

**NASHVILLE FERTILITY CENTER
IN-VITRO FERTILIZATION
FINANCIAL AGREEMENT**

Nashville Fertility Center	3000.00
Reproductive Specialty Lab	3500.00
NFC Surgery Center	<u>2300.00</u>
Total Flat Rate Fee	8800.00

Nashville Fertility Center is dedicated to providing state of the art assisted reproductive technologies at an affordable cost to the patient. For patients who do not have IVF insurance coverage, we have developed an IVF flat rate fee package. Patients that have IVF treatment/creation insurance coverage are excluded from participating.

The IVF process not only requires the services of the physicians of **Nashville Fertility Center**, but also laboratory services provided by **Reproductive Specialty Laboratory of Middle Tennessee**, and facility fees for the egg retrieval and embryo transfer by **NFC Surgery Center**. **The flat rate IVF cycle starts at the time of your suppression check and concludes once the serum progesterone is obtained after your embryo transfer. Other services before or after these two events are excluded.**

1. **Nashville Fertility Center** services include: a comprehensive exam, history and physical, ultrasounds, trial embryo transfer, office visits during monitoring, physician services for egg retrieval and embryo transfer. If your cycle is cancelled, you will be billed for services rendered to date, minus a 10% courtesy discount.

If you choose to have your pre-retrieval IVF monitoring performed in an agreed upon outside facility, any service provided by Nashville Fertility Center or Reproductive Specialty Laboratory will be charged per visit. We ask that these charges be paid at the time of service. As the flat rate fee will not apply in this situation, a 10% courtesy discount will be applied to these services.

2. **Reproductive Specialty Laboratory** services include: blood tests to monitor your hormonal levels of estradiol and progesterone, oocyte (egg) identification, semen processing, insemination of the eggs, assisted hatching (if indicated), embryo freezing, and frozen embryo storage fees through the first year.

3. **NFC Surgery Center** services include: operating room fees for egg retrieval and embryo transfer and anesthesia fees for egg retrieval.

EXCLUDED SERVICES

Only the services listed above are included in the IVF flat rate fee package. Costs that are excluded from the flat rate package include, but are not limited to, the following:

IVF Class, IVF Pre-Screening Tests, Sperm Freeze for IVF Back-Up, Sperm Penetration Assay, Surgical Sperm Retrieval, Medications, OB Ultrasounds, Psychological Screening and/or Testing, Donor Sperm, Donor Eggs, Gestational Carrier Services, any complication related to the IVF process such as Hyperstimulation, Pregnancy Complications, Miscarriage or Ectopic Pregnancy, Pregnancy Tests, Frozen Embryo Transfer Cycle, and Ambry Genetic services.

Other services that are commonly performed, but are excluded from the flat rate fee package, are: Intracytoplasmic Sperm Injection (ICSI, \$1450.00) and Preimplantation Genetic Diagnosis for Aneuploidy (\$4275.00).

My signature below indicates that I do not have treatment/creation coverage for In-Vitro Fertilization. By enrolling in this package plan, I understand that claims will not be filed to my insurance company. I understand that all outstanding account balances must be paid prior to beginning my IVF cycle. I understand that all fees must be paid within three days of obtaining a treatment plan from my IVF nurse in order to begin my treatment cycle.

Patient _____ Date _____

Partner _____ Date _____

IN VITRO FERTILIZATION PREPAYMENT FORM:

Please mail this form along with a signed copy of your IVF financial agreement. Please indicate your method of payment from the options below and include payment for your IVF services. Please note that all IVF fees must be paid within 3 days of receiving a plan from your IVF nurse.

Please mail this form, your financial agreement form, and payment to:

Nashville Fertility Center
ATTN: Richette Torok
345 23rd Avenue North, Suite 401
Nashville, TN 37203

Patient's Full Name: _____

Patient's Date of Birth: _____

Please check all services that you have included in your prepayment

- ☐ \$3000 Payable to **NASHVILLE FERITLITY CENTER**
- ☐ \$3500 Payable to **REPRODUCTIVE SPECIALTY LAB**
- ☐ \$2300 Payable to **NFC SURGERY CENTER**
- ☐ \$1450 ICSI Payable to **REPRODUCTIVE SPECIALTY LAB**
- ☐ \$4275 ANEUPLOIDY PGD Payable to **REPRODUCTIVE SPECIALTY LAB**

Method of Payment:

_____ **Check** _____ **Money Order** _____ **Other**
_____ **Mastercard** _____ **Visa**

(If using credit card, please complete the information below)

Name as it appears on the Credit Card: _____

Billing Address for Card: _____

Credit Card #:

Verification: 3 Digit Signature Code from the back of the card:

Expiration Date: _____