

**SOUTHEASTERN FERTILITY CENTER
AND
CENTER FOR REPRODUCTIVE SURGERY**

Patient's Name: _____

Physician: Dr. Jeffrey Keenan

SERVICES:

Intrauterine Insemination (IUI)
Surgical Procedures for Infertility
Other Tests/Procedures for Infertility (Including Postcoital Testing)
In Vitro Fertilization
Surgical Procedures (Any)
Semen Analysis
Antisperm/Antibodies Testing
Injectable Medicine Monitoring
Experimental or investigational services as defined by your insurance carrier

PATIENT AGREEMENT:

I have been notified by the physician that he believes that my commercial insurance may deny payment for the services identified above. These procedures may be non-covered by my insurance policy. I agree to be personally and fully responsible for any of the above services.

This waiver also gives permission for the office to contact the patient at home or work. If the patient is not present at the time of the call, a message will be left for the patient to contact their doctor's office.

Signature: _____ **Date:** _____