



# Palmetto Fertility Center of South Florida

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## Female Patient

Patient Name (Last, First MI)		Birthdate: Month /Day/Yr	Age	Marital Status Single Married
Address			Social Security Number	
City	State	Zip	Home Phone ( )	
Employers Name		Occupation	Work Phone ( )	
Drivers License Number	State	E-mail address	Cell Phone ( )	

## Spouse / Partner

Name (Last, First MI)		Date of Birth	Age	Sex Male Female
Address			Social Security Number	
City	State	Zip	Home Phone ( )	
Employers Name		Occupation	Work Phone ( )	
Drivers License Number	State	E-mail address	Cell Phone ( )	

## Insurance Information

Primary Insurance Carrier Name	Subscriber Name (Last, First MI)
Policy Number	Group Number
Street Address or PO Box	City, State Zip

\* Palmetto Fertility Center will only file primary insurance claims on your behalf. If you have a secondary or tertiary insurance, we will be happy to provide claim forms to you for balance billing; however you will be responsible for the remaining balance.

*I understand that if I do not have insurance, payment will be due the day of the visit.*

*I understand that insurance coverage may not be available for all forms of diagnosis and treatment at this office. I understand that I am financially responsible for payment of all charges regardless of insurance coverage or other determinations by our insurance carrier, including the costs of collection and reasonable attorney fees. I understand that my insurance company will directly assign all payable insurance benefits, if any, to Palmetto Fertility Center of South Florida, Inc. for services rendered. I authorize Palmetto Fertility Center of South Florida, Inc. to release any information required for the purposes of determining insurance benefits or to secure insurance payment(s) for services rendered. This order will remain in effect until revoked by me in writing. A photocopy of this order will be considered as valid as the original. By signing below, I acknowledge that I have read and understand this statement and that I authorize the use of my signature on all insurance claim forms submitted on my behalf.*

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_