Coastal Fertility Medical Center | RSMC Irvine

Medical Director: Lawrence B. Werlin M.D.

Permission to Contact Insurance Carrier and Agreement of Financial Responsibility

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 CARRIER(S)

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 the CFMC/RSL billing department.**

_____ _____

Patient's Signature Date Partner's Signature Date

****SIGN BELOW ONLY IF YOU DO NOT WANT US TO CONTACT YOUR INSURANCE CARRIER****

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

15500 Sand Canyon Ave., Suite 100, Irvine, CA 92618 Tel: 949 726-0600 Fax: 949 726-0601