DAVID G. DIAZ, M.D., Inc.
PRIVACY & FINANCIAL AGREEMENT

Thank you for selecting West Coast Fertility Centers for your Specialized Treatment.
To insure confidentiality, we will only report test results to you or your designee.

Please give us directions on how you would like to receive test results.

☐ **Patient Home #** _____ ☐ **Cell #** _____

☐ **Partner Home #** _____ ☐ **Cell #** _____

RESULTS AND RECOMMENDATIONS MAY BE REPORTED TO:

BOTH PARTNERS ◯ **YES** ◯ **NO**

If no, please indicate the name and phone numbers of the person you wish to receive the test results.

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Name **Home Number** **Cell Number**

Do you have an Advanced Directive? ◯ **Yes** ◯ **No**

If yes, please provide a copy to our office. West Coast Fertility Centers **will honor** Advanced Directives of the patient's choice.

FINANCIAL AGREEMENT: I authorize David G. Diaz, M.D., Inc. and staff to undertake testing recommendations and treatment. I understand I may ask questions about my testing, treatment, risks, complications and treatment options.

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full AT THE TIME OF SERVICE, unless other arrangements are made in advance with the business office. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I agree to take responsibility of any and all costs incurred for services rendered. If surgery is required, I authorize any payment of medical benefits to DGD M.D. Inc. I understand that any outstanding payment regardless of insurance payment is my responsibility. A photocopy of this signature is as valid as the original. I also authorize the physician to release any information required in processing of insurance claims.

I have received a copy of the patient rights and responsibilities.

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Patient Signature **Printed Name** **Date**

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Partner Signature **Printed Name** **Date**