THE CENTER FOR REPRODUCTIVE MEDICINE

CHART #_____

I am responsible for all charges incurred. I am responsible for any fees which my insurance companies deny for failure on my part to obtain referrals or prior authorizations. I am responsible for fees for all services rendered which are not paid by my insurance at the time of service such as deductibles, co-pays and for services which are deemed necessary by my physicians, but are not covered by my insurance. I understand and agree that if my delinquent account is referred to any collection agency or attorney I will pay a collection fee of 30% of the delinquent debt or $25.00, whichever is greater, and all costs, filing fees, service of process fees and attorney's fees permitted by law. I also authorize any person or entity attempting to contact me regarding services or goods provided, or collection of a delinquent account, to communicate with me by any means, including but not limited to my cell phone via text or voice call, land line, and e-mail. I authorize any person or entity contacting me regarding services or goods provided, or collection of a delinquent account to leave voice messages for me and to place any calls to me by any auto-dialer or predictive dialer system.

_____

PRINT NAME

_____

DATE OF BIRTH

_____

PATIENT SIGNATURE

_____

DATE