Idaho Center for Reproductive Medicine

1000 E Park Blvd, Suite 110, Boise, ID 83712 – (208)342-5900

Financial Policy

We are so pleased that you have chosen our practice as your partner for this important journey. We recognize that the investment you make in treatment is significant from both an emotional and financial perspective. As your treatment provider, we want to assure you that the practice strives to provide optimal patient care in a fiscally responsible manner. While each patient's journey is unique, certain financial policies are critical to ensuring consistent support and clarity for all patients seeking treatment.

Insurance Policies

We are participating provider with a few select insurance carriers, and we will file claims on your behalf if services are a covered benefit. You will be responsible for non-covered services and any services beyond your benefits maximum. If you have dual coverage, and we do not participate with your primary insurance, the practice reserves the right to request that services must be paid in full at the time services are incurred.

You must also advise us when your insurance information changes prior to the time of service. This is important because insurance companies often have time limits for filing claims and obtaining authorizations. Therefore, if you fail to notify us you may lose important benefits because we cannot file claims to your new insurance if it is outside your new insurance company's timely filing limits. Treatment may have to be placed on hold if your insurance changes and we are not advised. If your coverage changes under your new insurance, you will be financially responsible for services rendered that are not covered under your new insurance, even if such services were covered under your prior coverage.

Insured patients should read their policies carefully to become familiar with their infertility benefits and limitations. Your financial counselor will help guide you through the insurance process and help you obtain benefit information. Most infertility insurance policy coverage is based on an annual or lifetime benefit maximum. We encourage you to independently confirm the exact extent of coverage, if any, with your insurance carrier. The practice assumes no responsibility for representations made by your insurance company. It is important that patients understand that any coverage provided by insurance is usually designed to reduce patient cost, not eliminate it**. While we are here to assist you in working with your insurance company, ultimately *you* are responsible for the full resolution of the full amount of your bill, regardless of insurance coverage.**

Unfortunately, we cannot provide you with a guarantee of coverage. Claims must be submitted and reviewed by the insurance carrier prior to any payment. Any claims denied by your insurance company may become your responsibility for payment. If the insurance company requires additional information from you, and you do not respond to the insurance company within 30 days, you will be responsible for outstanding charges.

Many insurance companies require referrals and/or pre-authorization to cover treatment. In such case, if you wish to utilize your insurance coverage, treatment can only begin after we have obtained the necessary pre-authorizations and/or referrals. If you would like to start your treatment without authorization/referral, full payment is required and a waiver must be signed. Please ask for estimated treatment costs.

For our patients insured by a company with whom the practice has no contract ('non-participating'), payment for all services is required at the time of service. If you have a PPO plan and have benefits for infertility services, we will file claims for you as a courtesy. Your insurance company will then pay you directly.

Payment Policies

Please contact your financial counselor for approximate cost of your customized treatment, information on financial programs that may be available to assist you and any applicable pre-payments. To keep our billing costs down, co-payments, co-insurance and deposits are required prior to the time of service. Patients without insurance coverage are required to pay in full prior to services being rendered. For cycles, full cycle payment is expected before the start of treatment for the cycle. For your convenience, we accept the following forms of payment: Cash, Checks, Debit Cards, Visa, MasterCard, and Discover. If you pay by check and the check is returned, you will be responsible for a $25 returned check fee. Payment will then be required in the form of cash, money order, credit card or certified check.

If your account is not paid within 120 days, you may be turned over to an outside collection agency. Subject to applicable law, we reserve the right to collect all of our collection expenses, including collection agency fees, attorneys' fees, and court costs incurred to collect amounts due. If your account balance is the result of cryo storage and is outsourced to a collection agency you will continue to be responsible for accrued storage fees until balance is paid. Your treatment may be delayed until balance is resolved.

By signing below, you authorize the Practice to apply any excess payments from you to any outstanding account balance on either you or your partner's account resulting from prior charges or treatment.

Overpayments will be refunded to your account, or at your written direction, your partner's account, after review of the accounts. Any patient requested refund will not be processed until the account is reviewed and all active or patient due balance are paid in full. All overpayments are refunded by check.

Flex spending cards will only be accepted to pay outstanding account balances.

External Services

In the event we are required to use an external chemistry laboratory or other ancillary services, it is your responsibility to determine your financial obligations. The transaction is between you and the laboratory and we do not submit claims for such services on your behalf.

Medication benefits vary between the insurance companies. In certain instances, medication benefits may be included in your infertility benefit maximum or may be considered under your medical policy. Please obtain medication benefits from your pharmacy.

Please be advised that if you decide to receive monitoring services for your treatment cycle at another practice, whether in or out of state, you may have to pay for services rendered at that practice. Please ask your financial counselor for specifics. The transaction is between you and the other practice and we do not submit claims for such services on your behalf.

I /we have read and I/we understand the above financial policy and agree to be financially responsible for services rendered including co-insurance, deductibles, co-pays, non-covered services etc.

I/we hereby assign to Practice any and all benefits from any insurance plans where Practice is a participating provider, and I/we authorize and direct such benefits to be paid directly to Practice for services rendered.

Patient signature	Date	Partner signature	Date
Print name:		Print Name:	