

**SOUTHEASTERN FERTILITY CENTER  
AND  
CENTER FOR REPRODUCTIVE SURGERY  
OUR FINANCIAL POLICY**

**We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.**

- \* All patients must complete our "Patient Information Form" before seeing the doctor.
- \* FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
- \* WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER.

**REGARDING INSURANCE**

If you have insurance, we will help you receive maximum benefits.

We **MAY NOT** accept insurance on your first visit. However, we will be happy to file charges for the visit with your insurance company so that you can be reimbursed to the extent of your coverage.

On subsequent visits, we **MAY** accept your insurance if you obtain approval from our office staff prior to the date of service. If we accept your insurance, you must pay 20% of total charges at the time of service (some procedures require a higher percentage). If your insurance has not paid the **FULL BALANCE** within 45 days, you have 15 days to pay the balance. Late Payment Charges may be added to unpaid accounts after 60 days from the date of service. If your insurance company pays more than the balance due, we will send a refund check to you on a monthly basis.

**Insurance is a contract between you and your insurance company.** We are NOT a party to this contract, in most cases (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists). We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc. other than to supply factual information as necessary. **You are responsible for the timely payment of your account.**

**MISSED APPOINTMENTS**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**TELEPHONE CALLS**

In general, there is no charge for phone calls relayed by office nurses. However, occasional situations may require billing for this service.

**Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_