Brown Fertility Insurance Waiver for NON-COVERED SERVICES & NO REFERRAL

PATIENT INFORMATION

PATIENT'S NAME _____
Last First M.I.

ADDRESS _____

BIRTHDATE _____/_____/_____ **DAYTIME TELEPHONE NUMBER** _____
Month Day Year

SOCIAL SECURITY NO. _____ **INSURANCE**_____

NON-COVERED SERVICES and INSURANCE REFERRAL

☐ NON COVERED SERVICES

I understand that my insurance will only pay for services and supplies that it determines are covered benefits under my particular plan and medically necessary for my care and treatment. I have been informed by Brown Fertility that the following service ***is or may be a Non-Covered Service under my insurance plan***:

Ultrasounds/Scans: $150-$250; Office Visits: $42 - $500; Lab/blood draw: $10 - $200; IVF Cycle: $3,275.00 - $25,000.00; Other Procedures: $365 - $6,000.00.

I desire to have the service or supply provided with the understanding that the charge(s) will not be filed with my insurance, or if the charges are filed and my insurance company denies payment, **I will be financially responsible for the total cost of the service.**

Brown Fertility will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance.

☐ NO REFERRAL

I understand as **I do not have a referral for today's visit.** I **will be seen** as a "**Private Pay**" patient today.

SIGNATURE

Date: _____

Patient Signature: _____

Parent, Guardian or Legal Representative Signature:_____

Witness Signature:_____

09/03/2015

This waiver is not to be used for Medicare Beneficiaries. Please advise our office if you are covered by Medicare as they require their own Advanced Beneficiary Notice (ABN) is used.