NORTHEASTERN OHIO FERTILITY CENTER PATIENT INFORMATION

NAME

SOCIAL SECURITY # - -

DATE OF BIRTH - -

ADDRESS

CITY STATE ZIP

HOME PHONE EMPLOYER

CELL PHONE EMAIL

NAME (PARTNER)

SOCIAL SECURITY # - -

DATE OF BIRTH - -

CELL PHONE

EMPLOYER EMAIL

PATIENT INSURANCE INFORMATION			PARTNER'S INSURANCE INFORMATION		
CARRIER NAME			CARRIER NAME		
ID #			ID #		
GROUP #			GROUP #		
OFFICE VISIT COPAY?	YES	NO	OFFICE VISIT COPAY?	YES	NO
IF YES, WHAT AMOUNT?	$		IF YES, WHAT AMOUNT?	$	

SHOULD A REFERRAL BE NEEDED FOR INSURANCE REIMBURSEMENT, BE SURE TO CONTACT YOUR PRIMARY CARE PHYSICIAN TO ARRANGE ONE AND HAVE A COPY SENT TO OUR OFFICE.*

REFERRED BY: PRIMARY CARE PHYSICIAN OB/GYN NOT REFERRED

REFERRING PHYSICIAN INFORMATION

NAME

ADDRESS

CITY STATE ZIP

IN CASE OF EMERGENCY, PLEASE CONTACT: (PLEASE LIST AT LEAST 2)

NAME	RELATIONSHIP
ADDRESS	
PHONE #	PHONE#

NAME	RELATIONSHIP
ADDRESS	
PHONE #	PHONE#

NAME	RELATIONSHIP
ADDRESS	
PHONE #	PHONE#

Authorization to Release Information: I hereby authorize Northeastern Ohio Fertility Center, Fertility Unlimited, Dr Nicolas Spirtos, to release all medical records and other information with respect to myself or my dependents which may have a bearing on the benefits payable for this claim.

Authorization to Pay Insurance Benefits: I hereby authorize payment directly to the above named facility of the benefits and physician's benefits otherwise payable to me but not to exceed the regular charges for this period. I understand I am financially responsible for charges not covered by this authorization.

When Medicare Benefits are Applicable: Patients Certification, Authorization to Release Information, and Payment Request: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information or its intermediaries or carriers any information needed for this or any other related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signature Patient: _______________ Date: _______________

Signature Partner: _______________ Date: _______________