Oregon Fertility Institute and Oregon Fertility Institute Laboratory
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RECEIPT OF PRIVACY PRACTICES & PATIENT FINANCIAL POLICY

Patient Name: ____________________________________ Today's Date ____/_____/_____

RECEIPT OF PRIVACY PRACTICES:
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.
Patient or Responsible Party Signature ____________________ Date _____/______/_____

We are currently enrolled in numerous managed care health plans in order to meet the needs of our patients. While we would like to accommodate our patients in the best manner possible, it is difficult to know all the requirements and levels of service that each plan provides. Some plans may also require a referral from a primary care provider. Our main focus is to offer comprehensive medical care. Although we may get an overview of your medical coverage, it is your responsibility to understand your unique medical benefits and to call your insurance company to clarify coverage that is provided.

Please keep us informed of any special requirements with your health plan. If services are provided that are not covered, payment for these non-covered charges will be your responsibility.

PRACTICE FINANCIAL POLICY:
Cancellations: Please note that if an appointment is cancelled in less than 24 hours, you will be responsible for the full amount of the office visit.
Insurances: Patients are required to bring their current insurance identification card to *each appointment.* It is your responsibility to inform us of any changes in insurance, address, or telephone number. *If your insurance information is not received within 5 business days of your appointment, the balance incurred from your visit will be your responsibility and your insurance will not be billed.* _______ ***Initial if card not present***

Please note the following:

1. HMO/PPO co-payments are due at the time of each visit. You will be responsible for paying your annual deductible, copayment and charges for any non-covered services.
2. Managed care members are responsible for obtaining any necessary referrals prior to your appointment time. Please call your insurance company to determine if you need a referral. We reserve the right to reschedule your appointment if we do not have the necessary referrals by the time of your visit.
3. Unauthorized and non-covered services will be the responsibility of the patient and full payment is expected at the time of visit.
4. Full payment for all services is expected at the time services are rendered, unless you provide written documentation indicating that you have infertility benefits.
5. If payments are not made within 60 days of service, our collection service will be notified. A fee of 40% of the total balance will be added to the outstanding balance, if a bill is sent to collections.
6. A fee of $25 will be added to any canceled or returned checks.
7. **Please note, that all Laboratory charges are OUT OF NETWORK including semen analysis, sperm wash, and IVF Laboratory services.**
8. **A fee of $25 will be incurred for sending medical records to another institute.**
9. **If the medical chart is in archives or more than 5 years since active treatment the fee is $50**

IMPORTANT NOTE ABOUT YOUR INSURANCE BENEFITS:
Please be sure to check your insurance benefits. Treatments and procedures recommended for you are considered by your insurance company as a separate charge from the office visit with the physician, even if the appointment occurs on the same day as your appointment with the physician. Usually, co-pays and deductibles apply to these types of appointments. For specific questions regarding your insurance policy guidelines, please contact your carrier's customer service department.

I have read and agree to abide by the policies set forth in this document, and I agree to accept the responsibilities as described above.

___________________________________ _____/______/_____
Patient or Responsible Party Signature **Date**