



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

The following sets forth the general financial policy of Embryo Donation International (EDI). Please review this information and sign where indicated.

The patient agrees that she/he is responsible for all charges incurred for medical treatment or surgery associated with EDI. The patient is responsible to provide the office staff of EDI with current and accurate billing information at the time of service and to notify EDI of any changes.

EDI does not participate with any insurance carrier. Should the patient wish to seek reimbursement on their own from their insurance company, the EDI staff will be happy to assist in the process by providing detailed statements at the completion of the patient's treatment.

EDI accepts all forms of payment method as a means to provide convenience to all patients. There will be an insufficient funds fee charged to the patients account if a check is returned. The amount of the fee is dependent upon the amount of the check written. It will be \$25 for a check of \$50 or less, \$40 for check amounts of \$50-\$300 and for checks of \$300+, the charge will be the greater of \$40 or 5% of the check amount. To avoid an insufficient funds fee, the patient should ensure they have adequate funds in the accounts prior to payment.

The patient understands that the FEE THEY ARE QUOTED IS AN ESTIMATE based on the anticipated procedure to be performed and the current information provided to EDI. Payment is due in full at the time of service (on or before the date of the embryo transfer). The patient understands that they have a financial responsibility to pay these amounts, and their account will be placed to an outside collection agency should they breach this agreement.

In the event that the patient defaults on payment, legal action such as collections, small claims court or a lien on property may occur. The patient also agrees to pay any collection, finance charges or court costs/attorney 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)**

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Relationship to Patient

New Patient Financial Agreement, EDI (*cont.*)