Fertility & Surgical
ASSOCIATES OF CALIFORNIA

Assignment of Benefits, Authorization and Financial Statement

I hereby authorize payment directly to Fertility and Surgical Medical 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 Medical 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 Medical 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