SAN DIEGO Fertility Center
hold on to your dreams

Financial Agreement and Insurance Information

Please read this carefully. You are responsible for the information in this agreement. Please keep a copy of this agreement for your records. Please initial each of the agreement points below, sign and date the bottom.

- I understand that I am financially responsible for any services I receive at San Diego Fertility Center (SDFC). Please initial: _____ (patient) _____ (partner)

- I understand that it is my responsibility to inform the SDFC staff of any changes to my insurance as soon as I know changes have occurred. If I have not disclosed my updated insurance information to the staff, my insurance will not be billed and I will assume responsibility to pay for the visit in full. Please initial: _____ (patient) _____ (partner)

- Once I am an established patient of SDFC, the insurance team handles my authorizations. I am aware that I need to confirm my authorizations have been approved before I schedule appointments. If I come in for an appointment without being notified of authorization approval by SDFC, I assume the responsibility to pay for the visit in full. Please initial: _____ (patient) _____ (partner)

- I am aware the Del Mar Surgery Center is only contracted with Aetna Insurance with an authorization. The Del Mar Surgery Center is out of network with all other insurance companies. Please initial: _____ (patient) _____ (partner)

- I am aware the San Diego Fertility Center IVF and Andrology Laboratory not contracted with any insurance companies. Please initial: _____ (patient) _____ (partner)

- My insurance benefits are my responsibility. The SDFC staff receives a quote of benefits from insurance companies for patients, but these quotes are not a guarantee of benefits or payment by my insurance. I am responsible for any services that are unpaid by my insurance. Please initial: _____ (patient) _____ (partner)

- Payment is due, in full, at the time services are rendered. Please initial: _____ (patient) _____ (partner)

Insurance

San Diego Fertility Center (SDFC) provides a detailed, courtesy insurance verification of benefits. To ensure the accuracy of the information, please complete all fields below and *provide a copy of your insurance card (include your pharmacy card if separate)*. Be sure to copy the ***front and back*** of the card(s). Our financial team will follow-up with the coverage details upon completion of the insurance verification.

IMPORTANT: HMO insurances require a physician referral and approved authorization for SDFC to submit claims for treatment services. Please contact your primary care or OB/GYN as soon as possible to obtain the authorization letter and submit to SDFC. If the authorization is not approved or unavailable in time for SDFC services, the patient will be seen on a Self-Pay basis.

Patient 1

Full Name	
Name of Subscriber	**Date of Birth of Subscriber (if differs from patient)**
Subscriber Employer	
Name of Insurance Carrier	
Member ID Number	**Group Number**
Provider Services Phone Number	

Patient 2 (Partner or Spouse)

Full Name	
Name of Subscriber	**Date of Birth of Subscriber (if differs from patient)**
Subscriber Employer	
Name of Insurance Carrier	
Member ID Number	**Group Number**
Provider Services Phone Number	

The insurance verification is a quote of benefits only and is not a guarantee of payment. Payment is determined solely by the insurance carrier at the time of processing of claims and may be changed or retracted in the future if determined non-covered at the time of service and services were paid in error. Patients are responsible for non-covered services.

Self-Pay

If you wish to *waive your insurance coverage* and be seen on a Self-Pay basis at SDFC for all services, including but not limited to the New Patient Consultation, please check the box below:

☐ I/We acknowledge and agree to waive my insurance for any and all medical services at San Diego Fertility Center. I/We understand I/we will be seen on a Self-Pay basis and will be 100% responsible for any associated charges pertaining to these services.

If you *do not have insurance coverage* and will be seen on a Self-Pay basis at SDFC for all services, including but not limited to the New Patient Consultation, please check the box below:

☐ I/We acknowledge and agree to receive medical services at San Diego Fertility Center on a Self-Pay basis. I/We understand I/we will be 100% responsible for any associated charges pertaining to these services.

Acknowledgement

I/We acknowledge and certify that I/we have read the above information thoroughly and understand our payment options. I/We testify the information provided above is accurate to the best of our knowledge and will be responsible for any services charges uncovered by a third party (i.e. insurance), if applicable.

Patient Name:_____ **Spouse/Partner Name**:_____

Patient Signature:_____ **Spouse/Partner Signature**:_____

Date:_____ **Date:** _____