SAVE PRINT

Fertility & Cryogenics Lab

8635 Lemont Rd. Downers Grove, IL 60516
Tel: (630) 427 0300. Fax: (630) 427 0302

PERSONAL AND DEMOGRAPHIC INFORMATION

LAST NAME: _____FIRST NAME: _____M.I._____

ADDRESS: _____

BIRTHDATE: _____/_____/_____ AGE: _____ SOCIAL SECURITY # _____-_____-_____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐OTHER

PHONE-HOME: _____WORK: _____ CELL: _____

GENDER: ⊙MALE ○FEMALE RACE: _____

SPOUSE/PARTNER NAME: _____ SPOUSE/PARTNER BIRTHDATE_____/_____/_____

FINANCIAL AND INSURANCE INFORMATION

SELF PAY _____

PERSON RESPONSIBLE FOR BILL: _____ RELATIONSHIP: _____

INSURANCE #1 _____ POLICY HOLDER: _____

BIRTHDATE: _____/_____/_____ ID/POLICY # _____ GROUP # _____

RELATIONSHIP TO INSURED: _____EMPLOYER: _____

INSURANCE #2 _____ POLICY HOLDER: _____

BIRTHDATE: _____/_____/_____ ID/POLICY # _____ GROUP # _____

RELATIONSHIP TO INSURED: _____ EMPLOYER: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

REFERRING PHYSICIAN: _____

ADDRESS: _____ PHONE: _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned hereby consent for treatment and authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Fertility & Cryogenics Lab to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. Since the provider has special expertise and training, occasionally an insurance company may consider the fees and laboratory services above the usual and customary, and not be covered. I understand that I am financially responsible to the provider for charges not covered by my benefit plan including any service deemed by my benefit plan to be investigational, experimental or not medically necessary as defined by the benefit plan. I authorize Fertility & Cryogenics Lab to verify the insurance information I provided. I hereby authorize my Insurance Company to pay and hereby assign directly to Fertility & Cryogenics Lab all benefits for services rendered, unless paid in full by me at the time of service. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits when received and paid to Fertility & Cryogenics Lab will be credited to my account, in accordance with the above said assignment. I hereby authorize my Insurance Company to pay and hereby assign directly to Fertility & Cryogenics Lab all benefits for services rendered, unless paid in full by me at the time of service. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits when received and paid to Fertility & Cryogenics Lab will be credited to my account, in accordance with the above said assignment.

PATIENT SIGNATURE: _____DATE: _____