CAROLINAS FERTILITY INSTITUTE, P.A.
FINANCIAL RESPONSIBILITY, MEDICAL RECORDS RELEASE, AND ASSIGNMENT OF BENEFITS

Pre-certification & Financial Responsibility: I understand that my insurer may review anticipated courses of treatment from CFI. I understand that if the insurer determines that the treatment plan is medically necessary and issues certification, my benefits will be available according to my policy terms. *However, if certification is denied, benefits may be withheld*. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her referring physician. *I also understand that I may be financially responsible for any and all charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment, retrospectively determine that a service was inappropriate, or should the certification occur too late to be valid*. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and referring physician in advance of my appointment.

I have read and understand the above consent _____(Initials)

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to Carolinas Fertility Institute, P.A., all medical provider benefits payable and any related rights existing under my insurance policies. I authorize and direct the insurance company to pay all such benefits to Carolinas Fertility Institute, P.A. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and Carolinas Fertility Institute, P.A.

I have read and understand the above assignment _____(Initials)

HIPAA Acknowledgement and Consent: I understand that I have certain rights under the Health Insurance Portability & Accountability Act (HIPAA) regarding my protected health information (PHI). I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up care among all providers who may be involved, obtain payment from designated third-party payers, conduct normal health care operations such as quality assessments or evaluations, and physician certifications. I have been informed about CFI's *Notice of Privacy Practices* and have had the opportunity to review it.

I have read and understand the above release _____(Initials)

Authorization to Release Medical Information: I hereby authorize Carolinas Fertility Institute, P.A. to release a copy of my complete health records, including HIV, if applicable, covering the entire treatment period during which I received services from Carolinas Fertility Institute, P.A. I hereby authorize the release of information to _____ in either copied form or original form as requested by _____ employees. The purpose of this disclosure is to provide for continuation of my care when I transfer treatment to _____. I also understand that this consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate on _____(2 years out).

I have read and understand the above release _____(Initials)

WE HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS, ASSIGNMENTS AND RELEASES PRINTED ON THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM.

Date:_____Witness:_____ Patient:_____

Other Responsible Party:_____