
Assignment of Benefits and Authorization

The Assignment of Benefits and Authorization is required for all patients. Western Fertility Institute will gladly bill your insurance carrier however in order to do so this form must be completed and signed. Western Fertility will not bill your insurance carrier without this authorization.

I _____ hereby authorize and understand the following:

1. Payment of medical/surgical benefits, if any, otherwise payable to me as indicated on the attached claim is to be made directly to Western Fertility Institute.
2. Western Fertility Institute may release any medical information during the course of my medical services being rendered (examination, diagnostic testing and treatment) to my insurance carrier, laboratory, referring physician or pharmacy as necessary.
3. I am ultimately responsible for payment in full for all services rendered to me by Western Fertility Institute.

My Signature below indicates that I have read the agreement, understand and agree to the terms of the above policy in its entirety.

Patient Signature_____

Date_____

Office Representative_____

Date_____