Seattle Reproductive Medicine®
AN INTEGRAMED® AFFILIATE

Insurance Waiver

This statement is to confirm that I have opted to see Dr.________________________
and will be personally held responsible for the cost of services he/she renders.

1) It is my understanding that if a referral is required, it must be obtained from my insurance. As a patient, this is my responsibility. If a referral is required by my insurance carrier and not obtained, my appointment will be rescheduled. However, if denied, I will be responsible for the payment of the services. I choose to be seen prior to knowing whether the services are approved or not.

2) If I am being seen or treated for a non-covered benefit, contract exclusion, or ART cycle (IVF, DEP, FET), I understand that payment is required at the time of service.

________________________ ________________________
Patient Signature Date

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Print Name

________________________ ________________________
Witness Date

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____________________________	____________________________
Patient Signature	Date

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Print Name

____________________________	____________________________
Witness	Date

FINANCIAL POLICY

1. Patient is responsible for payment of known deductibles, co-insurance, co-payments, non-covered services, or ART cycle (IVF, DEP, FET) at or before the time of service.

2. Balances that are unknown at the time of service will be billed to the Patient. Patients are responsible for the prompt payment of these balances. Balances not paid within 30 days will be subject to finance charges.

3. A fee of $25.00 will be assessed for each returned check.

4. Patients are responsible for all fees associated with or incurred due to non-payment of account. These fees include, but are not limited to collection agency, legal and court fees.

5. **Patient is responsible** to verify insurance benefits and to ensure appropriate insurance authorizations; pre-certifications and referrals are obtained prior to services being rendered. SRM Financial Counselors are available to assist in this matter, however, failure to do so will result in the patient's financial responsibility for non-authorized services.

FINANCIAL COUNSELORS ARE AVAILABLE TO PROVIDE ADDITIONAL INFORMATION

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Patient Signature Date

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Print Name

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