SUBMIT THIS FORM WITH YOUR DEPOSIT TO RESERVE YOUR APPOINTMENT

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DrSnip®
THE VASECTOMY CLINIC™

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Patient Registration Agreement

PATIENT DATA

NO.

PATIENT (LEGAL NAME) _____ (NAME YOU PREFER TO BE CALLED) _____

BIRTHDATE _____ AGE _____ MARITAL STATUS: ☐S ☐M ☐W ☐D ☐LW PHONE 1 _____ ☐C ☐H ☐W

STREET _____ PHONE 2 _____ ☐C ☐H ☐W

CITY _____ STATE _____ ZIP _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT NAME _____ PHONE _____ RELATIONSHIP _____

WHO IS YOUR PRIMARY DOCTOR ? _____ ☐ DO NOT SEND REPORT

WHO REFERRED YOU TO US? ☐YOUR DOCTOR ☐A FRIEND ☐GOOGLE ☐YELP
☐ANOTHER DOCTOR ☐OUR WEBSITE ☐OTHER SEARCH ENGINE ☐MEDIA
NAME / LOCATION _____

FEE AND DEPOSIT INFORMATION

APPT.

If you do not have insurance coverage, your fee for vasectomy including consultation and after-test is $1000.00 payable by cash, check, or VISA/MC/AMEX at the time of your visit.

A deposit of $50.00 is required when you schedule your appointment. It may be refunded at your visit or applied to your balance. It is retained as a broken appointment fee if you do not keep your appointment. It is completely refundable if you cancel or reschedule with at least 48 hours notice.

INSURANCE DATA

PLEASE CALL OUR OFFICE 206.525.4090. WE WILL BE HAPPY TO CHECK ON YOUR INSURANCE BENEFITS

IF YOU HAVE SECONDARY INSURANCE, PLEASE CHECK HERE ☐ AND PROVIDE DATA ON REVERSE.

PRIMARY INS CO _____

PLAN NAME _____

GROUP NAME/NO. _____

SUBSCRIBER NO. _____

IF SPOUSE IS THE SUBSCRIBER, PLEASE COMPLETE:

SUBSCRIBER NAME _____

SUBSCRIBER'S EMPLOYER _____

SUBSCRIBER BIRTHDATE _____

TIME:

REFERRAL

IS REFERRAL REQUIRED? ☐ YES ☐ NO OBTAINED? ☐YES ☐NO DATE _____

YOUR DESIGNATED PCP _____ AUTHORIZATION NO. _____

DEDUCTIBLE

YEARLY DED AMT _____ AMT MET _____ AMT REMAINING _____ CO-PAY _____

INSURANCE BILLING

Most health insurance covers vasectomy. Call our office at 206.525.4090, and our staff will check your plan's benefits. If your insurance covers vasectomy, we will bill them directly according to our contract. We will collect your co-pay and deductible at the time of your visit.

To help us verify your coverage and benefits and determine the amount due at your visit, please call us or mail the above information at least one week in advance of your appointment.

You may also fax your forms to us at 206.985.2875 and bring the originals with you to your visit.

A deposit is required in any case, because insurance does not cover broken appointment fees.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier of services. I agree to pay according to the above terms.

PATIENT SIGNATURE REQUIRED FOR INSURANCE X _____ DATE _____

☐ MY SCHEDULED VASECTOMY APPOINTMENT IS (DATE/TIME) _____

☐ PLEASE CALL ME TO SCHEDULE MY APPOINTMENT

☐ I ENCLOSE A CHECK FOR ☐ $1000.00 FULL PAYMENT ☐ $50.00 DEPOSIT

☐ PLEASE CHARGE MY

☐VISA ☐MC ☐AMEX

AMOUNT $ _____

CARD # _____ CSC CODE _____ ☐ CARD ON FILE

NAME ON CARD _____ EXPIRES _____

CARDHOLDER SIGNATURE _____ DATE _____