

AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Payments for professional services are due at the time services are provided. We accept cash, personal checks, Visa, MasterCard, and Discover.

Insurance

BENEFITS ARE NOT DETERMINED BY OUR OFFICE. Benefits are not a guarantee of coverage or payment. Coverage is determined when the claim is actually received.

Please be advised that our surgery center is considered **in network** for most insurance plans. We bill a facility fee for each of the following procedures; as long as there is coverage available on your plan:

- | | | | |
|------------------|----------------|------------------|----------------------|
| -HSG | -Egg Retrieval | -Embryo Transfer | -Office Hysteroscopy |
| -Plastic Surgery | -ENT | -GYN Surgery | -PESA/MESA/TESA |

Our facility collects deductibles, copays and co-insurances for procedures at the time of service.

We have been notified that Blue Cross Blue Shield plans will send you the check for these facility services. Once the check has been received, you will need to turn it over to us within 10 days, or an administrative fee of \$150 will be accessed. Furthermore, each month that the balance goes unpaid, interest fees will be applied at 10% per month of the total billed charge.

This arrangement may not be modified by a verbal agreement.

I agree to be responsible for all charges incurred by me and to pay my account. If my account is sent to an attorney or collection agency, I agree to pay attorney's fees and/or collection agency expenses. The amount of the attorney's fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.

If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to AASC or to the provider group rendering service, for application on my bill. However I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL. In rendering treatment, AASC is relying on my agreement to pay the account.

I have read and understood the AASC payment terms and conditions.

Signature: _____ Date _____

Printed Name: _____