AUTHORIZATON OF CLAIMS AND PAYMENTS

3015 Williams Drive | Fairfax, VA 22031 | 703-698-7355 | www.givffertility.com

I acknowledge responsibility for payment for services rendered to me at GIVF Fertility ("GIVFF") is due at the time of service.

1. Assignment and Coordination of Insurance Benefits:

I agree to provide information regarding all health insurance benefits to which l/the patient may be entitled. I hereby assign payment(s), if any, from my insurance carrier's/carriers'(s) health benefit plan to GIVFF for services rendered to the me/the patient. Unless full payment is made by me on the date of service, I hereby authorize payments by my insurer directly to GIVFF, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to GIVFF for services rendered to me during the applicable periods of medical care.

2. Unauthorized, Non-covered, or Out of Plan Services:

I understand and acknowledge:

- If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay, and I agree to pay for these services.
- One or more of my physicians may not accept insurance or may be out of network with my health insurance.
- In the case of out of plan/network physician or services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible, or co-insurance amount.

3. Responsibility for Payment:

I acknowledge responsibility for payment for services rendered to me or my dependents at GIVFF. If such services are covered under a contract between GIVFF and my insurer, I agree to pay in full any applicable deductibles, copayments, co-insurance, and/or charges for any non-covered services. If my account becomes delinquent, I agree to pay all costs GIVFF may incur in collecting its fees from me, including any collection agency and/or attorney's fees. If charges on my account are not fully paid within 180 days of service, I agree to pay interest from that date at a rate of 1.5% per month.

Patient Signature: _____ Date: _____

Spouse/Partner Signature: _____ Date: _____

(If applicable)