Fertility Center of California
Family Fertility Cryobank
www.spermbankcalifornia.com
www.familyfertilitycryobank.com

Registration Form

PATIENT INFORMATION: **FCC ACCT** _____

Name: _____ Date of Birth: ___/___/____

SSN: _____

Address: _____ City: _____

State: _____ Zip _____ Home Phone (_____) _____-_____

May we contact you by email for information, billing or lab results? Yes or No (please circle one)

Email Address: _____

Partners Name: _____ Date of Birth: ___/___/____

SSN: _____

Work Number (_____) _____-_____ Cell Number (_____) _____-_____

Email Address: _____

Have you ever **tested positive** for HIV-I or II, Hepatitis B, Hepatitis C, HTLV-I or II, RPR? Yes No

if Yes specify: _____

Privacy Policy: FCC/FFC requires a personal identification number (PIN) for release of information about your account. Please clearly print your PIN number now that you will remember _____

To whom, other than yourself, may FCC/FFC release information about your account

_____ name _____ relationship

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: _____ Relationship _____ Home phone _____

Address: _____ Work phone _____

SSN# _____

Referring Physician

Name_____ **Phone#**_____ **Fax#**_____

PAYMENT POLICY

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 verity 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/FFC updated with your current address and contact information. After the billing interval assigned above, FCC/FFC will make one attempt to contact the patient via the address above. If there is no response by the patient or estate (in the case of death), then if any and all cryopreserved reproductive materials shall become the property of FCC/FFC to be disposed of by FCC/FFC or their delegates as solely and unilaterally determined by FCC/FFC management.

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

_____ signature ___/___/___ date

If the patient above is a minor, a parent or guardian of the minor must sign below:

_____ signature parent or guardian if applicable

6699 Alvarado Rd #2208
San Diego, CA 92120
Tel:619-265-0102 Fax:619-265-1429

12791 Newport Ave., #206
Tustin, CA 92780
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