# SOUTHEASTERN CENTER FOR FERTILITY AND REPRODUCTIVE SURGERY

**Patient's Name**: _____

**Physician: Jeffrey Keenan, M.D.**

**SERVICES**:
Intrauterine Insemination (IUI)
Surgical Procedures for Infertility
Other Tests/Procedures for Infertility (Including Post-coital 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**:_____