AMERICAN FERTILITY MEDICAL CENTER
2 Hughes, Suite 175, Irvine, CA 92618

Financial Policy

The following information is provided to ensure that patients understand their financial responsibility prior to seeking treatment at AFMC.

1. Patients are responsible for obtaining prior authorization(s) from their Primary Care Physicians (PCP) and/or insurance company. Please bring this authorization with you to your first visit or have your PCP mail or fax it to us prior to your initial consultation. We will preauthorize all surgical and hospital treatments with your insurance carrier. _____ (Initial)
2. All patients must schedule a financial consultation with our financial counselor after your first consultation with a physician and prior to starting any treatment. _____ (Initial)
3. After your initial consultation, it is your responsibility to make sure that you have subsequent authorizations prior to initiating any treatment. Any services not authorized by your insurance company will be denied and will ultimately become your financial responsibility. Remember that a prior authorization does not guarantee benefit payment. Contact your insurance company for verification of benefits. _____ (Initial)
4. For patients undergoing IVF, GIFT or ZIFT, payment is due prior to initiating treatment. This will be discussed in detail during your financial consultation. _____ (Initial)
5. For patients in need of an egg donor and/or gestational carrier, all fees are due prior to the donor and/or gestational carrier initiating treatment. _____ (Initial)
6. We encourage you to take an active role in understanding your insurance benefits and coverage prior to beginning any fertility treatment. No one is as interested in your insurance coverage as you are. _____ (Initial)
7. Sometimes it may take up to 4 to 6 weeks to obtain authorization from your insurance company. If you choose to start treatment before we receive the authorization, a deposit or payment will be required in full. _____ (Initial)
8. If your insurance company covers ART treatment (IVF, GIFT or ZIFT), we must have complete benefits and the authorization directly from your insurance company. We will send a form letter explaining your course of treatment and requesting the insurance company to correspond to us in writing. We will collect any co-payments, deductible or out-of-pocket expenses before beginning treatment. _____ (Initial)
9. All past due accounts must be paid in full prior to starting a new cycle. _____ (Initial)
10. We accept payment by cash, Mastercard, Visa. If any of your checks are returned unpaid by your bank for any reason, AFMC reserves the right to charge you a handling fee and you promise to settle the returned amount plus the handling fee within five (5) working days. _____ (Initial)
11. If you and/or your insurance company do not pay AFMC promptly which leads to any legal actions to collect the delinquent fees or any returned check, you hereby agree to reimburse AFMC fully for the incurred legal and collection expenses. _____ (Initial)
12. We deal ethically and honestly with every insurance provider and with every service claim we file. We will only submit for services rendered, specifically as they are rendered with the appropriate diagnosis. _____ (Initial)
13. No itemized receipts will be provided for non-covered or discounted services.
14. AFMC is sensitive to the high cost of infertility treatment and the variability of insurance coverage. We have designed our program to keep our costs competitive and to help you maximize your insurance benefits. Prompt payment and reimbursement for services will be facilitated if you understand the terms of your insurance coverage for infertility as well as the AFMC payment policy. Please note we are not a party to your insurance contract. Your insurance coverage is specified in a contract between you, your employer and the insurance company. All services are not covered benefits in all insurance contracts. AFMC does not accept “usual and customary payment” as payment in full. As a courtesy, AFMC may assist in verifying insurance benefits for you; however, we do not make any assurance that the information we obtain is correct. Verification of benefits from an insurance company is not a guarantee of payment. All insurance payments are subject to review of claims submitted. AFMC will not be responsible if your insurance should deny payment. Regardless of insurance

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coverage, you are ultimately responsible for the full payment of your account. _____ (Initial)

Feel free to contact any of our financial counselors to answer any questions you may have regarding financial issues. AFMC reserves the right to adjust our service fees periodically without prior written notice to any of our patients. We respectfully ask for your cooperation in not directing any financial questions to our physicians, as they may not be able to provide you with the appropriate answers.

I have read and fully understand the financial policy listed above.

Patient Name(please print) _____

Patient Signature _____ Date _____

AFMC Team Member Signature _____ Date _____