

Assignment of Benefits, Authorization and Financial Statement

I hereby authorize payment directly to Fertility and Surgical Associates of California of the surgical and/or medical insurance benefits, if any, otherwise payable to me for the services as described on the attached claim.

I hereby authorize Fertility and Surgical Associates of California to release any medical information during the course of my examination and treatment to my insurance company, pharmacy, or laboratory as necessary.

I realize that I am responsible for payment in full of the charges on my account for services rendered to me by Fertility and Surgical Associates of California.

As a courtesy to our patients we offer to verify insurance coverage. This benefit quote is not a guarantee of coverage as we do not have a mechanism of being able to guarantee the accuracy of the information being provided to our benefit coordinator by your insurance carrier's customer service line. **We encourage our patients to verify their insurance coverage prior to receiving services.**

By signing this agreement, I acknowledge that I have read, understand and agree to the terms of the above policy in its entirety.

Date: _____

Patient's Signature

Patient's Name