

Syracuse Office:

195 Intrepid Lane
Syracuse, NY 13205
800.539.9870

Albany Office:

38A Old Sparrowbush Rd.
Latham, NY 12110
866.375.4589

Rochester Office:

2244 East Avenue
Rochester, NY 14610
585.244.1280

Information & Authorization Form

Date ___/___/___ Patient's Name _____ SS# _____

Address _____
Number street apt. # box # city state zip code

Home Tel. No. (____) _____ Date of Birth ___/___/___ Age _____

Patient's Cell Phone No. (____) _____ Patient's Email _____

Patient's Employer _____ Tel. No. (____) _____

Employer's Address _____

Emergency Contact _____ Home # (____) _____

Emergency Contact Work # (____) _____ Emergency Contact Cell # (____) _____

Partner's Name _____ DOB _____ SS# _____

Partner's Cell Phone No. (____) _____ Partner's Email _____

Partner's Employer _____ Tel. No. (____) _____

Employer's Address _____

Referred by _____ Tel. No. (____) _____

MEDICAL INSURANCE

PRIMARY INSURANCE: Subscriber _____ Ins. Company _____
ID # _____ Group # _____ Phone No. (____) _____

OTHER INSURANCE: Subscriber _____ Ins. Company _____
ID # _____ Group # _____ Phone No. (____) _____

If a patient does not have the appropriate prior authorization/referral from their insurance company, services to be rendered by CNY Fertility Center may not be covered under their benefit plan. CNY Fertility has the right as a participating provider to either cancel/reschedule the appointment or the patient, if seen, will be held responsible for payment of medical expenses incurred for these services.

I hereby authorize Robert J. Kiltz, MD to release any and all information necessary to file claims for services I received to the insurance companies listed above. I hereby authorize the insurance companies listed above to make payment of benefits directly to Robert J. Kiltz, MD for services rendered by them. I also hereby acknowledge I am financially responsible for all charges not paid by insurance. This agreement will remain in effect until revoked by me in writing. Photocopy of this assignment is to be considered as valid as an original.

In the event that this account becomes past due, I understand that it is subject to a 1.5% per month finance charge. Also, I understand that if the account becomes 60 days past due it will be turned over for collection and I agree to pay an additional collection fee based on the total amount due.

_____ **Initial to authorize CNY Fertility Center to send emails to either address above**

DATE _____ **PATIENT SIGNATURE** _____

DATE _____ **PARTNER SIGNATURE** _____