

Account Number	<b>GEORGIA REPRODUCTIVE SPECIALISTS</b>					Date
<b>PATIENT INFORMATION</b>			GRS M.D.		Referring M.D.	
Patient's Name (Last)	(First)	(Middle)	(Maiden)	Sex	Age	Birthdate
Home Address	Street/P.O. Box	City	State	Zip		Email Address
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Social Security Number	Home Phone	Work Phone		Beeper	
Employer	Occupation		Fax Phone		Car Phone	
Employer Address	Street/P.O. Box	City	State	Zip		

<b>SPOUSE / RESPONSIBLE PARTY</b>					Please indicate responsible party <input checked="" type="checkbox"/> here <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name (Last)	(First)	(Middle)	(Maiden)	Sex	Age	Birthdate
Home Address	Street/P.O. Box	City	State	Zip		
Relationship	Social Security Number	Work Phone	Fax Phone		Beeper	
Employer	Occupation					
Employer Address	Street/P.O. Box	City	State	Zip		

<b>EMERGENCY INFORMATION</b>			<i>Person to contact if unable to reach you directly. Name of friend or relative not living with you</i>			
Name (Last)	(First)	(Middle)	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other			Phone
Home Address	Street/P.O. Box	City	State	Zip		

<b>INSURANCE INFORMATION</b>		Is a referral required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care MD (if different than referring MD)	
Primary Insurance	Policy Holder	Policy Number		Group Name	Group Number
Secondary Insurance	Policy Holder	Policy Number		Group Name	Group Number

## FINANCIAL POLICY

**CREDIT POLICY** It is our policy that payment be made at the time of service. As a courtesy to you we will file for insurance coverage for surgical procedures or when required by insurance participation agreements. But, all deductibles, co-pays, or percentages of fees, must be paid at the time service is provided. If insurance is denied, payment in full is required immediately.

Accounts will be considered delinquent if not paid per this policy or 15 days from the date of notice that insurance is denied. If your check is dishonored by the bank that check must be good immediately and you will be responsible for all bank charges. Delinquent accounts will accrue interest at a rate of 10% per annum.

**AGREEMENT OF FINANCIAL RESPONSIBILITY** I acknowledge full responsibility for the payment of services provided and agree to pay at the time of service. I understand that the charges for professional services may not be covered. I understand that the charges for professional claims may be filed. I understand that the patient or responsible party is solely responsible for the payment of all services. If the account becomes delinquent in payment, I agree to pay all costs of collections, including a reasonable attorney's fee.

**ASSIGNMENTS OF BENEFITS** I hereby authorize that payment of the amount due me in my pending insurance claim be made directly to: Georgia Reproductive Specialists, L.L.C.

**RELEASE OF INFORMATION** I hereby authorize my GRS physician or GRS staff to release to my referring physician, insurance company, or legal guardian, any information, including diagnosis and records of treatment concerning my past medical history and medical care.

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**Signature (Patient, Parent or Guardian)**

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**Date**