

WELCOME TO THE FERTILITY CENTER, LLC

Thank you for choosing The Fertility Center, LLC for your care. Our practice participates with the following health insurance plans:

- Health America (HMO)** – No referral is needed and an office visit co-pay applies.
- Health Assurance (PPO)** – No referral is needed and an office visit co-pay applies.
- Highmark BlueShield** – No referral is needed and an office visit co-pay applies.
- Keystone (HMO)** – A referral is needed for all services and an office visit co-pay applies.
- Preferred Health Care (PHC), (PPO)** – No referral is needed and an office visit co-pay applies.
- South Central Preferred (SCP)** – No referral is needed and office visit co-pays may apply.

Our office will confirm benefits with your insurance carrier. **For patients with health insurance plans that require a referral, you must obtain a referral from your primary care physician PRIOR to being seen in our office for ALL services. If you do not have a referral for a particular visit, you will be asked to either reschedule your appointment or sign a waiver and pay in full for services rendered at the appointment.**

If your plan has a co-payment for office visits, this must be paid at the time of service. We may collect this prior to you being seen by a provider.

If you have an insurance plan which we are non-participating with, payments in full are due at the time of service. Laboratory and ultrasound charges are due at the time of service. For these services, in addition to services performed outside of our office, we will give you an appropriate receipt to submit to your insurance company.

If you have any questions regarding the above information, please feel free to ask us. We are here to help you.

CONTINUE WITH THE FINANCIAL POLICY ON THE BACK OF THIS SHEET

Initials (female)

Date

(Initials Male)

Date

FINANCIAL POLICY

The Fertility Center, LLC is committed to providing you the best possible care at a reasonable cost. For your information, here is an explanation of our financial policy.

If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

For insurance companies we participate with, we will do your claim filing for you. All co-pays, deductibles and any non-covered services are the patient’s responsibility. You will be billed for these balances by our office.

If you have a commercial insurance, or one we do not participate with, we will give you proper receipts for you to file your claims. Please refer to the back of this sheet for information regarding referrals and insurance companies we participate with. We will be happy to assist you in receiving payment from your insurance company.

Our office accepts VISA, MasterCard, and Discover, as well as cash or personal checks. All payments are expected at the time of service and any outstanding balances are due within 30 days, unless prior arrangements have been made with the Office Manager. Returned checks are subject to a \$25.00 service charge.

All past due balances may be assessed a 1.5% per month finance charge after 60 days. All balances that reach 90 days past due will be sent to The Credit Bureau of York. Should your account be sent to The Credit Bureau of York, you would be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY THE FERTILITY CENTER AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL TO RELEASE TO MY/OUR INSURANCE COMPANIES ANY INFORMATION NEEDED FOR AN INSURANCE CLAIM. I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ALL SERVICES RENDERED. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Signature of Patient and/or Guarantor (SEAL) – Female

Date

Signature of Patient and/or Guarantor (SEAL) – Male

Date