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 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 all current and outstanding co-pay, co-insurance, and deductible amounts at each date of service. Failure to pay for treatments rendered and/or any outstanding balances may result in further treatment being postponed or terminated. 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 Explanation of Benefits (EOB) or FFC statement.

If FFC does not participate with your insurance plan, or if services are not covered under your insurance plan, you will be responsible for paying all charges prior to services being rendered by FFC. Discounted fee packages are available for patients with no insurance coverage for treatment; payment plans are not available.

Any unpaid patient balances remaining after 90 days for any reason 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 owed by you.

FFC participates in Northampton County Bad Check Restitution Program. For each check returned due to non-sufficient funds (NSF), a $50 service fee will be charged to you. Failure to pay the amount of NSF check and service fee within 10 days after receiving written notice by FFC will result in a Bad Check Crime Report being filed with the Bad Check program. You will incur additional costs and/or be prosecuted by the District Attorney's office.

We reserve our 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. I/WE ALSO AUTHORIZE FAMILY FERTILITY CENTER TO CHARGE MY/OUR CREDIT CARD, AS MAY BE REQUESTED BY PHONE, FOR ONE-TIME AGREED-UPON PAYMENTS. I/WE UNDERSTAND CREDIT CARD INFORMATION WILL NOT BE SAVED FOR FUTURE TRANSACTIONS.

Patient
Signature: _____ **Date**

Partner
Signature: _____ **Date**

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YOUR SIGNATURE IS REQUIRED FOR US TO SUBMIT INSURANCE CLAIMS AND RECEIVE PAYMENT

The Non-Medicare Patient: I authorize the release of all medical information pertinent to my medical care which is necessary to process any claims. 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 payment of authorized Medicare benefits for me or on my behalf be made directly to H. CHRISTINA LEE, MD for any services furnished me by that provider and/or its agents. I authorize the release of all medical information pertinent to my medical care to the Health Care Financing Administration and its agents as 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 VALID DRIVER'S LICENSES AND INSURANCE CARDS READY TO PHOTOCOPY. Thank you.