**SERVY INSTITUTE FOR REPRODUCTIVE ENDOCRINOLOGY**
812 CHAFEE AVENUE ~ AUGUSTA, GEORGIA 30904
Phone 706-724-0228 ~ Fax 706-722-2387

Referred by:________________ Date:______________ SS#:_____________________

Patient:____________________________________ Phone:_____________________

Address:___________________________________ Cell:_______________________

City:_______________________ State:_______________ Zip:___________________

Age:________ Birth Date:_______________________ Sex:_____________________

Employer:__________________________________ Phone:_____________________

Address:______________________________________________________________

City:_______________________ State:______________ Zip:____________________

Responsible party:_____________________________ Marital status:______________

Parent or
Spouse:____________________________________SS#:______________________

Address:___________________________________ Phone:_____________________

City:_____________________ State:________________ Zip:___________________

Age:_________ Birth Date:________________ Religion:_______________________

Employer:__________________________________ Phone:_____________________

Address:______________________________________________________________

City:____________________ State:_________________ Zip:___________________

Nearest relative not living with you___________________________________________

Emergency contact:______________________________________________________

Phone:_____________________________ Relation:__________________________

I herby authorize assignment of benefits to **Dr. Servy and Associates** for medical services rendered and the release of any information necessary to process this claim.

Signed:______________________________________ Date:_____________________

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Print name:_______________________________________________________

Please complete the following information and return to our office before your appointment by mail or fax. If you fax the information, please bring the originals with you. Please enclose an enlarged copy of your insurance card. Please arrive 15 minutes early to make sure that we have everything in order. If you can't return these forms before your appointment, you may be asked to reschedule.

**Payment Policy:** Please bring your insurance card the day of your appointment. Without your insurance card, we will not file your insurance. Payment in full will be expected at the time of service. Initials_________

**Financial Responsibility:** We will file your insurance claim, but you are ultimately responsible for paying for services received in this office. Our office requires each patient to have an annual exam. During this visit, we will update your known conditions as well as evaluate for new problems. Along with this examination, your provider might suggest some screening test. Depending on your insurance contract, these services may not be covered. Federal law requires that we submit every claim to an insurance company accurately, reporting the exact services performed and the exact reason. We are not allowed to change information on a claim so that it will be paid by your insurance company. Please do not ask us to make an exception. If you are unsure if a service will be covered, please call your insurance company so that they can explain your benefits to you. Initial__________

Ever changing contracts with insurance companies require our office to ask you to provide our office with a network contracted laboratory, hospital and radiology in the Augusta area. We draw blood for Mullins Laboratory. If no laboratory is provided, your labs will be sent to Mullins Lab or University Hospital. Other available labs include Quest Diagnostics, LabCorp, Lab One and University Hospital. Augusta Lab and St. Joseph hospital cannot be listed exclusively, because they do not process pap smears. Because we are not affiliated with MCG, we cannot use their laboratory for test.

**Insurance Company:** _________________________________________________

**Laboratory:** _________________________________________________________

**Hospital:** ___________________________________________________________

**Radiology:** _________________________________________________________

I have read the above information and understand I am responsible for any charges incurred during my visit.

Signed: ___________________________________ Date: ______________________