AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I (We), _____ , here by assign
Patient and Partner's Names

to Damien Fertility Partners, my (our) right to any and all insurance payments under my (our) insurance carrier, _____, for all services
Insurance Carrier(s)

rendered to me (us) by Damien Fertility Partners.

It is my (our) understanding and that of Damien Fertility Partners that any and all insurance payments for all services rendered to me (us) will be paid directly to Damien Fertility Partners, and that notice of this assignment of benefits will be sent to

_____.
Insurance Carrier(s)

I (We) understand that I (we) am (are) responsible for any amount not covered by my (our) insurance company and any insurance balance outstanding after 45 days.

This assignment of benefits will continue as long as I (we) receive treatments and/ or services, or until cancelled in writing by both me (us) and Damien Fertility Partners.

_____ _____
Patient's Signature Date

_____ _____
Partner's Signature Date

Authorization to Release Medical Information

I (We),_____ , consent to your use and
Patient and Partner's Names

disclosure of my (our) protected health information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's Signature Date

_____ _____
Partner's Signature Date