Advanced Fertility Associates Medical Group, Inc.
Application for Discounted Treatment

At Advanced Fertility Associates (AFA), we recognize that fertility treatment is expensive, and patients may not have all the resources needed to start the process. Even with careful planning, treatment costs may exceed expectations. We know financial stressors can only add to this struggle. Unfortunately, the cost of providing fertility care is real. Everyday the AFA Team strives to deliver the highest quality care in the most comprehensive way. This process requires specialized supplies, medications, and equipment. The safety and security of your treatment requires meeting both national and state standards to assure the success of the procedures performed. We strive to deliver you support, instructions, and technology through the most cost efficient and effective manner.

If the cost of fertility treatment is especially difficult for you because of a financial hardship or special circumstances, we invite you to request a discount to assist in paying for your care. Our ability to give discounts is limited so they are given on an individual needs basis for a single treatment cycle only. If you would like to be considered for such discount, please complete the questions below and submit this application to our office. The Finance Committee meets twice a month and will consider your request.

Application DATE:_____ Anticipated Cycle Date: _____

PATIENT INFORMATION:

Patient Name:_____ DOB_____

Partner Name: _____ DOB_____

Address:_____

Phone # :_____ Email:_____

Type of Treatment/Cycle currently Undergoing: _____

Patients Annual Gross Income: $_____ Partners Annual Gross Income: $_____

Additional Household Income: (Any other sources: earned, alimony, real estate, etc.) $_____

Monthly Expenses? Please List:

Rent or Mortgage	$_____	Auto Insurance	$_____
Auto Loans	$_____	Cable/Internet	$_____
Other Loans	$_____	Cell Phone	$_____
CC Payments	$_____		$_____
Insurance Premium	$_____		$_____
Utilities	$_____		$_____

Please Explain your Financial hardship or Special circumstances to be consider:

_____

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Please List Other Resources that you have explored to cover the cost of treatment: (Loans, Grants, Family donations, Personal Loans)

_____

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_____

Applied for Medication Discount: Granted or Denied _____

Discount Amount you are applying for: $ _____ (will apply to 1 cycle only)

Cycle Fee Per AFA Financial Agreement: $ _____

Your signature below certifies that all sections have been completed with accuracy and true information to the best of my knowledge.

_____ _____

Patient Signature Date

Committee Comments:

_____

Discount Granted: YES / NO Reason: _____

Discount Amount Granted: _____ Date of Meeting: _____

Amount Approved by Director _____ List/Wisdom Updated: _____

Patient Notified By: _____