Charles L. Wilson, M.D.
Kelly R. White, M.D.

DrSnip®
simply vasectomy℠

888.SNIP.DOC

Patient Registration Agreement

NO.

PATIENT DATA

PATIENT (LEGAL NAME) _____ PREFERRED NAME _____

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

STREET _____ PHONE 2 _____ ☐M ☐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 _____

APPT.

FEE AND DEPOSIT INFORMATION

If you do not have insurance coverage, or choose not to use your insurance, your fee for vasectomy, including consultation and after-test is $1,000.00. This is paid at the time of your visit. We accept all major credit cards.

We ask to have a credit card number on file to reserve all appointments. There is a broken appointment fee of $50.00 if you cancel or reschedule your appointment within 48 hours of the scheduled appointment. There is no fee if you cancel or reschedule outside of the 48-hour period.

INSURANCE DATA

PLEASE CALL OUR OFFICE 888.SNIP.DOC 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 _____ IF SPOUSE IS THE SUBSCRIBER, PLEASE COMPLETE: _____

PLAN NAME GROUP _____ SUBSCRIBER NAME

NAME/NO. _____ SUBSCRIBER'S EMPLOYER _____

SUBSCRIBER NO. _____ 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 888.SNIP.DOC, 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 888.SNIP.DOC 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 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

☐ PLEASE CHARGE MY CREDIT CARD # _____ CVV CODE _____

NAME ON CARD _____ EXPIRES _____ AMOUNT $ _____

CARDHOLDER SIGNATURE _____ DATE _____