

The Muasher Center for Fertility and IVF Patient Information		DR. Suheil J Muasher M	GROUP #	Medical Records No.	Chart # 3420	
		PRIMARY CARE PHYSICIAN			PCP TELEPHONE NO.	
		<input type="checkbox"/> NEW	<input type="checkbox"/> ESTAB.	DATE		
NAME		AGE	BIRTH DATE	SOC SECURITY #	SEX	
STREET ADDRESS, APT#, CITY, STATE, ZIP				HOME TELEPHONE NO		
OCCUPATION (INDICATE IF STUDENT)		EMPLOYED BY		WORK TELEPHONE NO		
HOW WHERE YOU REFERRED? (PHYSICIAN, FRIEND, PHONE BOOK, ETC)			MARITAL STATUS [] Married [] Single [] Divorced			
NAME OF NEXT OF KIN (not living with you)		RELATIONSHIP		TELEPHONE NO		
RESPONSIBLE PARTY INFORMATION						
RESPONSIBLE PARTY NAME			DATE OF BIRTH	SOC SECURITY #	SEX	
STREET ADDRESS	CITY	STATE	ZIP	HOME TELEPHONE NO		
OCCUPATION		EMPLOYER				
EMPLOYER'S ADDRESS				WORK TELEPHONE NO		
PAYMENT/INSURANCE INFORMATION						
PLEASE CHECK IF APPLICABLE <input type="checkbox"/> NO INSURANCE		PLEASE CIRCLE: HOW WILL YOU BE PAYING? CASH CHECK MC VISA				
PRIMARY INSURANCE CARRIER NAME:			SUBSCRIBER NAME:			
ID #:			PLAN #:			
RELATIONSHIP TO SUBSCRIBER:		EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL REQUIRED?		
SECONDARY INSURANCE CARRIER NAME:			SUBSCRIBER NAME:			
ID #:			PLAN #:			
RELATIONSHIP TO SUBSCRIBER:		EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL REQUIRED?		

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I AUTHORIZE SUHEIL J. MUASHER, MD TO DISCLOSE COMPLETE INFORMATION CONCERNING HIS MEDICAL FINDINGS AND TREATMENT OF THE UNDERSIGNED FROM THE INITIAL OFFICE VISIT UNTIL THE DATE OF THE CONCLUSION OF SUCH TREATMENT, TO THOSE INDIVIDUALS WHO, IN SUHEIL J. MUASHER, MD SOLE DETERMINATION, ARE REQUIRED TO RECEIVE SUCH INFORMATION FOR THE PURPOSE OF MEDICAL TREATMENT, MEDICAL QUALITY ASSURANCE AND PEER REVIEW.

I HEREBY AUTHORIZE ANY MEMBER OF THE MUASHER CENTER FOR FERTILITY AND IVF AND/OR THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT, RELEASE OF INFORMATION PERTAINING TO TREATMENT FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR PROFESSIONAL TREATMENT OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, UNLESS PAYMENT ARRANGEMENTS HAVE BEEN ESTABLISHED. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR VALID REFERRAL FORMS, REQUIRED BY THEIR MANAGED ARE CARRIER, OR THEY WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE BALANCE DUE. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR COURT COST, 25% ATTORNEY'S FEES ASSOCIATED WITH COLLECTION PROCEDURES BROUGHT BY THE MUASHER CENTER FOR FERTILITY AND IVF AND A \$20 RETURN-CHECK CHARGE, SHOULD THAT BECOME NECESSARY. IF MY INSURANCE CARRIER DOES NOT PAY MY CLAIM, I GIVE THE MUASHER CENTER FOR FERTILITY AND IVF MY PERMISSION TO ALLOW VIRGINIA INSURANCE COMMISSIONER'S OFFICE TO BE CONTACTED ON MY BEHALF.

Signature: _____
 Witness: _____

Date: _____
 Date: _____