Fertility & Midwifery Care Center

FINANCIAL RESPONSIBILITY FOR PATIENTS WITHOUT CONTRACTED INSURANCE CARRIERS
(OUT OF NETWORK PROVIDERS)

Fertility & Midwifery Care Center, LLC. does not have a contract with the Medical Health Insurance Carrier that provides your medical insurance coverage. Our office has the following policies for Out of Network patients. Please read the following policies carefully, as you will need to accept and agree to abide by these policies.

- All office charges must be paid at the time of service. We accept cash, checks, VISA, Mastercard and Discover. As a courtesy to you, we will submit your claim to your insurance company. Payment arrangements can be made for any outstanding balances.

- If surgery is recommended and scheduled, you will be required to make a pre-payment prior to the surgery. The amount will be determined after our office contacts your insurance company to obtain an estimated payment amount.

- Many Out of Network Medical Health Insurance Carriers mail their reimbursement payments directly to the patient. If that is anticipated with your plan (i.e. Blue Shield), I agree to endorse and mail the insurance check to Fertility & Midwifery Care Center, LLC. (along with any documentation that accompanies the check) within seven days of its receipt. Any unreimbursed balance must be paid within 60 days from the date of surgery.

- I agree that if I refuse or fail to fulfill these above-stated agreements, I agree to pay any and all collections costs incurred by Fertility & Midwifery Care Center, LLC. during the process of collecting full payment for the services provided to me.

<u>Please note that by choosing an Out of Network provider, you accept the fact that you may have a significantly larger out of pocket financial responsibility.</u>

I agree to the above conditions and fully understand my financial responsibility for medical services that I receive from Fertility & Midwifery Care Center, LLC. as an out of network medical provider with my Medical Health Insurance Carrier.

Patient's Signature: _____

Patient's Printed Name: _____ Date: _____

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