BROWN FERTILITY
CONCEIVING MIRACLES™

I, _____, understand that I am choosing to not use my insurance coverage and be a "self-pay" patient for all and any treatment received at Brown Fertility.

- **I understand that the charge(s) will not be filed with my insurance.**
- **I will be financially responsible for the total cost of the services.**

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, these fees are only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I understand that I will be responsible for paying in full for any balance accrued by the due date specified by Brown Fertility.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**
_____	_____	_____
Partner Name	**Partner Signature**	**Date**
_____	_____	_____
Witness Name	**Witness Signature**	**Date**