

**INSURANCE AND PAYMENT INFORMATION****PATIENT INFORMATION****Patient Name (Last, First, Middle):** \_\_\_\_\_**Date of Birth (MM-DD-YYYY):** \_\_\_\_\_**Social Security #:** \_\_\_\_\_**Home Address:** \_\_\_\_\_**City:** \_\_\_\_\_**State:** \_\_\_\_\_**ZIP Code:** \_\_\_\_\_**Home Phone:** \_\_\_\_\_

Communication Preference:

 Mail Phone No Preference**Relationship to Patient:** \_\_\_\_\_**Phone Number:** \_\_\_\_\_**Primary Physician:** \_\_\_\_\_**Referring Physician:** \_\_\_\_\_**PARENT (OR GUARDIAN) INFORMATION****Name of Mother or Father (Last, First, Middle):** \_\_\_\_\_**Date of Birth (MM-DD-YYYY):** \_\_\_\_\_**Social Security #:** \_\_\_\_\_**Driver's License #:** \_\_\_\_\_**Employer:** \_\_\_\_\_**Work Phone:** \_\_\_\_\_**Work Address:** \_\_\_\_\_**INSURANCE INFORMATION****Primary Insurance:** \_\_\_\_\_**Address:** \_\_\_\_\_**Policy Number:** \_\_\_\_\_**Subscriber Name:** \_\_\_\_\_**Secondary Insurance:** \_\_\_\_\_**Address:** \_\_\_\_\_**Policy Number:** \_\_\_\_\_**Subscriber Name:** \_\_\_\_\_

Your signature below confirms that the information submitted above is true and correct to your knowledge and that you have read, understood, and accept our Insurance, Payment, and Other Terms on a separate page.

**Patient's Signature:** \_\_\_\_\_**Date:** \_\_\_\_\_

**Insurance, Payment, and Other Terms**

**AUTHORIZATION TO RELEASE INFORMATION FOR BILLING**

I authorize the Genetics Center and its medical affiliates to release any information acquired in the course of my examination and treatment to my insurance company for billing purposes.

**AUTHORIZATION TO RELEASE PAYMENT(S) TO GENETICS CENTER**

I irrevocably assign and transfer insurance payment(s) directly to the Genetics Center.

**INSURANCE ELIGIBILITY**

I certify that I am eligible with my insurance company. I understand that if this is not true or if I am not eligible for some or all of the Genetics Center services under the terms of my insurance contract, I am liable for any and all charges for services rendered. Also, if I am not eligible, I agree to pay in full for all services rendered within thirty days of receiving a bill from the Genetics Center.

**INSURANCE AND PAYMENT TERMS**

I acknowledge that all medical bills are due and payable at the time services are rendered. However, as a courtesy to me the patient, Genetics Center will submit my claim to my insurance company for me. I understand that my insurance coverage is a contract between me and my insurance carrier. If it is my desire to have Genetics Center bill my insurance carrier for these services, I will present my insurance card.

I also acknowledge that **all co-pays and unmet deductibles are due and must be paid at the time of service.** In certain cases, Genetics Center may also require some deposit in advance. If my insurance company pays more than was collected, Genetics Center will promptly reimburse me that amount of the deposit. In some cases, my insurance will only cover a portion of the fees. If I have made an initial payment, it will then be applied to my balance.

**If Genetics Center does not receive payment from my insurance carrier within 60 days from the date of my service, Genetics Center may look to me for payment in full.** A monthly 1.5% service charge will be added to balances over 30 days old, and a \$10 statement fee will be added to balances over 60 days old. **The charges for Genetics Center services are ultimately my responsibility.**

**BENEFITS AND COVERAGE CHECK IS SUBJECT TO CHANGE**

**Genetics Center cannot accept responsibility for any differences between what was quoted to them by my insurance during their courtesy benefits and coverage check (copay, deductible, etc), and the final benefit determination performed by my insurance when my claim is processed. Therefore, I may owe a different amount than what was quoted to me prior to services.**

**ACKNOWLEDGEMENT OF INDEPENDENT CONTRACTORS**

I acknowledge that some providers involved here are not employees, but are independent contractors, specifically including the NT practitioners, sonographers, and perinatologists.

**ACKNOWLEDGEMENT OF POTENTIAL BILLING BY OTHER PROVIDERS**

I acknowledge that there could be other providers involved, such as ultrasound, hospital, perinatologist, etc., which will have their own billing.

**AUTHORIZATION TO RECEIVE VOICE MESSAGES**

I authorize the doctor and/or facility and/or staff to identify themselves as being from Genetics Center when calling to leave a message regarding my appointment, results, or other medical information on any answering device or with another person answering the phone

**NOTICE OF OPEN PAYMENTS DATABASE**

To comply with Assembly Bill (AB) 1278, I acknowledge receiving the required notice: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was offered a copy of the Genetics Center's Notice of Privacy Practices.

**AUTHORIZATION TO RECEIVE TEXT MESSAGES**

[Yes No ] I expressly consent and authorize receipt of text messages from Genetics Center at the telephone number you provide for appointment reminders and general information related to my health care treatment, and I understand that I can opt-out at anytime.

*My signature confirms that I have read, understand, and accept these terms.*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or parent if minor)