

Associates in Womens Health, L.L.C

Infertility services agreement

Effective 2/22/2017

Associates in Womens Health (AWH) is committed to providing quality care to our patients. The following is our financial policy regarding provision of infertility related services. All patients desiring infertility services must sign this agreement prior to any services being rendered.

Insurance coverage and infertility services

Insurance coverage for infertility services and treatment can be confusing. We encourage patients to review their insurance policy and contact their insurance company with any questions about coverage.

We will file the first cycle of claims (typically an ultrasound and intrauterine insemination (IUI)) to the patient's insurance plan, if desired. If/when insurance denies as a non-covered service then future claims will not be filed to insurance unless there is a policy change.

Financial policy regarding infertility services

All infertility services are provided on a pre-pay basis. We require a pre-payment deposit of \$1000 prior to the first infertility appointment. We will draw on this balance for any amount due after insurance has processed the claims. Please see the attached estimate sheet for a list of our most common infertility services and associated fees. Once the pre-payment balance is exhausted (approximately 2 cycles, depending on plan of treatment) another \$1000 must be paid to continue receiving services. Any balance remaining in pre-pay credit will be refunded to the patient after infertility services are discontinued. If pregnancy is achieved and the patient will be continuing care with our office, we will use the pre-pay balance to satisfy any patient balance for OB charges throughout the pregnancy.

In some cases, insurance may hold infertility claims while they investigate the patient's policy and medical history; this can result in claims being delayed for several months and then processed all at once, resulting in a large balance due from the patient. If the \$1000 pre-payment deposit is insufficient to cover the entire balance, payment is due in full within 30 days and prior to receiving further infertility services.

Each patient's account must be current and have no existing balance prior to receiving infertility treatments.

Please contact the billing department at (402) 614-8181 or go to www.awhomaha.com to make your pre-payment.

Certain insurance companies require the patient to sign an Advance Beneficiary Notice (ABN) or similar waiver prior to each visit, which will be addressed upon check-in.

Coding

All infertility services rendered will be coded as such when the claim is filed to insurance. We cannot change this coding for the sole purpose of getting insurance to pay for the services; changing the coding of insurance claims for this reason is considered insurance fraud.

Surgical procedures

If the physician recommends a surgical procedure to diagnose or treat infertility we will contact insurance to determine benefits. If the procedure is not covered, or if it will be subject to the deductible, we will require pre-payment of the full amount prior to the procedure, aside from whatever balance remains from the \$1000 pre-payment. If surgery is to be done in a hospital setting there will be additional facility charges (anesthesia, equipment use, etc.) billed by the hospital, and may result in a balance due directly to the hospital. We are a private practice, and have no involvement in the hospital's billing practices. Please contact them directly with any questions about facility charges.

Disclaimer

Please note that all fee amounts listed are subject to change at any time. Any information provided by insurance regarding coverage is an estimate, and not a guarantee of payment or coverage. Final determination of coverage will be determined when a claim is submitted. Occasionally the insurance company may quote benefits inaccurately with regards to coverage of infertility services which may result in a higher amount due from the patient than originally anticipated.

Non-compliance

Failure to provide prompt payment for infertility services may result in postponing further services until the account is current, and/or any applicable pre-payment is collected.

Acknowledgement

Name (printed): _____

Signature: _____ Date: _____

My signature serves as acknowledgement that I have read the Infertility Services Agreement, and I agree to abide by the procedures laid out within. I also understand and agree that, due to changes in the medical and medical insurance industry, the practice may amend such terms from time to time. I understand that this agreement will remain in effect for six (6) months. If I choose to no longer receive services from AWH within the six (6) month period, I can terminate this agreement by giving a written notice of my decision. If I have any questions at any time, I should contact the AWH billing department at (402) 614-8181.