Austin Fertility Surgery Center
6500 N. Mopac Bldg III, Suite 3104
Austin, TX 78731
(512)614-4830
(512)284-7899 Fax

PRE-ADMISSION FORM

ALL FORMS MUST BE RETURNED TO AUSTIN FERTILITY SURGERY CENTER PRIOR TO YOUR SCHEDULED PROCEDURE.

For Financial responsibility and insurance questions call : 512-614-4830

SELECT YOUR PHYSICIAN:

❒VAUGHN ❒SILVERBERG ❒HANSARD ❒BURGER ❒PROPST ❒OTHER: _____

PATIENT INFORMATION: (PLEASE PRINT)

NAME LAST	FIRST	MI		
NAME AS LISTED ON PICTURE ID (I.E. DRIVER'S LIC)				
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	MARITAL STATUS
HOME PHONE	CELL PHONE	EMAIL ADDRESS		
HOME ADDRESS STREET	APT#	CITY	STATE	ZIP
EMPLOYER	OCCUPATION			
PARTNER NAME LAST	FIRST	MI	DATE OF BIRTH	AGE / SEX / HOME PHONE/CELL PHONE

By providing the above information, I am consenting to be contacted by Austin Fertility Surgery Center (AFSC) using the information provided above.

Patient Signature_____Date:_____

❒ **Check this box if you elect to be self-pay and waive all insurance billing. _____ initial**

❒ ***Check this box to request a receipt from AFSC to self-file to your insurance. This is only offered if AFSC is out of network with your insurance company. (Do not complete the insurance section below)*** **_____ initial**

❒ ***Check this box if you would like AFSC to file a claim to your insurance. A claim will be filed to your insurance only if you have IVF coverage or coverage for the procedure performed.***

_____ initial

INSURANCE INFORMATION: *(PROVIDE COPY OF FRONT & BACK OF INSURANCE CARD) The below section should only be completed if you would like AFSC to file a claim to your insurance company.*

PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY		
PRIMARY SUBSCRIBER NAME	DOB	PRIMARY POLICY NO.	SECONDARY SUBSCRIBER NAME	DOB	SECONDARY POLICY NO.
PRIMARY SUBSCRIBER EMPLOYER	GROUP #	RELATION TO PATIENT	SECONDARY SUBSCRIBER EMPLOYER	GROUP #	RELATION TO PATIENT
INSURANCE MAILING ADDRESS CITY STATE ZIP			INSURANCE MAILING ADDRESS CITY STATE ZIP		
INSURANCE CLAIMS PHONE NUMBER			INSURANCE CLAIMS PHONE NUMBER		

I understand that Austin Fertility Surgery Center is not contracted with all insurance companies including government sponsored health plans, such as Medicare, Medicaid, or Tricare. I understand that upon request, Austin Fertility Surgery Center will submit a claim to my insurance company (excluding any government sponsored health plans), and I acknowledge that it is my responsibility to contact them regarding the status of any claims submitted. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I authorize the release of any medical records or other information necessary to process my claim. I authorize payment of medical benefits to Austin Fertility Surgery Center. I further agree that a photocopy of this agreement is as valid as the original.

Patient Signature_____Date:_____

**If you have anesthesia with your procedure and it is covered by your insurance you will need to complete a separate form providing information to Austin Anesthesia Group.