THE WEEKEND VASECTOMY CLINIC

Date:_____

PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient Middle Name	
Date of Birth	Social Security #	Cell Phone	Home Phone
Address	City	State	Zip
Occupation	Employer	Business Phone	
Employer Address	City	State	Zip
Driver License #	Email Address		
Emergency Contact Information (Full Name/Relationship to the Patient)		Phone (REQUIRED)	

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES)

Primary Insurance Company	Policyholder Name	Policy #	Effective Date
Insurance Company Address		Group #	Group Name
2nd Insurance Company	Policyholder Name	Policy #	Effective Date
Insurance Company Address		Group #	Group Name

I make the following consents, understandings, and agreements on my own behalf, in consideration of healthcare services to be provided to me, the Patient, by the Weekend Vasectomy Clinic (WVC) and/or its affiliates.

CONSENT FOR SERVICES: I hereby give consent to the WVC, its Physicians, Employees and Affiliates to provide healthcare services to me and to administer physician orders for my benefit for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk involved in such healthcare services and I accept this risk. No promises of any particular outcome or successful result have been made to me. I understand and accept that there is some uncertainty involved in the healthcare services for which this consent is given.

ASSIGNMENT OF BENEFITS: Any and all benefits from insurance companies and other third-party payers that are payable to me, will be transferred by me and assigned to the WVC for the exclusive purpose of paying for the healthcare services provided to me. I understand and intend that all insurance companies and other third-party payers should pay benefits directly to the WVC for services rendered to me and that the WVC and its affiliates are authorized to bill in connection for the healthcare services provided.

RELEASE OF INFORMATION: The WVC is required by law to make and keep records of the Patient's medical treatment. The WVC safeguards those records and discloses such records and information they contain only in accordance with State and Federal privacy laws. Such uses and disclosures are described in detail in the Weekend Vasectomy Clinic Notice of Privacy Practices. I understand that I may request a copy of the current privacy notice or review it at www.WeekendVasectomy.com/Forms/ any time.

MEDICARE/MEDICAID/TRICARE PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under the titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or billing or other information about me involving my care to be released to the Social Security Administration, to other intermediaries or carriers, or to the State as needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the WVC, its physicians or affiliates for whom the WVC is authorized to bill in connection with its service.

FINANCIAL RESPONSIBILITY: I, the undersigned, jointly and severally agree to pay for all the healthcare services rendered to me, including but not limited to any amounts not paid by any insurance company or other third-party payer, excluding insurance related contractual discounts. I remain responsible for all copayments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third-party payers. I understand and agree than any amounts not paid within 30 days of the date of the patient bill or statement shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. If any unpaid balance is placed with a collection agency or attorney for collection, I jointly and severally agree to pay all costs of collections and reasonable attorney's fees in connection with the collection process. As a courtesy to our private pay patients, a discount is extended for specified services. The largest discount is available when services are paid in full on the date of service. Please ask about any discounts that may be available to private pay patients.

I sign this document as the Patient and agree to accept its terms. I have read the foregoing and have had the opportunity to ask any questions concerning its content. Such questions have been answered to my satisfaction, and I indicate my understanding by signing this document. I understand that I am entitled to request and obtain a copy of this document, as well as a copy of my billing rights according to the Fair Credit and Billing Act. This document will remain in effect unless revoked in writing by me.

SIGNATURE:_____ DATE:_____

I hereby acknowledge that I have received or been offered a copy of the Weekend Vasectomy Clinic Notice of Privacy Practices available at https://Weekend-Vasectomy.com/patient-forms/.

DATE:_____ INITIALS:_____

The Health Insurance Portability Accountability Act (HIPAA) of 1996 was created with the sole purpose and goal of protecting patients' medical records and financial information. Please authorize below who you would like Weekend Vasectomy Clinic to release your medical and financial information to. This will allow us to protect your private information. Please be specific when designating your choices.

I authorize the staff of Weekend Vasectomy Clinic to release any FINANCIAL INFORMATION to the following people:

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_____

I authorize the staff of Weekend Vasectomy Clinic to release any MEDICAL INFORMATION to the following people:

_____

_____

_____

I authorize the staff of Weekend Vasectomy Clinic to leave laboratory or radiology tests results on my voicemail at the following telephone numbers:

HOME: _____

CELL: _____

OTHER: _____

SUBMIT*

*Clicking "Submit" will generate an email that will send this completed form to Weekend Vasectomy Clinic.