

**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