MONTGOMERY FERTILITY CENTER

Patient Financial Responsibility Disclosure Statement

Thank you for choosing Montgomery Fertility Center as your healthcare provider. We are committed to providing you with the highest quality of fertility services. We ask that you carefully read and sign this document to acknowledge your understanding of our patient financial policies.

We are pleased to assist you by billing your insurance company however you the patient is responsible for co-pays, co-insurance, deductible and procedures that are not covered by your insurance company.

Patient Authorizations

☐ **By my signature below I hereby authorize Montgomery Fertility Center to bill my insurance company on my behalf. Moreover, I understand that I will be financially responsible for all medical services provided by Montgomery Fertility Center if they are not covered by my health plan.**

I have read, understand and agree to the provision of this patient financial responsibility statement.

Print Name (Last, Middle, First) **Date**

Signature of Patient **Date**

3202 Tower Oaks Blvd I Suite 370 I Rockville, MD 20852 I Tel: 301-946-6962 I Fax 301-946-6022
Yemi Famuyiwa, M.D. F.A.C.O.G. Board Certified: Reproductive Endocrinology & Infertility
www.montgomeryfertilitycenter.com