Oregon Fertility
institute

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Information & Authorization Form

Date___/___/___ Patient's Name _____ SS#_____
Pronoun

Address_____
Number street apt. # box # city state zip code

Home Tel. No.(____) _____ Date of Birth ____/____/____ Age _____

Patient's Cell Phone No. (____)_____ Patient's Email _____

Patient's Employer _____ Tel. No. (____)_____

Partner's Name _____ DOB_____ SS#_____
Pronoun

Partner's Cell Phone No. (____)_____ Partner's Email _____

Partner's Employer _____ Tel. No. (____)_____

Referred by _____ Tel. No. (____)_____

MEDICAL INSURANCE

PRIMARY INSURANCE: Subscriber _____ Ins. Company_____
ID #_____ Group #_____ Phone No. (____)_____

OTHER INSURANCE: Subscriber _____ Ins. Company _____
ID #_____ Group #_____ Phone No. (____)_____

If a patient does not have the appropriate prior authorization/referral from their insurance company, services to be rendered by Oregon Fertility Institute may not be covered under their benefit plan. Oregon Fertility Institute has the right as a participating provider to either cancel/reschedule the appointment or the patient, if seen, will be held responsible for payment of medical expenses incurred for these services.

I hereby authorize Aimee S. Chang, MD to release any and all information necessary to file claims for services I received to the insurance companies listed above. I hereby authorize the insurance companies listed above to make payment of benefits directly to Aimee S. Chang, MD for services rendered by them. I also hereby acknowledge I am financially responsible for all charges not paid by insurance. This agreement will remain in effect until revoked by me in writing. Photocopy of this assignment is to be considered as valid as an original.

In the event that this account becomes past due, I understand that it is subject to a 1.5% per month finance charge. Also, I understand that if the account becomes 60 days past due it will be turned over for collection and I agree to pay an additional collection fee based on the total amount due.

DATE _____ **PATIENT SIGNATURE** _____

DATE _____ **PARTNER SIGNATURE** _____