Reproductive Partners
MEDICAL GROUP, INC.

PATIENT FINANCIAL POLICY / ASSIGNMENT OF BENEFITS

Insurance Coverage
The patient or his/her legal guarantor is ultimately responsible for all services incurred. The fertility centers will bill participating insurance plans if the patient provides the required insurance information and signs an Assignment of Benefits statement. Some fertility centers may bill for non-participating insurance plans as a courtesy, however, the services must be paid in full at the time services are incurred. If you have dual coverage, and we do not participate with your primary, the services must be paid in full at the time services are incurred. All information given regarding the ability to pay, third-party insurance, employment, etc., will be subject to verification. Patients with insurance policies that cover only a portion of the services must pay the difference between the charges and the anticipated insurance payment at the time the services are incurred. A pre-pay deposit may be required prior to all all services beginning.

Insurance claims are subject to eligibility, coverage and plan provisions which are determined by my insurance carrier. In some cases, certain services, supplies or medical care may be denied if found to be considered experimental, investigational or unproven by my carrier. I understand that I will be financially responsible for any denied or non-payable services rendered.

Uninsured Patients/Non-covered Services
Uninsured patients are required to pay all services in full prior to the services being incurred.

Payment Methods
The following payment methods are accepted: cash, check, money order, credit cards, outside lending institutions, and payment arrangements. Returned checks will be handled in accordance with Patient Financial Services Department NSF check procedures. A $35.00 bank fee will be assessed for each returned check.

In-House Collections
All patient balances must be paid within 30 days of time of service. Patients with unpaid delinquent accounts over 90 days old will be referred to outside collection and will be denied any further services. If future services are requested, all services will be considered on a Fee For Service basis and payment in full will be required prior to time of service.

Referral for Outside Collections
Accounts that cannot be collected by the fertility center will be referred to a collection agency, magistrate, or attorney for further collection action in accordance with established guidelines as deemed appropriate by the Fair Debt Collection Practices Act. Any fees assessed will be the responsibility of the debtor.

Refunds
Overpayments will be refunded to the appropriate party after review of the account. Any patient requesting a refund will not be processed until the account is reviewed and all active or past due

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balances are paid in full. Any outstanding accounts receivable balance $5.00 or under will be adjusted to zero. Any credits ($5.00) to ($0.01) will not be refunded.

Assignment of Benefits

I hereby authorize Reproductive Partners Medical Group, Inc. to release the requested and necessary information to my insurance company to complete my claim. I hereby authorize my insurance company to pay all my medical benefits, otherwise payable to myself, directly to Reproductive Partners Medical Group, Inc.

If my healthcare insurance is not contracted with Reproductive Partners Medical Group, Inc., I hereby assign Reproductive Partners Medical Group, Inc any insurance or other third-party benefits available for health care services provided to me. I understand the Reproductive Partners Medical Group, Inc has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Reproductive Partners Medical Group, Inc, I agree to forward the practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

"I have read, understand, and agree to the above financial policy and assignment of benefits. I understand that charges not covered by my insurance company, as well as applicable copayment, co-insurance and deductibles, are my responsibility."

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient Date