



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