

**GENETICS & IVF INSTITUTE**

MicroSort Division

3015 Williams Dr., Suite 101

Fairfax, VA 22031

**PATIENT REGISTRATION FORM****PATIENT NUMBER:** \_\_\_\_\_*Please PRINT all Information*

PATIENT				SPOUSE/PARTNER					
Name (last, first, middle initial)				Name (last, first, middle initial)					
Address				Address					
City/State/Zip				City/State/Zip					
Home phone	Work phone	Social Security #		Home phone	Work phone	Social Security #			
email address:				email address:					
Date of Birth	Age	Sex	Driver License No. & State	Date of Birth	Age	Sex	Driver License No. & State		
Race(optional)	Religion(optional)	Married	Divorced	Single	Race(optional)	Religion(optional)	Married	Divorced	Single
PATIENT EMPLOYMENT				SPOUSE/PARTNER EMPLOYMENT					
Company Name:		Your Occupation:		Company Name:		Your Occupation:			
Address:				Address:					
City/State/Zip:				City/State/Zip:					
PRIMARY OR PATIENT'S INSURANCE				SECONDARY/PARTNER INSURANCE					
Insurance Company Name:				Insurance Company Name:					
P.O. Box/Address:				P.O. Box/Address:					
City/State/Zip:				City/State/Zip:					
Group Name:		Group No.:		Group Name:		Group No.:			
Policy No.:	Subscriber Name:			Policy No.:	Subscriber Name:				
REFERRING PHYSICIAN				OBSTETRICIAN (IF DIFFERENT FROM REFERRING PHYSICIAN)					
Name:				Name:					
Address:				Address:					
City/State/Zip:				City/State/Zip:					
Phone:	Practice Name:			Phone:	Practice Name:				

Emergency Contact:	Day Phone:	Night Phone:	Relationship:
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In consideration for services provided to me, I acknowledge responsibility for payment for services rendered to me or my dependents at the Genetics & IVF Institute. If such services are covered under a contract between the Institute and my insurer, I acknowledge responsibility for any deductibles, co-payments, and non-covered services. I understand that I must obtain any exception from standard Genetics & IVF Institute payment or billing policy in writing or it will not be considered binding. If my account becomes delinquent, I agree to pay all costs the Institute may incur in collecting its fees including collection agency and attorney's fees (25%). If charges on my account are not fully paid within 180 days of the date of service, I also agree to pay interest from that date at a rate of 1.5% per month. Unless full payment is made on the date of service, I authorize my insurer to pay my medical benefits directly to the Genetics & IVF Institute. I agree that any possible dispute or claim in relation to services which I/we received from the Institute shall be settled solely by arbitration by the American Arbitration Association (using its health care claim settlement arbitration rules). The locale will be Fairfax County, Virginia, and the arbitrators' judgement may be entered in any appropriate court and shall be binding and enforceable. I authorize the release of any medical information necessary to permit processing of claims made to insurance for services performed by the Genetics & IVF Institute.

\_\_\_\_\_  
PATIENT'S SIGNATURE\_\_\_\_\_  
DATE\_\_\_\_\_  
SPOUSE/PARTNER SIGNATURE (required)\_\_\_\_\_  
DATE\_\_\_\_\_  
AUTHORIZED GIVF REPRESENTATIVE\_\_\_\_\_  
DATE