



I, _____, understand that I am choosing to not use my insurance coverage and be a “self-pay” patient for all and any treatment received at Brown Fertility.

- I understand that the charge(s) will not be filed with my insurance.
- I will be financially responsible for the total cost of the services.

Brown Fertility will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure, or pregnancy, these fees are only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I understand that I will be responsible for paying in full for any balance accrued by the due date specified by Brown Fertility.

Patient Name

Patient Signature

Date

Partner Name

Partner Signature

Date

Witness Name

Witness Signature

Date