to Policyholder: Self / Spouse / Child / Other

Insured's Birth Date_____/_____/_____ Insured's Social Security #_____-_____-_____

Insured's Phone (____)_____ Insured's Employer_____ Work Phone (____)_____

CONSENT AND SIGNATURE

□IVF Services Patient

□Endocrine Services Patient

□Andrology Services Patient

I give permission for requested/scheduled laboratory service(s) to be performed using my blood, urine and/or semen sample as presented by me, my partner, or delivered by courier to Virginia IVF and Andrology Center.

I understand that most semen analysis are performed under subcontract with LabCorp and that if I have a semen analysis, whether a separate test or part of a diagnostic test, protected health information about me may be released to LabCorp for billing and payment purposes.

I understand it is Virginia IVF and Andrology Center's policy NOT to file insurance for any services which are paid in full by me, unless requested to do so in writing via the *Supplemental Patient Information Form*. For Endocrine and Andrology Services that have not been paid in full, I hereby consent to allow Virginia IVF and Andrology Center and/or LabCorp to release information regarding my services to the insurance company(ies) whose information is provided above. I understand that I am responsible for obtaining any referrals or authorizations. I understand that I am financially responsible for all charges incurred by me and in the event my account is referred to an attorney for collection, I will also be responsible for attorney's fees in the amount of 33⅓% of the unpaid balance due, court costs, and interest. I also agree that any legal disputes will be settled through the court system of the City of Richmond, Virginia.

Patient Signature _____ **Date**____/____/_____

□ Patient not present

Partner Name_____ **Signature**_____ **Date** ____/____/_____