IVF Procedure Financial Consent

Patient Name_____ **Date of Birth** ____/____/____ **Account #**_____

Partner Name_____ **Date of Birth** ____/____/____ **Account #**_____

GENERAL

I/we understand that Virginia IVF & Andrology Center is non-participating with all insurance plans and that I/we am(are) responsible to pay all charges at the time of service, unless otherwise directed by Virginia IVF & Andrology Center. I/We further understand and agree that I/we am(are) responsible for the full cost of the services rendered, regardless of insurance coverage. All charges that remain unpaid will be billed to me/us until such time as the charges are paid by me/us or my/our insurance carrier. I/We agree that in the event that my/our account(s) is referred to an attorney for collection, I/we will be responsible for attorney's fees in the amount of 33 ⅓% of the unpaid balance, court costs, and interest.

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS

If no option is selected; no claim will be filed to insurance

Patients Not Filing Insurance or Who are Enrolled in the Shared IVF Success, Multicycle, WINFertility, or other Discount Program

☐ **DO NOT FILE AN INSURANCE CLAIM FOR ANY PORTION OF THIS SERVICE**

Patients Who Wish to File Insurance

I/We understand that I/we am(are) responsible to obtain any necessary referrals or authorization for treatment. I/We hereby authorize Virginia IVF & Andrology Center and/or Anesthesia Connections to release information regarding services rendered to me/us to the insurance company(ies) on file; and assign payment directly to Virginia IVF & Andrology Center.

Patient Insurance _____ **ID#**_____ **Group#**_____

Partner Insurance _____ **ID#**_____ **Group#**_____

☐ **FILE AN INSURANCE CLAIM FOR ALL PORTIONS OF THIS SERVICE**

☐ **FILE AN INSURANCE CLAIM FOR A PORTION OF THIS SERVICE, please explain in detail**

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CRYOPRESERVATION

I/We also understand that in the event that I/we cryopreserve any tissue at Virginia IVF & Andrology Center; I/we will be responsible for storage charges until such time as I/we complete and notarize the appropriate termination of storage paperwork.

Virginia IVF and Andrology Center strongly encourages patients with ongoing tissue storage to place a credit card on file to enjoy the convenience of automatic payment of storage fees. If you would like to place a credit card on file, please contact our Business Office for assistance.

Patient Signature _____ **Date** _____/_____/_____

Location Signed (county/city and state)_____

Partner Signature _____ **Date** _____/_____/_____

Location Signed (county/city and state)_____