Noble Fertility Center
Making Your Dreams Into Precious Gifts

FINANCIAL AGREEMENT

ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits to the P.L. Chang, MD P.C., Noble Fertility Center For Reproduction & Recurrent Miscarriages, its physician(s), or supplier(s) of services named on the claim. I understand that I am responsible for annual deductibles, non-covered services, co-payments, and all services categorized as "NOT MEDICALLY NECESSARY," "COSMETIC," "INFERTILITY,"OR "DENIED" for any reason by my insurance company.

FINANCIAL POLICY

I understand that monetary deposits collected from me by your office for services rendered are non-customary, discounted fees. In addition, I understand that, *unless otherwise specified,* your office will bill my insurance company the customary non-discounted rates, and that every effort will be made to collect benefits from my insurance carrier(s). I understand that any payment received from my insurance company will be applied to my account according to the insurance company's explanation of benefits statement(s). If after 45 days my insurance carrier has not responded, payment is due in full and I will be liable for all uncollected fees. In the events that payment for services rendered comes directly to me, I will sign, endorse, and forward all checks immediately to your office. I understand that I will be responsible for all administrative, legal, and/or collection agency fee involved with recouping any and all outstanding payments due.

RELEASE OF MEDICAL RECORDS TO MY INSURANCE CARRIER

I hereby authorize my treating physician to release to my insurance carrier(s) any information required to process my claims.

I have read the *Assignment Of Benefits, financial Policy,* and *Release Of Medical Records to My Insurance Carrier* clauses and agree with the above terms.

Signature: ____ Date: _________________

Print Name: ____

REQUEST ***NOT*** TO BILL MY MEDICAL INSURANCE

I hereby request that the P.L. Chang, MD P.C., Noble Fertility Center For Reproduction & Recurrent Miscarriages, Dr. Peter Chang, and/or designated employees/third party administrators, DO NOT BILL MY MEDICAL INSURANCE FOR SERVICES RENDERED. I understand that no effort will be made to collect benefits on my behalf from my insurance carrier for services rendered, and that I am *fully responsible for payment for services at standard rates at the time services are performed.*

Signature: ____ Date: _________________

Print Name: ____