IMPORTANT
FERTILITY CENTER PATIENT FINANCIAL AGREEMENT

I, ____________________________ (the patient), would like the Fertility Center (FC), the provider of medical services, to process my medical claims through my insurance carrier.

In addition, I understand:

- Upon verification by my insurance company that services are not covered by my plan, claims will not be filed.
- I am responsible in full **at time of service** for any services provided that are not covered by my insurance carrier and will be prepared to pay in full at time of service.
- I accept responsibility for all cash payments including co-pays and deductibles as required by my insurance carrier.
- I am responsible for contacting my insurance carrier prior to my new patient visit to verify that this physician participates in my insurance plan.
- I am responsible for verifying with my insurance company the coverage I have for labs as well as whether or not the labs can be done in office or are required to be sent out to an outside lab.
- I am responsible for any referrals from my primary care provider that are required for treatment by FC physicians.
- FC will be responsible for pre-certification of surgery and covered medical procedures performed by its physicians once I have been seen.
- It's my responsibility to call FC to verify that a referral has been received when needed before my appointment.
- Failure to follow these guidelines may result in unnecessary expenses incurred by me.
- I agree that failure to return this signed document at or before my new patient visit will cause forfeiture of my scheduled appointment.

I have read the above statement and agree with my responsibilities as the patient.

______________________________ ________________________
Signed Dated

Received By ________________ Date______________