Reproductive Health & Wellness Center

FINANCIAL AGREEMENT

Assignment of Benefits
I hereby authorize payment of benefits to Reproductive Health and Wellness Center, its physician(s), or supplier(s) of services named on the claim. I understand that I am responsible for annual deductibles, non-covered services, co-payments, and all services categorized as "NOT MEDICALLY NECESSARY," COSMETIC," INFERTILITY," or "DENIED" for any reason by my insurance company.

Financial Policy
I understand that monetary deposits collected from me by Reproductive Health and Wellness Center for services rendered are non-customary, discounted fees. In addition, I understand that, unless otherwise specified, Reproductive Health and Wellness Center will bill my insurance company the customary non-discounted rates, and that every effort will be made to collect benefits from my insurance carrier(s). I understand that any payment received from my insurance company will be applied to my account according to the insurance company's explanation of benefits (EOB) statement(s). If after 30 days from claim submission my insurance carrier has not responded, payment is due in full and I will be liable for all uncollected fees. In the event that payment for services rendered comes directly to me, I will sign, endorse, and forward all checks immediately to Reproductive Health and Wellness Center. I understand that I will be responsible for all administrative, legal, and/or collection agency fee(s) involved with recouping any and all outstanding payments due.

Payment and Refund Policy
Payment in full is required and should be paid upon commencement of treatment. Payment is expected regardless of outcome of treatment. Cash, cashier's check, wires, and credit card (Visa, Master Card, Discover, and American Express) are accepted. Refunds for cancelled treatment cycles will be processed within 30 days of cycle cancelation, and will be subject to a 3% credit card processing fee if originally paid by credit card.

I have read the Assignment of Benefits, Financial Policy, and Payment and Refund Policy clauses and agree with the above terms.

Request to Bill or Not to Bill My Insurance Carrier
___ I consent to having Reproductive Health and Wellness Center bill my insurance carrier(s) for services rendered. I hereby authorize Reproductive Health and Wellness Center to release to my insurance carrier(s) any information required to process my claims.
_____I request NOT to bill my insurance carrier(s) for services rendered.

Patient's Name	**Patient's Signature**	**Date**
Partner's Name	**Partner's Signature**	**Date**
RHWC staff	**RHWC signature**	**Date**