New Leaders In Fertility & Endocrinology
www.fertilityleaders.com

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Patient Accounts and Insurance Policy

To help you understand and anticipate any difficulties in insurance benefits that you may encounter, please review this document thoroughly. Insurance coverage in the field of fertility management is not as straightforward as in most other areas of medicine.

For example,

- Testing is often covered to determine a cause of infertility, but treatment may not covered,
- Many times payment depends on "why" the service was performed. For instance, an ultrasound of your ovaries to ensure that an ovarian cyst is shrinking, will be paid, but an ultrasound to track your response to fertility medications ("treatment"), will often not be paid.
- Many times the information we ask for over the phone from a representative of your insurer, or obtain from an insurance company website is incorrect or incomplete, or ignored for when claims are submitted.

To best serve you best and to avoid misunderstanding, we have developed and comply with this approach:

Determination of Insurance Benefits

When you become a patient at NEWLIFE, we contact your insurance company to obtain information regarding the coverage you have for infertility care. We have developed a list of the questions that we ask so as to get a picture of the nature and extent of your coverage. If desired, we will provide you with a copy of this summary. Please review this information. If you think you have different coverage, or a different level of benefits, please notify us, so we may clarify the information. We suggest that you also call your insurance company directly for clarification. Unfortunately, this verbal 'verification' of benefits does not oblige insurers to pay. Insurance companies protect themselves by stating that verbal verification of your insurance coverage by them is:

- not a guarantee of payment, and is
- not a guarantee of what is and what is not actually covered

Because of this disclaimer, even when they have told you or us that a service is covered, there is no obligation for them to pay. The true determination as to whether a service is covered is made at the time the claim is received by the insurance company. Whether insurance will pay is dependent on whether:

- The service you received is covered by your plan,
- The reason for the service (the diagnosis) is covered by your plan,
- The appropriate deductibles and co-pays have been met, and
- a "pre-existing condition" exclusions clause does not apply

Further complicating payment is that some plans require that:

- You have experienced infertility for a specified amount of time before services will be covered, or
- The infertility is not due to prior elective sterilization, or
- Certain treatment steps must be taken before other treatment steps will be covered. This may not always be consistent with the course of treatment that we think is best for you. For instance, some companies will pay for IVF treatment, but only after 3 attempts of other treatments have failed.

There may be occurrences where your insurance company denies payment and deems that a service "is not consistent with the diagnosis" assigned to you.

Filing of Claims

- ***For Insurance Companies/Networks With Which We Are Contracted***

We will routinely plan to file a claim for coverage of rendered services with your insurance company if you have insurance with a network with which we participate, if your plan provides benefits for the service provided for the reason it was provided, and if there are no other restrictions on covered services of which we are aware. At the time of your visit, we will collect any required co-payment, co-insurance or other fees noted as patient responsibilities.

If you have insurance with an insurer with which we participate, but your plan does not provide benefits for your diagnosis or for the procedures/services rendered, then full payment is required at each visit. It is our policy that all balances will be settled on the day it occurs. Please contact the office for a list of currently contracted insurance carriers.

- ***For Insurance Companies/Networks With Which We Are Not Contracted***

If you have health insurance with an insurer with which we do not participate, then at our discretion, we may elect to file a claim on your behalf or full payment for all services rendered is required at the time of your visit. As noted above, we require that each patient's balance be settled on the day it occurs. If we elect to collect for services rendered, we will provide you with a statement that can be submitted as a claim to your insurance company for reimbursement directly to you.

- **Other Items**

We collect in full for each service as it is rendered, except in the case of IVF/ART Services, which is discussed further below. We strive to anticipate how much each service will cost you for each and every visit (by calculating your portion of charges after insurance is applied), and expect that costs be paid at that visit.

On occasion, however, this is not possible. In some cases the actual charge can only be estimated (as with surgery). In other cases, we discover amounts that are owed after a visit has occurred. These situations and the way we handle them are described below.

- ***All IVF and Assisted Reproduction Technology (ART) Cycles and Services***

Fees for all IVF Treatment Cycles and ART services (IVF, Laboratory procedures, Frozen Embryo Transfers (FET), sperm retrieval, cryopreservation of sperm or embryos, etc.) are collected in advance of the start of the Treatment Cycle. Prior to the cycle start, patients receive a detailed statement of which services are included/excluded from the package.

- ***Surgery***

If you are having surgery, the actual procedure(s) to be performed may not be known beforehand. Therefore, we will calculate an estimate of the charges you would be responsible to pay based on the expected procedure(s), your "in" or "out" of network status and based on the information the insurance company provides to us. This payment is required prior to the surgery. We will file the claim with your insurance company. If you are "in" network, you are responsible for any patient balance after insurance adjustments have been taken. If you are "out" of network, you are responsible for the difference between what we charge and what insurance pays.

- ***Outside Lab Testing***

As a convenience to our patients, some laboratory specimens are collected in the NewLIFE office but are sent to outside laboratories for completion of the testing. These laboratories will bill patients separately and these charges may or may not be covered/paid by our insurance carrier and therefore may become patient responsibility. NewLIFE is unable to determine reliably which tests or labs are contracted, but may use a particular laboratory for the quality and value of its testing methods or for the speed of its turnaround.

➢ ***Additional Services Rendered***

Occasionally, when the doctors review lab results, they determine that another test is needed to make a complete evaluation. When this occurs, the charges for the additional test(s) will be posted to your account at the time test is ordered.

Similarly, our audits may occasionally detect that services were incorrectly posted to your account, resulting in overcharges or undercharges. When we identify such errors, we will correct your account, resulting in a credit or a balance.

***Please initial each box below to acknowledge your understanding and agreement.**

➢ ***Settling of Balances***

As discussed above, there are times when insurance companies process a claim in a manner different than expected. In these cases,

- a claim may be completely denied as not covered, with no payment being made, thereby making you entirely responsible for the charge, or
- a claim may pay differently than was anticipated, also thereby making you responsible for a larger portion of the charge than expected.
- even though your insurance company communicated to us and we in turn communicated to you that a given service or set of services is covered, this IS NOT A GUARANTEE BY US of your insurance company's coverage for that service or set of services. If your insurance company denies coverage for any reason, you are responsible for full payment of the services billed. Because the insurance company states that the verbal information they provide is not a guarantee of payment nor can it be relied on as a guarantee of coverage, we are not bound by or responsible for any statement made by your insurance company, nor any statement made by us to you based on information given to us by your insurance company. It is very important for you to understand that the only TRUE representation of whether a given service is covered is when your insurance company actually processes the claim.

When this type of conflict occurs, we will first try to understand why the problem arose: Was the claim processed correctly? Were the appropriate diagnoses used? Were benefits incorrectly stated to us at verification? Typically an insurance company will send an EOB ("Explanation of benefits") that outlines what they paid and didn't pay and why. If we believe there are errors in the claim, we will resubmit it. If you receive an EOB that processed your claim differently than you expected, please call your insurance company to clarify.

If the insurance company states that they processed the claim incorrectly, please obtain the name of the person you spoke with, and call us with that information so we can note this in your account. If your insurance company reprocesses the claim, when you receive the corrected EOB showing payment was made to us, please call us to issue a refund to you.

If however there are no errors, we will make the corresponding adjustments to your account, determine the portion of the charge you are responsible for, and post this portion to your account.

As stated previously, there are times when an insurance company states that the test or procedure performed is not consistent with the diagnosis assigned to you. The physicians at NewLIFE perform or order services to be performed when it is determined that they are important in the diagnosis and treatment of the patient for the particular circumstances of the patient. When your insurance company denies payment and renders the decision that the services are "not consistent with the diagnosis," your insurance company, though not licensed to practice, has decided against the clinical judgment of your doctor.

When services have been performed by/ordered by a NewLIFE physician, and your insurance deems the services to be "inconsistent with the diagnosis," your physician has deemed them to be important in your diagnosis and treatment and for your particular circumstances. Your signature below acknowledges your agreement that you will be responsible for the payment for these services, should your insurance company deny payment and state that these services are "inconsistent with the diagnosis" assigned to you.

Initial each box

➢ ***Credit Card Authorizations***

As you may now understand, there are instances where charges are being generated or recognized on days when there is no office visit scheduled. With the very busy lives of our patients, it is difficult to reach patients to come in and settle balances as they arise. Therefore, it is our office's policy to require a credit card authorization be maintained on file so that your balances can be settled as they occur. For convenience, our patients generally like this strategy.

When these cases arise, we will call you before:

- making any charge in excess of $500
- making any charges to a Debit Card, regardless of the amount
- making any charge for a service provided more than 6 months ago

We will mail to you a copy of your credit card receipt and your statement on the day the charge is made. A charge pre-authorization form will be supplied to you and your spouse for your signatures.

Initial each box

➢ ***Insurance Company Look Back Periods***

Insurance companies often perform audits of paid claims. These audits can be performed for up to two years from the later of the following (a) the date of service, (b) the receipt of the claim, (c) the payment of the claim, or (d) the receipt of an appeal. When an insurance company performs an audit of and determines that claims were paid in error and should not have been, the insurance company contacts us for a refund of the monies they paid. They then direct us to collect for these services from the patient. Unfortunately, this may mean that for a period of up to two years after any one of the above listed events your insurance company may reverse their decision. If this should occur we will then contact you for payment of these services.

Initial each box

➢ ***Interest on Unpaid Balances***

If we are unable to charge your credit/debit card account for an outstanding balance on your account that is your responsibility and that is greater than 30 days old, we will assess simple interest on the unpaid balance at the rate of 1.5% per month. This represents an annual interest rate of 18%.

Initial each box

➢ ***Administrative Billing Fee When Your Co-Pay, Co-Insurance or Patient Responsibility Balance Is Not Paid at the Time of Service***

When your co-pay, co-insurance or patient responsibility balance for that day's visit is not paid nor able to be charged to your card at the time of service delivery, we will assess a $25.00 administrative billing fee and subsequently bill you for the unpaid amount.

Initial each box

➢ ***Account Representatives***

We truly understand the challenges associated with infertility alone. Unfortunately, managing insurance benefits is often troublesome for this field. We have Patient Account Representatives who are well trained to help you navigate these often, difficult issues. Feel free to work with them. Thank you.

Patient's Attestation:

I/We fully understand the Patient Accounts and Insurance Policy described above for New Leaders in Fertility & Endocrinology, LLC. I/We understand that I/we am/are responsible for any balance not covered by or paid by insurance for any reason.

Signature **Date**

Signature (partner/spouse) **Date**

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Credit Card Authorization:

I / We give New Leaders In Fertility & Endocrinology, LLC (aka NewLIFE) authorization to keep credit card information on file and to charge the credit card account below for outstanding balances on my/our account as described in the Patient Accounts Policy.

_____ _____
Signature (patient) **Date**

_____ _____
Signature (partner/spouse if joint account) **Date**

Credit Card Number: _____

Circle the type of card (circle): Visa MasterCard Debit

Expiration Date: _____

3 digit code on back of Card: _____

Name as it appears on the Card: _____

Billing Address for the Card: _____

_____

Patient's EMR Account Number: _____
(to be entered by NewLIFE Office)

Copy front and back of card for file: