

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 | |
| 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 |
| | | | | | | | |
| PRIMARY SUBSCRIBER EMPLOYER | | GROUP # | RELATION TO PATIENT | | SECONDARY SUBSCRIBER EMPLOYER | | GROUP # |
| | | | | | | | |
| INSURANCE MAILING ADDRESS | | CITY | STATE | ZIP | | INSURANCE MAILING ADDRESS | |
| | | | | | | | |
| 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: _____