



DO NOT CONTACT INSURANCE CARRIER

I wish to be a cash account. **PLEASE DO NOT CONTACT MY INSURANCE CARRIER FOR ANY REASON**, unless I request (in writing) for you to do so.

Patient's Signature

Date

Partner's Signature

Date

AUTHORIZATION FOR COASTAL FERTILITY MEDICAL CENTER / REPRODUCTIVE SPECIALTY LABS TO CONTACT MY INSURANCE CARRIER

I authorize Coastal Fertility Medical Center/Reproductive Specialty Labs to inquire on my behalf, regarding information about my benefits and coverage. I also authorize the release of any medical or other information necessary to process my insurance claim(s).

Patient's Signature

Date

Partner's Signature

Date

AGREEMENT OF FINANCIAL RESPONSIBILITY and AUTHORIZATION TO BILL DESIGNATED INSURANCE CARRIERS

I authorize Coastal Fertility Medical Center (CFMC) / Reproductive Specialty Labs (RSL) to bill my insurance carrier(s), and I also authorize benefits to be paid directly to CFMC and RSL. **If my insurance carrier, for any reason, will not cover a particular treatment, medication, or procedure, either in full or part, I understand, and agree it is my responsibility to remit payment in full, unless prior written arrangements have been made with our billing department.**

Patient's Signature

Date

Partner's Signature

Date