Michigan Center for Fertility & Women's Health

Michigan Center for Fertility And Women's Health, P.L.C.
Michigan Center IVF, PLLC
Fertility Storage, Inc.
4700 13 Mile Road / Warren, Michigan 48092
Phone: (586) 576-0431 / Fax: (586) 576-0924

PATIENT AUTHORIZATION

PLEASE INITIAL NEXT TO EACH STATEMENT

_____I authorize my insurance benefits to be paid directly to Michigan Center for Fertility and Women's Health, P.L.C.; Michigan Center IVF PLLC and authorize the release of pertinent medical information to my Insurance carrier, as they require.

_____I agree that I, and/or the third party (e.g. spouse, parent, or guardian) may have to pay for services that are rendered, even though I may have insurance coverage. I therefore agree to pay all medical charges that my insurance carrier does not cover, including services that my insurance considers not medically necessary.

_____**I agree to keep my balance below $250.00 at all times.**

_____I agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement insurance carrier is inappropriate and is a fraudulent act. ****Please contact your insurance company regarding infertility benefit coverage. It is the responsibility of the patient to be familiar with their insurance coverage. The easiest way to obtain information from your insurance company is to call the number on your card.**

_____I understand there may be times that Dr. Kowalczyk may need to send out my ultrasound to get a second opinion. In this instance I am aware that I may receive a bill from Reynolds & Associates for this service.

_____I authorize the Michigan Center for Fertility and Women's Health P.L.C.; Michigan center IVF, PLLC; Fertility Storage, Inc.,to send medical information back to my referring physician.

_____**I understand that if I participate in Ovulation Induction for the IVF program, my blood testing will need to be done at the Michigan Center for Fertility and Women's Health P.L.C. due to the critical timing for results for appropriate medication dosing. My insurance may not cover this testing, and I agree to pay for this testing. For HAP (Health Alliance Plan) patient's infertility bloodwork is not covered in our lab and will be your responsibility.**

_____I understand that if I participate in the Ovulation Induction or the IVF program and my insurance does not pay for certain procedure(s) or test(s); I agree to pay for the procedures(s) or test(s) not covered.

_____If Michigan Center for Fertility and Women's Health need to contact you with test results, or follow up from Dr. Kowalcyzk, they will leave you a message on your home phone number only. Please make sure to have an answering machine on that number. If this is not acceptable please let us know where to leave you a message.

Patient Signature:_____ Date:_____