Insurance Information

Date ________________

Name _____________________________ Date of Birth ______________

Spouse Name _______________________ Date of Birth ______________

Primary Insurance Name: ______________________________

Subscriber's Name: ____________________________________

ID# _____________________ Group # ___________________

Secondary Insurance Name: ____________________________

Subscriber's Name: ____________________________________

ID# _____________________ Group # ___________________

- I here by authorize the Fertility Center, LLC (hereafter referred to as FC,LLC) to furnish my insurance company(s) all requested information.
- I hereby assign to the FC,LLC all money to which I am entitled for medical and/or surgical expenses relative to the services rendered but not to exceed my indebtedness to the FC,LLC.
- I understand that I am financially responsible to the FC,LLC for charges not covered and waives all rights of exemption under the laws of the state.
- I understand that FC, LLC is **NOT a Medicare, Medicaid, PeachCare** or **BlueCare/TennCare** provider and cannot submit claims. LC,LLC also is not a provider for **Tri-Care** but does submit claims to the company.
- I understand that it is **my** responsibility to inform FC, LLC of **any and all changes** regarding my insurance.

Patient Signature _________________________ Date ___________________

Public/Front Office/Forms/New Patient/Insurance Form
Revised: 05.06.08