RELEASE OF PAYMENT AGREEMENT**

Dear Reproductive Endocrinology;

I understand that this is a specialist office and not all services provided are covered under my health insurance because:

- **I did not first contact my primary care physician to obtain the required prior approval for my visit to you; or**
- **Authorization to you was denied by my primary care physician or my insurance company; or**
- **The procedure(s) is/are not a covered benefit under my insurance contract; or**
- **Authorization is still pending approval**
- **Self Pay**

Nevertheless, I have directed you to render the health services requested. I understand that the cost of such services will not be paid by my insurance. I hereby agree to pay you in full on the date required by your practice.

Your disclosure to me as described above and my signing of this agreement were done prior to your providing the health services to me.

PATIENT SIGNATURE:_____DOB:_____

PLEASE PRINT:_____DATE:_____

**** By contract agreement with Blue Cross/Blue Shield, Preferred Care, Empire Metropolitan, GHI, Aetna, United Health Care, Medicaid, and Medicare, we are required to obtain this release, prior to service, for uncovered procedures. This release will be active for your entire treatment cycle with our office.**

If you have any questions the billing, please contact our Billing Office at (585) 487-3443.