THE WEEKEND VASECTOMY CLINIC

Date:_____

PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient Middle Name	
Date of Birth	Social Security #	Cell Phone	Home Phone
Address	City	State	Zip
Driver License #	Email Address		
Occupation	Employer	Business Phone	
Employer Address	City	State	Zip
Emergency Contact Information (Full Name/Relationship to the Patient)		Phone (REQUIRED)	

I make the following consents, understandings, and agreements on my own behalf, in consideration of healthcare services to be provided to me, the Patient, by the Weekend Vasectomy Clinic (WVC) and/or its affiliates.

SIGNATURE:_____ DATE:_____

I hereby acknowledge that I have received or been offered a copy of the Weekend Vasectomy Clinic Notice of Privacy Practices available at https://Weekend-Vasectomy.com/patient-forms/.

DATE:_____ INITIALS:_____

CONSENT FOR SERVICES: I hereby give consent to the WVC, its Physicians, Employees and Affiliates to provide healthcare services related to a vasectomy and to administer physician orders for my benefit for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk involved in such healthcare services, and I accept this risk. No promises of any particular outcome or successful result have been made to me. I understand and accept that there is uncertainty involved in the healthcare services for which this consent is given.

ASSIGNMENT OF BENEFITS: Any and all benefits from insurance companies and other third-party payers that are payable to me, will be transferred by me and assigned to WVC for the exclusive purpose of paying for the healthcare services provided to me. I understand that my insurance companies and other third-party payers should pay benefits directly to the WVC for services rendered to me and that the WVC and its affiliates are authorized to bill my insurance companies in connection with the healthcare services provided.

RELEASE OF INFORMATION: The WVC is required by law to make and keep records of the patient's medical treatment. The WVC safeguards those records and discloses such records and information they contain in accordance with State and Federal privacy laws. Such uses and disclosures are described in detail in the Weekend Vasectomy Clinic Notice of Privacy Practices. I understand that I may request a copy of the current privacy notice or review it at www.WeekendVasectomy.com/Forms/.

FINANCIAL RESPONSIBILITY: I jointly and severally agree to pay for all the healthcare services rendered to me, including but not limited to any amounts not paid by my insurance companies or other third-party payers, excluding insurance-related contractual discounts. I remain responsible for all copayments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third-party payers. I understand and agree that any amounts not paid within 30 days of the date of the patient bill or statement shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. If any unpaid balance on my account is placed with a collection agency or attorney for collection, I jointly and severally agree to pay all costs of collections and attorney's fees in connection with the collection process. As a courtesy to self-pay patients, a discount is extended for specified services. The largest discount is available when services are paid-in-full on the date of service.

NO SHOWS AND CANCELLATIONS: Cancellations and rescheduling appointments must be done three days (72 hours) prior to my scheduled appointment. If I fail to show up for my appointment, a no-show fee of $100 will be assessed. If I reschedule an appointment after I failed to show up, WVC will apply the $100 no-show fee towards a procedure that is to be completed within three months of my initial scheduled appointment.

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES)			
Primary Insurance Company	Policyholder Name	Policy #	Effective Date
Insurance Company Address		Group #	Group Name
2nd Insurance Company	Policyholder Name	Policy #	Effective Date
Insurance Company Address		Group #	Group Name

The Health Insurance Portability Accountability Act (HIPAA) of 1996 was created with the sole purpose and goal of protecting patients' medical records and financial information. Please authorize below who you would like Weekend Vasectomy Clinic to release your medical and financial information to. This will allow us to protect your private information. Please be specific when designating your choices.

I authorize the staff of Weekend Vasectomy Clinic to release any FINANCIAL INFORMATION to the following people:

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_____

I authorize the staff of Weekend Vasectomy Clinic to release any MEDICAL INFORMATION to the following people:

_____

_____

_____

I authorize the staff of Weekend Vasectomy Clinic to leave laboratory or radiology tests results on my voicemail at the following telephone numbers:

HOME: _____

CELL: _____

OTHER: _____