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

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

PRE-ADMISSION FORM

Physician Name: ____

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**

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 and if AFSC is an in-network provider with 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 for any covered service to my insurance company (excluding any government sponsored health plans) as long as they are contracted providers. 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.