FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

YOUR FINANCIAL RESPONSIBILITY

Having insurance is not a substitute for payment. Family Fertility Center (FFC) cannot guarantee payment of claims by your insurance company. At all times, patients are responsible to advise FFC of any and all changes in insurance coverage. You are responsible for knowing the terms of your benefit plan and making sure all action is taken by you in order to ensure optimal reimbursement, including, but not limited to, obtaining referrals and/or pre-authorizations, appealing denials, etc. If FFC participates with your insurance plan, claims for covered services will be submitted directly to your insurance. You are responsible for paying co-pay, co-insurance, and deductibles at the time of service. It is the patient's sole responsibility to appeal any denied charges. Payment for any denied charges, regardless of rejection reason or appeal status, is due within 30 days of receiving your insurance (EOB) Explanation of Benefits or FFC statement. If FFC does not participate with your insurance plan, or if services are not eligible under your insurance plan, you will be responsible for paying all charges prior to services being rendered by FFC or, if credit is extended, within 30 days of receipt of your insurance EOB or FFC invoice. Any unpaid patient balances remaining after 90 days will be forwarded to an outside agency for collection and/or may be reported to the Credit Bureau as a bad debt without further notice to you. Any and all costs incurred (attorney fees, collection expenses of 33.3%, etc.) to collect any unpaid balances will be payable by you. All terms and payment agreements are subject to credit approval, and a credit report may be retrieved without further notice to you. While we do reserve the right to waive payment in the event of financial hardships or based on individual consideration, any payment waiver and/or reduction will be made at our sole discretion and is not to be construed as an agreement or contract to reduce/waive any or all fees.

I/WE, THE UNDERSIGNED, HAVE READ THIS INFORMATION, UNDERSTAND IT, AND AGREE TO BE FINANCIALLY RESPONSIBLE IN ACCORDANCE WITH THE TERMS SET ABOVE.

SS #: _____ **SS#:** _____

Patient Signature: _____ **Date**

Partner Signature: _____ **Date**

FFC Financial Policy given to patient by: _____ Date: _____

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YOUR SIGNATURE IS NECESSARY FOR US TO SUBMIT ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT IS RECEIVED FOR SERVICES RENDERED:

The Non-Medicare Patient:
I authorize the release of all medical information that is necessary to process any claims and is pertinent to my medical care. I assign all medical and/or surgical benefits to which I and/or my partner are entitled to H. CHRISTINA LEE, MD. This assignment will remain in effect until revoked by me or my partner in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient:
I request that payment of authorized Medicare benefits be made to me or on my behalf to H. CHRISTINA LEE, MD for any services furnished me by that provider and/or its agents. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I/WE AUTHORIZE THE RELEASE OF MEDICAL INFORMATION AS INDICATED ABOVE AND THE PAYMENT OF MEDICAL BENEFITS TO H. CHRISTINA LEE, MD d/b/a FAMILY FERTILITY CENTER, ON MY/OUR BEHALF.

Patient Signature:_____ **(Parent, if minor)** **Date**

Partner Signature: _____ **Date**

PLEASE HAVE A VALID DRIVER'S LICENSE AND INSURANCE CARD READY FOR PHOTOCOPY. Thank you.

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