



**Embryo Donation**  
INTERNATIONAL  
Building Families

## **New Patient Financial Agreement, EDI**

Embryo Donation International (EDI) is a subsidiary of Specialists in Reproductive Medicine and Surgery, P.A. (SRMS) and will be referenced throughout this document.

The following sets forth the general financial policy of SRMS-EDI. Please review this information and sign where indicated.

The patient agrees that she/he is responsible for any and all charges incurred for medical treatment or surgery associated with SRMS-EDI.

The patient is responsible to provide the office staff of SRMS-EDI with current, accurate billing/insurance information at the time of service and to notify SRMS-EDI of any changes in this information. SRMS-EDI will verify my insurance eligibility, deductible amounts and co-insurance amounts prior to any elective procedures that I may have.

I understand that Craig R. Sweet, M.D. participates with select insurance companies and does not bill any secondary insurance carriers. If my insurance company is one of the accepted carriers, I understand that I am responsible for my co-payment amount, deductible and any non-covered services on my plan. I understand that if my insurance company is non-participating, all charges incurred are my responsibility and are due in full at the time of service.

I understand that I have a contractual agreement with my health carrier to pay my co-pay at the time of service and that SRMS-EDI also has a contractual agreement to collect my co-pay at the time of service. Should I **fail to pay my co-pay** at the time of my visit, there will be a \$15.00 Statement Fee charged to my account.

I further understand that it is the policy of SRMS-EDI to collect the co-insurance amount for surgical procedures prior to or at my pre-operative visit. I also understand that the FEE I AM QUOTED IS AN ESTIMATE based on the anticipated procedure to be performed and the current information provided to SRMS-EDI by my insurance carrier.

There will be an insufficient funds fee charged to my account if my check should be returned. The amount of the fee is dependant upon the amount of my check written. It will be \$25 for a check of \$50 or less, \$30 for check amounts of \$50-\$300 and for checks of \$300+ I will be charged the greater of \$40 or 5% of the check amount.

HMO and certain other types of insurance require authorization by a physician. I understand that SRMS-EDI **does not obtain** authorization for any office visits or lab work and that it is my responsibility to do this **prior** to my scheduled appointment. I further understand that prior authorization is not a guarantee of payment and that I am responsible for any amounts not paid by my insurance carrier.

If my health insurance contract requires a second opinion, and /or precertification prior to hospital admission or surgical procedures, I agree to inform the staff of SRMS-EDI. Also, if my insurance company requires laboratory test and x-rays to be scheduled with a particular lab or hospital due to my health insurance contract, I will notify SRMS-EDI promptly.

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New Patient Financial Agreement, EDI (cont.)

If I fail to do any of the above, I understand that I will be responsible for payment in full at the time of service and /or held responsible for rejected claims. I will be billed for any deductible or co-insurance amounts applied by my insurance carrier. I understand that I have a financial obligation to pay these amounts and will be provided with at least three (3) statements as an opportunity to settle unpaid balances. If I have not made payment after the third statement being mailed, I understand that my account will be considered for placement with an outside collection agency.

In the event that I default on payment, legal action such as collections, small claims court or a lien on property may occur. I also agree to pay any collection, finance charges or court costs/attorney's fees associated with the collection efforts.

\_\_\_\_\_  
Patient Name (PRINT)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse or person financially  
Responsible (other than patient)  
**(MUST BE SIGNED IF APPLICABLE)**

\_\_\_\_\_  
Relationship to patient

Initials:	Date:
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