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, PLC, Michigan Center IVF PLLC, or Fertility Storage, Inc and authorize the release of pertinent medical information to my insurance carrier as required.

_____ 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 the diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely to secure reimbursement from the 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 my ultrasound scan(s) may need to be sent to an outside facility for a second opinion. In this instance, I am aware that I may receive a bill from Reynolds & Associates for this service.

_____ I authorize Michigan Center for Fertility and Women's Health PLC, Michigan Center IVF, PLLC, and Fertility Storage, Inc to send medical information back to my referring physician.

_____ I understand that if I participate in Ovulation Induction Therapy or the IVF program, my blood testing may need to be done at a Michigan Center for Fertility and Women's Health PLC facility 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. Infertility bloodwork for HAP (Health Alliance Plan) patients is not covered in our lab and will be your responsibility.

_____ I understand that if I participate in Ovulation Induction Therapy 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, PLC needs to contact you with test results or otherwise, a message will be left only on phone numbers authorized by you. Please make sure to have voicemail set up on that phone number. If this is not acceptable please let us know how to contact you.

Patient Signature _____ Date _____