Ohio Reproductive Medicine

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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 physicians 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

ORM chart # _____