***Male Fertility and Sexual Medicine Specialists / Fertility Center of California / Family Fertility CryoBank***

MARTIN BASTUBA, M.D., F.A.C.S.

# PATIENT INFORMATION

| | | |
|---|---|---|
| **Patient Name:**<br>**Last:** **First:** **Date:** | | |
| **Date of birth:** | **SSN:** | |
| **Cell Phone #:** **Work#:** **Email:** | | |
| **Address:** | | |
| **City:** | **State:** | **ZIP Code:** |
| **Employer:** | **Occupation:** | |
| **Circle all that apply:**<br>**Male Female Minor Single Married Divorced Widowed Separated Transgender** | | |
| **Spouse/Sig. Other:**<br>**Name:** **Date of birth:** **Phone:** | | |
| **Referring Physician:** | | |
| **Where do you prefer to receive calls? (circle one)**<br>**Cell Work** | **Is it okay to leave a message? Yes No** | |
| **PERSON RESPONSIBLE FOR THIS ACCOUNT (If other than the patient or if patient is a minor)**<br>**Name:** **Relationship to patient:** **Phone:** | | |
| **Address:** | **City, State, Zip Code:** | |
| **In the case of emergency whom should we contact? (Not living with you)**<br>**Name:** **Relationship:** **Cell#** **Work#** | | |
| **To whom other than yourself may we release Personal/Health information about your acc. Name:** | | |

**MALE FERTILITY & SEXUAL MEDICINE SPECIALISTS PATIENTS ONLY**

**Authorization and release:**
I authorize the release of any medical information necessary to process this bill to my insurance company, and request payments of the benefits to Male Fertility & Sexual Medicine Specialists. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature:_____ Date:_____

**PAYMENT& PRIVACY POLICY FOR FERTILITY CENTER OF CALIFORNIA / FAMILY FERTILITY CRYOBANK**

**Payment is due at time of service unless previous arrangements are made**. We accept cash, checks and certain credit cards. Our office follows the California Civil Code 1719 for all returned checks. The patient named above acknowledges that should collection become necessary, the patient agrees to be responsible for all collection costs and attorney fees to collect the amount for services rendered. Personal information such as Social Security Number (SSN) will only be used by our office to turn the account over to collection. The copy of the photo ID will only be used to verify and ensure that no one else can claim to be you to access your records. All information provided by you is used strictly by Fertility Center of California/Family Fertility CryoBank.

**PATIENT SIGNATURE BELOW IS REQUIRED**
Your signature below acknowledges acceptance of our payment and privacy policies and agreement to keep FCC/FFCB updated with your current address and contact information. After the billing interval assigned above, FCC/FFCB will make one attempt to contact the patient via the address above.

I,_____ agree with all of the terms and conditions as listed above without recourse.

Signature:_____ Date:_____