



Ohio Reproductive Medicine

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ORM chart # _____

Insurance Agreement and Release

I certify that I have coverage with (Name of Insurance Company(ies)) _____ and assign directly to Ohio Reproductive Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician's office may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This Consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient/Parent or Guardian/Personal Representative

Date

Printed Name of Patient/Parent or Guardian/Personal Representative

Relationship to Patient