

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT

Thank you for choosing the Rinehart Center for Reproductive Medicine for your infertility treatment. We understand that by your coming to our practice you consent to the treatment of your fertility needs by the physicians and staff of our center.

To meet the needs of our patients, we participate in many insurance programs. Each insurance company has its own specific rules regarding the level of care, the amount of reimbursement and the physician practice where you may obtain infertility care. While we will work with you to provide your care within the guidelines of your plan, our main concern is providing you with quality health care.

It is your responsibility to inform us of your plan's guidelines for infertility coverage. You are financially responsible for all charges for health care services that you receive at our center unless you are insured for such services. If you have **full insurance coverage and/or our center is one of your network providers**, you are responsible for paying annual deductibles, co-payments, co-insurance and all charges for non-covered services at the time that the services are rendered, and we will bill your insurance plan for your charges. If your insurance plan considers our center an **out-of-network provider**, you are also responsible for your annual deductible, all charges for non-covered services and your share of the charges for all services rendered for each office visit or procedure. As most out-of-network plans cover 70% of usual and customary services, until we verify your specific benefits you will need to pay 30% of your charges at the time you receive any services. [This amount will be adjusted if we learn that your plan covers more, or less, of your infertility services.] We will bill your insurance plan for the remaining charges. If your insurance plan does not reimburse us for your care after two claims submissions (45 days), we will also have to bill you directly for the balance owed on your account that was not covered by insurance.

Please be sure to tell us when any of the following occur:

- You change insurance companies.
- You change plans within the same insurance company.
- Your plan has special rules for services such as lab work, ultrasounds, surgery, etc.
- You receive any notice of a change in your infertility benefits.

Payment for all services is your financial responsibility. We will have to bill you directly if you do not inform us of the above information and your coverage for care at our center is denied.

If your plan requires you to have a **referral** to be seen at our center, you must bring or send the referral to us before you begin treatment. You may choose to receive services without the proper referral forms, however, you will be financially responsible for these services.

We will assist you when we can so that you receive all of the insurance benefits to which you are entitled, and our staff and billing service are available to answer your questions. Thank you for your cooperation in this process.

I HAVE READ AND UNDERSTAND THE POLICY STATED ABOVE.

I CONSENT TO MEDICAL TREATMENT BY THE RINEHART CENTER FOR REPRODUCTIVE MEDICINE AND TO THE DISCLOSURE OF MY HEALTH INFORMATION AS NEEDED FOR MY TREATMENT AND THE OPERATIONS OF THE RINEHART CENTER.

I ACCEPT THE FINANCIAL RESPONSIBILITY AS EXPLAINED TO ME ABOVE.

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS FOR CLAIMS SUBMITTED ON MY BEHALF, AND I EXPRESSLY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS SUCH CLAIMS.

Patient Signature _____ Print Name _____ Date _____

Partner Signature _____ Print Name _____ Date _____