

REPRODUCTIVE CARE CENTER

Patient Registration (Wife)

Last Name:		First Name:		Middle Name or Initial:			
Address Line:		City:		State:	Zip:		
Phone #: Home:		Work:	Cell:	Pager:	Voice Mail:		
Email Address:		Preferred contact method:		Home Phone	Work Phone	Cell Phone	Email
Date of Birth:		Sex:	Marital Status:		Race:	Religion:	
Social Security #:		Driver's License # & State:					
Occupation:		Patient's Employer:					
Employer Address:		City:		State:	Zip:		
Referred by:		Current OB/GYN:					
Current primary care physician:		Other current physicians:					
Preferred local pharmacy:		Pharmacy phone #:					

Spouse Information (Husband)

Spouse's Last Name:		First Name:		Middle Name or Initial:			
Phone #: Home:		Work:	Cell:	Pager:	Voice Mail:		
Email Address:		Preferred contact method:		Home Phone	Work Phone	Cell Phone	Email
Date of Birth:		Sex:	Marital Status:		Race:	Religion:	
Social Security #:		Driver's License # & State:					
Occupation:		Patient's Employer:					
Employer Address:		City:		State:	Zip:		
Current primary care physician:		Current Urologist:					

Insurance Information

Insurance #1 Name:		Coverage: Patient: Yes No		Spouse: Yes No	
Insurance #1 Address:		Ins #1 Phone:			
Policyholder Last Name:		First Name:		Relationship:	
Certificate No.:	Group No.:	Member No.:			
Insurance #2 Name:		Coverage: Patient: Yes No		Spouse: Yes No	
Insurance #2 Address:		Ins #2 Phone:			
Policy Holder Last Name:		First Name;		Relationship:	
Certificate No:	Group No.:	Member No.:			

Emergency Contact Information

Emergency Contact Name (Not Living With You):		Relationship:	
Address:	Day Phone #:	Evening Phone #:	

Payment/Insurance - In consideration for services provided to me (us) or my (our) dependents, I (we) acknowledge responsibility for payment for services rendered at the Reproductive Care Center (RCC). If such services are covered under a contract between RCC and my (our) insurer, I (we) acknowledge responsibility for any deductibles, co-payments, and non-covered services. I (we) understand that I (we) must obtain any exception from standard RCC payment or billing policy in writing or it will not be considered binding. If my (our) account becomes delinquent, I (we) agree to pay all costs the RCC may incur in collecting its fees including collection agency and attorney's fees. If charges on my (our) account are not fully paid within 30 days of the date of service, I (we) also agree to pay interest from that date at a rate of 1.5% per month. Unless full payment is made on the date of service, I (we) authorize my (our) insurer to pay my (our) medical benefits directly to the RCC.

Dispute resolution - Unless otherwise agreed to in writing, I (we) agree that any possible dispute or claim in relation to services which I (we) received from RCC shall be settled solely by arbitration. Any arbitration proceeding will be conducted in accordance with the laws of the State of Utah. The locale will be Salt Lake County, Utah, and the arbitrators' judgment may be entered in any appropriate court and shall be binding and enforceable.

Information release - I (we) authorize the release of any medical information necessary to permit processing of claims made to insurance for services performed by the RCC. I (we) acknowledge that I (we) have been given the opportunity to read and if requested have a copy of the "Notice of Privacy Practices" of the Reproductive Care Center. I (we) authorize our spouse (if applicable) to receive medical information regarding my (our) treatment/tests. I (we) understand that I (we) may withdraw my (our) authorization at any time by stating the desire in writing and mailing it or faxing it to RCC and then calling to verify that the request to withdraw information was received.

Patient Signature

Date

Spouse Signature (required)

Date