

**SUBMIT THIS FORM WITH YOUR DEPOSIT TO RESERVE YOUR APPOINTMENT**

# THE VASECTOMY CLINIC™

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## Patient Registration Agreement

DrSnip.com®

### PATIENT DATA

PATIENT (LEGAL NAME) \_\_\_\_\_ (NAME YOU PREFER TO BE CALLED) \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS: S M W D LW HOME PHONE \_\_\_\_\_

STREET \_\_\_\_\_ CELL PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NO.

WHO IS YOUR PRIMARY DOCTOR ? \_\_\_\_\_  DO NOT SEND REPORT

WHO REFERRED YOU TO US?  YOUR DOCTOR  A FRIEND  GOOGLE  YELLOW PAGES

ANOTHER DOCTOR  OUR WEBSITE  OTHER SEARCH ENGINE  AD/MEDIA

NAME / LOCATION \_\_\_\_\_

### FEE AND DEPOSIT INFORMATION

If you do not have insurance coverage, your fee for vasectomy including consultation and after-test is \$940.00 payable by cash, check, or VISA/MC/AMEX at the time of your visit.

A deposit of \$50.00 is required when you schedule your appointment. It may be refunded at your visit or applied to your balance. It is retained as a broken appointment fee if you do not keep your appointment. It is completely refundable if you cancel or reschedule with at least 48 hours notice.

APPT.

### INSURANCE DATA PLEASE CALL OUR OFFICE 206.525.4090. WE WILL BE HAPPY TO CHECK ON YOUR INSURANCE BENEFITS

IF YOU HAVE SECONDARY INSURANCE, PLEASE CHECK HERE  AND PROVIDE DATA ON REVERSE.

PRIMARY INS CO _____ PLAN NAME _____ GROUP NAME/NO. _____ SUBSCRIBER NO. _____	IF SPOUSE IS THE SUBSCRIBER, PLEASE COMPLETE: SUBSCRIBER NAME _____ SUBSCRIBER'S EMPLOYER _____ SUBSCRIBER BIRTHDATE _____
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TIME:

REFERRAL IS REFERRAL REQUIRED?  YES  NO OBTAINED?  YES  NO DATE \_\_\_\_\_

YOUR DESIGNATED PCP \_\_\_\_\_ AUTHORIZATION NO. \_\_\_\_\_

DEDUCTIBLE YEARLY DED AMT \_\_\_\_\_ AMT MET \_\_\_\_\_ AMT REMAINING \_\_\_\_\_ CO-PAY \_\_\_\_\_

**INSURANCE BILLING** Most health insurance covers vasectomy. Call our office at 206.525.4090, and our staff will check your plan's benefits. If your insurance covers vasectomy, we will bill them directly according to our contract. We will collect your co-pay and deductible at the time of your visit.

To help us verify your coverage and benefits and determine the amount due at your visit, please call us or mail the above information at least one week in advance of your appointment.

You may also fax your forms to us at 206.985.2875 and bring the originals with you to your visit.

A deposit is required in any case, because insurance does not cover broken appointment fees.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier of services. I agree to pay according to the above terms.

PATIENT SIGNATURE REQUIRED FOR INSURANCE

**X**

MY SCHEDULED VASECTOMY APPOINTMENT IS (DATE/TIME) \_\_\_\_\_

PLEASE CALL ME TO SCHEDULE MY APPOINTMENT

I ENCLOSE A CHECK FOR  \$940.00 FULL PAYMENT OR  \$50.00 DEPOSIT

PLEASE CHARGE MY  VISA  MC CARD # \_\_\_\_\_ AMOUNT \_\_\_\_\_

AMEX NAME ON CARD \_\_\_\_\_ EXPIRES \_\_\_\_\_

CARDHOLDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_