BOSTON IVF

UNDERSTANDING YOUR INSURANCE BENEFITS

Welcome to Boston IVF. We know that insurance and financial matters can be complicated. This document is designed to outline important insurance and financial information that you need to know while receiving services at Boston IVF. Please read this document carefully as your signature on this form indicates you have read and understand the information. This document will be valid during your entire time as a patient here at Boston IVF.

- Please contact your insurance company as it is **your** responsibility to obtain your infertility benefits. Your insurance company's customer service representatives, as well as your employer's benefits personnel will help you to understand your plan**, what it covers, and what it does not.**
- Your insurance company may require referrals from your primary care physician for your visits. It is your responsibility to obtain these referrals. If you are not able to obtain a referral from your primary care physician you will be charged for your visit(s).
- If your insurance plan imposes a dollar limit on your treatment, you are responsible for keeping track of the money paid by your insurance. Once you have met this dollar maximum, you will be responsible for the cost of services that are provided to you.
- Please notify us **immediately** of any changes to your insurance. If your coverage terminates while you are undergoing treatment, you will be financially responsible for charges incurred during your lapse in coverage. Due to the pre-authorization requirements of the insurance companies, if you change insurance plans while undergoing a treatment cycle, your cycle may be delayed or cancelled and you may be responsible for the cost of that treatment cycle. If you proceed with any treatment that has not been approved by your insurance company, you will be responsible for those charges.
- Many patients choose to freeze sperm and/or embryos at our facility. This may or may not be a covered benefit under your plan. Please check with your insurance company to determine if these services are a covered benefit for you.
- There are annual storage charges for frozen embryos as well as frozen sperm that are not covered by insurance. Contact your financial counselor for our current prices for these services.
- We require 48-hour notice if you are canceling your appointment. If you do not cancel your appointment with a **48 hour notice** or if you do not appear for your appointment you will be responsible for a late cancellation or no show fee of up to the full cost of the visit.
- All charges on your account are due prior to services being rendered. In the event your account becomes delinquent, you will be responsible for all collection costs including any attorney fees.

CREDIT POLICY: It is our policy that payment is required at the time of service. If you have insurance and your insurance plan provides coverage for infertility services, we will bill them for you. All deductibles, co-pays, or percentages of fees must be paid at the time of service. If insurance is denied, payment in full is required prior to commencement of any services

BOSTON IVF

UNDERSTANDING YOUR INSURANCE BENEFITS

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize that payment of all insurance claims on my behalf be made directly to Boston IVF.

RELEASE OF INFORMATION: I hereby authorize Boston IVF to release to my insurance company, any medical information, including diagnosis and records of treatment, necessary to process my insurance claims.

AGREEMENT OF FINANCIAL RESPONSIBILITY: I understand that if I do not have insurance I am financially responsible to Boston IVF for any services I receive. I also understand that if I have insurance coverage, I will be financially responsible for any amount not covered by my insurance company. **During my treatment monitoring with ultrasounds and blood work may be required. I understand that if I use a monitoring site other than one of the Boston IVF and IVF New England centers I will be responsible for all charges incurred. I understand that I must provide Boston IVF and IVF New England with any changes to my personal and insurance information immediately and by signing below indicate that the information I reviewed on this form is correct.** Failure to provide this information will result in my account becoming my sole financial responsibility, payable immediately. In the event that this account becomes delinquent, I agree to pay all costs associated with collecting this debt, which may include reasonable collections and attorney's fees.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED IN THIS DOCUMENT.

___________________________________ ________________________

Signature Date

____

Print Name