The Possibility Program Case Rate Waiver

We (I) the undersigned understand that The Possibility Program products do not participate with any insurance plans and are designed for patients with no fertility treatment coverage and who qualify financially. We (I) will have no insurance coverage for infertility treatment under this IVF Case Rate Plan, and we (I) will be responsible for all charges from services rendered to us (me) by Center for Advanced Reproductive Services, P.C.

Furthermore, we (I) understand that insurance will not directly reimburse us (me) for any services received from Center for Advanced Reproductive Services, P.C. and that Center For Advanced Reproductive Services, P.C. will not accept reimbursement from insurance, including without limitation Medicare and Medicaid, for any services rendered to us (me) under the Possibility Programs. Therefore, we (I) agree that we (I) will not independently seek reimbursement for expenses from services received at Center for Advanced Reproductive Services, P.C. under the Possibility Programs, and we (I) will not directly submit to any insurance company for reimbursement.

Possibility Program enrolled in: _____

We (I) understand that our/my most recent tax returns will be required to determine financial eligibility for all Possibility Plans.

We (I) understand that all blood work in the Possibility Plans must be drawn and run in the Center's Farmington, Hartford or Branford offices.

We (I) understand that the Possibility Program Case Rate we (I) are enrolled in is for one cycle only. We (I) must be financially qualified/cleared and re-enrolled for all subsequent cycles. Failure to do so will mean we (I) will revert to standard normal and customary fee schedule for services rendered.

In the event our (my) cycle is cancelled we (I) understand that all services for the canceled cycle will revert to fee-for-service billing with a 20% discount and will be deducted from the original amount paid. The balance will then be refunded to us (me).

As a self-pay, Possibility Program patient, we (I) understand that payment is due prior to starting medication, and payments on all outstanding patient balances are required prior to services. I (we) understand that Center for Advanced Reproductive Services, P.C. accepts CASH, Check, DISCOVER, MASTERCARD, AMEX AND VISA.

We (I) understand that in the event our (my) account is turned over to a collection agency or to an attorney, we (I) will be responsible and hereby agree to be responsible for all associated fees, including attorney's fees and court costs.

OUR (MY) SIGNATURE BELOW INDICATES THAT WE (I) HAVE CAREFULLY READ AND FULLY UNDERSTAND THE TERMS OF THIS WAIVER.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Partner Date

Imagine the possibilities...

Center for Advanced Reproductive Services

Note: Prices subject to change.
The Center reserves right to end program at any time.

02/21/22

www.uconnfertility.com