Patient Insurance Information

Name _____ Date of Birth _____ /_____ /_____

□ I choose not to share any medical insurance information as I elect to pay out of pocket (cash) for all clinical and laboratory encounters.

□ I do not have medical insurance.

Primary Insurance – See attached card	**Secondary Insurance – See attached card**
Carrier _____	Carrier _____
Address _____	Address _____
Contact # _____ Policy/Member # _____ Group # _____	Contact # _____ Policy/Member # _____ Group # _____
Name of Policy Holder (if not self) _____ Effective Date _____	Name of Policy Holder (if not self) _____ Effective Date _____

FERTILITY SPECIALISTS MEDICAL GROUP (FSMG) AUTHORIZATION: I understand that I am financially responsible for all charges, including those associated with the initial consultation, whether or not covered by my insurance plan. Payment is due at the time service is rendered unless insurance is being billed. If I have not disclosed relevant insurance changes, I accept full financial responsibility for services rendered if FSMG is unable to bill my insurance.

ASSIGNMENT: I permit payment directly to FSMG for any benefits due for services.

MEDICAL RECORDS: Authorization is hereby granted for release of any information required to process an insurance claim. A copy of this authorization is as valid as the original.

- I have received a copy of the FSMG Financial policy.
- All of my insurance coverage is listed above.
- All pertinent information has been disclosed and I hereby give permission for FSMG to bill my insurance.
- It is my responsibility to notify FSMG of any changes in my insurance coverage.

SAN DIEGO CENTER FOR REPRODUCTIVE SURGERY (SDCRS) AUTHORIZATION:

SDCRS is the facility that is used for IVF and reproductive surgeries and has separate HMO/PPO contracts.
I understand that I am financially responsible for all charges whether or not covered by my insurance plan. Payment is due at the time service is rendered unless insurance is being billed. If I have not disclosed relevant insurance changes, I accept full financial responsibility for services rendered if SDCRS is unable to bill my insurance.

ASSIGNMENT: I permit payment directly to SDCRS, Inc. for any benefits due for services.

MEDICAL RECORDS: Authorization is hereby granted for release of any information required to process an insurance claim. A copy of this authorization is as valid as the original.

- I have received a copy of the SDCRS Financial policy.
- All of my insurance coverage is listed above.
- All pertinent information has been disclosed and I hereby give permission for SDCRS to bill my insurance.
- It is my responsibility to notify SDCRS of any changes in my insurance coverage.

Signature:_____ Date:_____/_____/_____