Reproductive Solutions, LLC.Financial Disclosure and Agreement

Please review carefully and retain for your records

THIS FINANCIAL DISCLOSURE AND AGREEMENT PERTAINS TO ALL SERVICES PROVIDED AT REPRODUCTIVE SOLUTIONS, LLC, d.b.a. ADVANCED REPRODUCTIVE CARE (ARC).

INSURANCE AND BILLING

During the course of your evaluation and treatment, physicians and other medical professionals may be involved in your care. It is common to be billed for physician and advanced practitioner services, anesthesia services, pathology services (if a biopsy was taken) and facility fees. Some entities may bill separately for services provided. You are free to utilize the health care facility or provider of your choice, subject to the terms of your physician's affiliation or restrictions which may exist under your health insurance coverage. Patients should check with their health insurance provider if they have any questions or concerns about their coverage.

PROOF OF INSURANCE COVERAGE

Copies of insurance cards are required for proof of coverage and submission of claim to insurance. If more than one insurance policy exists, proof of coverage is required for both insurance policies. Payment in full will be required the same day service is provided when proof of insurance has NOT been provided, unless otherwise arranged with our office.

CHANGE OF INSURANCE COVERAGE

It is patient responsibility to notify the physician office of any changes to insurance coverage PRIOR to any scheduled visits. Any balance deemed patient responsibility by the insurance carrier, including payment denials resulting from failure to update insurance information, are the responsibility of the patient.

VERIFICATION OF INSURANCE BENEFITS

The physician's office will attempt to verify Insurance benefits to determine the level of coverage and financial responsibility for services requested. Information obtained from insurance and/or any verbal/ written correspondence received is NOT a guarantee of payment. Any information obtained from insurance is used for the sole purpose of helping patients navigate the potential out of pocket costs associated with their care, to the best of our ability. It is patient responsibility to be aware and understand his/her insurance plan(s), limitations of coverage and benefits and to determine and/or inquire of prior authorization requirements that need to be completed prior to each scheduled visit.

BILLING

Patient authorizes payment of medical benefits to the medical service provider. Claims will be submitted to insurance on file with our office. Services provided that are not covered by the patient's insurance policy will be deemed "self-pay" and will be billed directly to the patient.

FINANCIAL RESPONSIBILITY

PATENT RESPONSIBILITY and NON PAYMENT

Payment for any amount deemed patient responsibility is due prior to or at the time of service. Patient responsibility for co-pays, co-insurance, non-covered services or other categories deemed patient responsibility may be determined through the benefit verification process, prior to a patient receiving an account statement. These payments will be due prior to or at the time of service.

Failure to pay an account balance past 90 days may result in the account being referred to a collection agency and/or suspension of the patient account for care that is not identified as a medical emergency. Continued failure to reconcile an outstanding balance may result in dismissal from the practice.

Patients are required to pay co-payments and/or co-insurance. The physician's office is contractually obligated to collect on this category of financial responsibility and these fees cannot be waived by our office.

PAYMENT OPTIONS

Credit or debit is the preferred form of payment, however, cash or check will be accepted, if necessary.

PERSONAL CHECKS and NON-SUFFICIENT FUNDS

In the event a check is returned due to non-sufficient funds (NSF), the **physician office** works directly with a third-party check collection agency in an attempt to electronically debit the amount of the check plus processing fees with equitable taxes. It is the discretion of Reproductive Solutions, LLC to terminate any attempts to collect by the third-party check collection agency and assess a $35.00 service fee to the face value of the returned check and decline personal checks as a form of payment. Any fee incurred by Reproductive Solutions, LLC is transferable to the patient. Additional charges may also be incurred from your banking institution in addition to any fees assessed by Reproductive Solutions, LLC.

FEES

Reproductive Solutions, LLC reserves all rights to make any and all necessary changes to its established fees at any given time without advanced notification.

COST ESTIMATES

Cost estimates are **only an estimate** of fees for **the period of time and services requested**. Fees are subject to change without prior notice. It is patient/consumer responsibility to request an up-to-date cost estimate, **if the timing or scope of services change**. **Some** out-of-pocket expenses for services provided **may not** be **able to be** determined until **after** services or course of treatment has been completed.

I have read and understand the payment policy and agree to abide by its guidelines:

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Signature of patient or responsible party Date