



PATIENT INFORMATION (Please Print)

Last Name:		First Name:		M.I.	Birth Date:m/d/y	Marital Status:	Social Security No:
Street Address:				City:		State:	Zip Code:
Home Phone No:	Work Phone No:	Other Phone No:	Occupation		Referring Physician Name:		
Employer Name and Address:							
Name of Partner:				Birth Date:m/d/y		Social Security No:	
Partner's Employer and Address:						Phone No:	

PRIMARY INSURANCE INFORMATION (Please Print)

Subscriber's Last Name:		First Name:		Relationship:	Subscriber's Employer:		
Insurance Company Name:			Group No.:	Identification or Social Security No.:			
Address to Which Claims are Sent:				City:		State:	Zip Code:

SECONDARY INSURANCE INFORMATION (Please Print)

Subscriber's Last Name:		First Name:		Relationship:	Subscriber's Employer:		
Insurance Company Name:			Group No.:	Identification or Social Security No.:			
Address to Which Claims are Sent:				City:		State:	Zip Code:

FOR OFFICE USE ONLY

Account No.:	Doctor No:	Date:	Initials:
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**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS
FINANCIAL RESPONSIBILITY AGREEMENT**

I/We hereby authorize Drs. Rifka/Butler/Sacks/Abbasi/Sarhan/Sherins to apply for benefits on my behalf for covered services rendered by Drs. Rifka/Butler/Sacks/Abbasi/Sarhan/Sherins. I/We request payment from _____ or Medical Service of D.C. be made directly to Columbia Fertility Associates, PLLC (or in the case of Medicare Part B benefits, to myself or to the party who accepts assignment). I/We certify the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to _____ or Medical Service of D.C.

I/We agree to accept full financial responsibility for medical expenses incurred. I/We are fully responsible for balances due after insurance payments, for those claims for which insurance has not paid within 90 days of submission, and for expenses incurred if it is subsequently determined that services provided are not a covered benefit by my insurance company.

Patient/Guarantor Signature

Date

Updated Patient/Guarantor Signature

Date

Updated Patient/Guarantor Signature

Date