Financial Disclosure

Family Beginnings, P.C. is committed to providing quality care to our patients. The following are financial policies we have established for our practice. If you have any questions regarding these policies, please talk with our billing department.

It is important to recognize your insurance policy is a contract between you and your insurance company. We recommend reviewing your insurance policy to understand your infertility/IVF benefits and limitations. If there is no coverage for fertility diagnosis or treatment, all services will be self-pay and due at the time of appointment.

Insurance Coverage and Financial Counseling

- Family Beginnings financial counselors are available to help guide you through understanding your infertility and IVF insurance benefits. We will provide an estimate of your expected financial responsibility prior to treatment whenever possible.
- Insurance benefit information is provided to Family Beginnings by your insurance company. Family Beginnings cannot guarantee coverage or payment, as final determinations are made by the insurance carrier after claims are processed. Because infertility coverage can be complex, patient deposits may be required prior to treatment.

Coverage Limitations & Patient Responsibility

- Even with infertility or IVF coverage, some services may be considered non-covered or experimental under your plan. Family Beginnings will review benefit details when possible; however, if insurance denies coverage for any reason, you are responsible for all charges not covered.

Referrals, Authorizations & Case Management

- Many insurance plans require referrals, prior authorizations, or enrollment in plan-specific case management programs before infertility services are covered.
- **Treatment cannot begin until Family Beginnings confirms that all required referrals and authorizations are on file.**
- If you choose to begin treatment without required referrals, authorizations, or enrollments, insurance coverage will not apply, and you will be considered self-pay. Full payment will be required prior to services being rendered.

Self-Pay Patients

- **Payment Requirement:** Patients without insurance coverage are required to pay in full prior to the start of treatment or any scheduled appointments. Services will not be provided until payment has been received.
- **Out-of-Network / Non-Participating Insurance:** If Family Beginnings does not participate with your insurance plan, or is considered out of network, all services are self-pay and payment is due at or before your scheduled appointment. As a courtesy, Family Beginnings may provide an itemized statement (HCFA/ledger) for patients who wish to submit claims directly to their insurance for possible reimbursement. Reimbursement is not guaranteed.

Third Party Labs

Family Beginnings takes no responsibility for any outside lab costs to patients. Utilizing non-Family Beginnings entities, such as pharmacy, anesthesia, or laboratory services, requires the details outlined below:

- **Anesthesia:** Anesthesia costs are self-pay. Patients will be responsible for a $625 anesthesia fee that is paid directly to **Northside Anesthesia Services. THESE CHARGES MUST BE PAID PRIOR TO PROCEDURE.**
- **Laboratory Services:** Patients are responsible for confirming whether laboratory services are covered under their insurance plan and for any financial responsibility owed directly to the laboratory.
- **Out-of-Network Providers:** Some services, including laboratories, anesthesia, or third-party vendors, may be considered out of network and may result in additional patient responsibility.

Specimen Storage

- I acknowledge that a valid credit card must be maintained on file for payment of annual storage fees for any cryopreserved specimens, including embryos, oocytes, or sperm. I authorize automatic annual billing to the credit card on file unless written notice and alternative payment arrangements are approved in advance.
- I understand that it is my responsibility to keep my contact information up to date, including my phone number, email address, and physical mailing address, to ensure I receive all storage-related notifications and billing communications. The clinic will make reasonable attempts to contact me for up to 90 days. If I do not respond or update my contact information within that time, the account may be referred to collections.
- I understand that additional fees may apply for specimen intake, handling, coordination, and shipping when specimens are transported to or from the clinic, including transfers to other clinics or storage facilities. These fees are separate from treatment or storage costs and may vary based on the destination and services required.

Settling Your Financial Obligations

- All outstanding balances that remain unpaid after 120 days may be referred to an outside collection agency or attorney.
- If we refer the unpaid balance to a collection agency, you are responsible for paying any reasonable attorneys' fees and legal expenses Family Beginnings may incur in attempting to collect payment from you.
- Any further treatment may be delayed until your outstanding balance is resolved.

If I_____*(initial)* decline recommended testing (such as genetic carrier screening or repeat testing), my insurance may deny coverage or prior authorization for certain services. Some insurance plans require specific testing to show that a procedure is medically necessary.

I_____*(initials)* acknowledge I have read and understand the following financial disclosures. If any of the disclosures apply, I could be financially responsible for payment in full. It is my responsibility to provide accurate and timely benefit information prior to all visits.

I_____*(initials)* understand insurance verification is completed prior to my scheduled visit utilizing the insurance information I have provided, if applicable. I may present new or updated insurance at or after my visit. Family Beginnings will be unable to provide accurate estimates if the correct insurance is not provided at least 72 hours prior to my/our scheduled visit.

For patients with insurance/self-pay, I_____*(initials)* may be required to seek treatment/lab from a physician, anesthesiologist, genetic testing facility, laboratory, or other providers. Family Beginnings recommends outside testing based on treatment and does not have any responsibility for outside testing billing/costs or benefit verification for referrals outside of Family Beginnings.

I acknowledge_____*(initials)* and understand I have elected to be seen as a self-pay patient, and I agree to assume all financial responsibility to pay in full today for all service(s) rendered, as applicable.

I acknowledge_____*(initials)* refunds are subject to an account review and may take up to 30 days to process. All pending insurance claims must be fully resolved in both the patient's and partner's accounts before a refund can be issued. Refunds are returned to the original credit card used for payment. Any payments made in cash will be refunded by check.

I have read and understand all the terms and conditions presented in this financial policy. I agree to be financially responsible for services rendered.

For services that have not been paid in full, or those requested by me to be submitted to insurance, I hereby consent to allow Family Beginnings to release information regarding my/our services to the insurance carrier(s) whose information has been provided by me/us.

By typing my name in the signature field below, I acknowledge that I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual signature on this form.

_____

Patient Name

_____

Date