North Houston Center for Reproductive Medicine, PA

DOROTHY J. ROACH, M. D.

PAYMENT IS REQUIRED AT THE TIME SERVICES OR TREATMENT IS RENDERED. We do not mail statements

PATIENT REGISTRATION (PLEASE PRINT)

TODAY'S DATE: / / 2010 **REFERRED BY: Dr.** **Friend:**

LAST NAME: FIRST MI:

HOME ADDRESS: CITY: STATE: ZIP:

TELEPHONE - PRIMARY #: SECONDARY #:

DATE OF BIRTH: AGE DRIVER'S LICENSE #: STATE

SS #: MARITAL STATUS: EMAIL ADDRESS:

PATIENT EMPLOYER: EMPLOYER PHONE #:

SPOUSE NAME: DATE OF BIRTH: AGE:

SPOUSE EMPLOYER: EMPLOYER PHONE CELL PHONE:

EMERGENCY CONTACT NAME: RELATIONSHIP: PHONE #:

CALLING INSTRUCTIONS: CAN WE LEAVE A PRIVATE/CONFIDENTIAL BRIEF / DETAILED MESSAGE FOR YOU? (PLEASE LIST NUMBER)

HOME: WORK: CELL:

INSURANCE INFORMATION

INSURANCE #1: PRIMARY MEMBER NAME: PATIENT: RELATIONSHIP TO INSURED:

COBRA INSURANCE: PLEASE CIRCLE YES / NO

SUBSCRIBER ID # (INCLUDE ALPHA LETTERS): INSURED SS#:

GROUP # : EMPLOYER: PHONE #:

INSURANCE CLAIM ADDRESS: CITY: STATE: ZIP:

INSURANCE #2: SECONDARY MEMBER NAME: PATAIENT: RELATIONSHIP TO INSURED:

COBRA INSURANCE: PLEASE CIRCLE YES / NO

SUBSSCRIBER ID # (INCLUDE ALPHA LETTERS): INSURED SS#:

GROUP # : EMPLOYER: PHONE #:

INSURANCE CLAIM ADDRESS: CITY: STATE: ZIP:

PATIENT RESPONSIBILITY

I certify that the above information is true and correct to the best of my knowledge. I authorize payment of benefits directly to Dorothy J. Roach, M. D. and I authorize Dorothy J. Roach, M. D. to appeal all insurance claims as appropriate on my behalf. I understand that I have a contract with my insurance company and it is my responsibility to understand my benefits and how my plan works. VERIFICATION OF YOUR BENEFITS IS NOT A GUARANTEE OF PAYMENT AS QUOTED BY THE HEALTH PLAN. My health plan determines whether a claim is eligible for payment at the time it is received and processed based on plan description, member eligibility, terms, exclusions, limitations, policy guidelines waivers, riders, benefit maximums, pre-existing and coverage at time of service. I understand that legally my insurance has 45 days to pay claims at which point I may be billed in full. I agree to be fully responsible for all lawful debts incurred by myself for services whether or not covered by insurance. I authorize the undersigned Provider to release confidential and/or protected health information (PHI) or any information necessary to process this or any future or past claim in the course of my examination, treatment, operations or payment as defined by HIPAA. This authorization shall remain valid unless revoked in writing by patient.

Signature: _____ Date: _____

PROVIDER: Dorothy J. Roach, M.D., 530 Wells Fargo Drive, #116, Houston TX 77090 **TAX ID#: 76-0299153**

OUR OFFICE REQUIRES 48 HOUR CANCELLATION NOTICE FOR APPOINTMENTS. A $50 FEE WILL BE CHARGED FOR "NO SHOWS" OR "MISSED" APPOINTMENTS. THIS CHARGE IS NOT COVERED BY HEALTH INSURANCE