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EMAIL: INFO@MANHATTANCRYOBANK.COM
WEBSITE: WWW.MANHATTANCRYOBANK.COM

# REGISTRATION FORM

| PATIENT INFORMATION | | |
|---|---|---|
| First Name: | Last Name: | Date of Birth: |
| Current address: | | |
| City: | State: | Zip Code/Country: |
| Phone (Day): | Phone (Eve): | Email: |
| Emergency Contact: | Phone: | |

| SPOUSE/PARTNER INFORMATION | | |
|---|---|---|
| First Name: | Last Name: | Date of Birth: |
| Current address: | | |
| City: | State: | Zip Code/Country: |
| Phone (Day): | Phone (Eve): | Email: |

| HEALTH PROFESSIONAL WHO REFERRED YOU TO MANHATTAN CRYOBANK | |
|---|---|
| First Name: | Last Name: |
| Address: | |
| City: | State: Zip Code/Country: |
| Phone: | Fax: Email: |

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PAYMENT INFORMATION**

Payment is due at the time of service unless previous arrangements are made in writing. We accept cash, checks and certain credit cards.

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.

The copy of the photo ID will only be used to verify and ensure that no one else can claim to be you to access your records. Furthermore, we do not share your personal information with marketing or sales companies under any circumstances. All information provided by you is used strictly by Manhattan CryoBank Inc.

I (we) acknowledge that I (we) have received a copy of the "Notice of Privacy Practices". This Notice describes how Manhattan Cryobank may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

| | |
|---|---|
| Patient Signature: | Date: |
| Partner Signature: | Date: |