



FINANCIAL POLICY

INSURANCE:

We bill participating insurance companies as a courtesy to you. Please verify that your insurance company participates with our practice prior to your appointment. You are expected to pay your deductible and co-payments at the time of service. *If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full.* You are responsible for all charges.

If you need assistance, or if you have any questions, please contact our collections coordinator between 8:00 AM and 4:30 PM on Monday through Thursday, and 8:00AM to 12:00PM on Friday at 337-989-8795.

REFUNDS:

Overpayments less than \$100.00 will be refunded upon request to the responsible party within 30 days. Refunds over \$100.00 will be processed and mailed to the responsible party without a prior request. Payments made with credit card will be refunded to card or charged a 5% fee to recoup credit card discount and check processing.

MISSED APPOINTMENTS / LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for your appointment. Cancellations are requested prior to the appointment. We reserve the right to charge \$50.00 for missed or late-canceled appointments. Two no-shows of scheduled appointment will result in discharge from the practice.

CONSENT:

I, _____, have read and understand the Fertility Answers Practice financial policy. I agree to assign insurance benefits to the Fertility Answers Practice whenever necessary. I also agree if it becomes necessary to forward my account to a collection agency for cost of collections.

I agree to be financially responsible for charges incurred. I authorize payment of medical benefits directly to the physician or supplier of treatment. I understand and agree that I am ultimately responsible for my account of any professional services rendered, regardless of my insurance status. I agree to pay for the services rendered even though my insurance company may determine that the services are not covered. I agree to be responsible for any billing charges, finance charges, collection fees, or attorney fees assessed to my account, should it become delinquent.

(Signature)

(Date)