MIDWEST REPRODUCTIVE CENTER

Patient Financial Responsibility Policy

Thank you for choosing Midwest Reproductive Center. We are committed to providing the best possible medical care for you. The following information is provided to avoid any confusion regarding payment for professional medical services. Please sign your name below to indicate that you have read and agree to the terms and conditions of this Financial Responsibility Policy.

Payment Policy

- Your insurance policy is a contract involving your insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We accept assignment with most major insurance companies and participating provider plans. All fees are your responsibility whether your insurance company pays or not.
- We accept checks, Visa, MasterCard, American Express and Discover. We offer a small discount for non-covered services paid at the time of service with a check.
- Returned checks are subject to a $30.00 fee. Any future visits and provision of services will be on a cash-only basis.
- All fees are based on the type of services provided for your care.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the terms and conditions of this policy.
- For services not covered by your insurance, payment is due in full at the time of service. Financing for infertility treatments is available through Advanced Reproductive Care, Inc. (888) 990-2727.
- The amount of any unmet deductible and/or coinsurance will be estimated and must be paid prior to scheduling surgery, saline sonograms, hysterosalpingograms, and in vitro fertilization procedures. Please contact our office before scheduling to get an estimate of your responsibility.
- Any unpaid balance must be paid in full before beginning another cycle of treatment.
- If you have an unpaid balance, you must pay that balance in full at your visit.
- Unpaid balances more than 90 days overdue are subject to collection. You agree to pay all costs of collection (including court costs, attorneys fees and/or collection agency fees) incurred by Midwest Reproductive Center to the extent permitted by law. If your unpaid balance is subject to collection by a collection agency, you will have to settle your collection balance with the collection agency before you can continue treatment. You will then become a cash-only patient.
- Any non-emergency calls made to the physician after office hours may be subject to a $30 fee. This fee will not be billed to your insurance company. It is the patient's responsibility.
- If you must cancel your office visit, please notify 2 business days in advance. Failure to notify our office 2 business days in advance will result in a cancellation fee of $75 (new patient) or $55 (return patient). This fee will not be billed to your insurance company. It is the patient's responsibility. After payment of the cancellation fee, you will be re-scheduled in the next available opening.
- We must complete multiple forms required by your insurance company to obtain coverage and request laboratory tests. When indicated, we will provide you with written notices for leave of absence from work for medical procedures. Additional requests for completion of forms, such as leave of absence (FMLA) from work, disability or "letters of medical necessity" will be completed after receipt of a $30 fee for each. This fee will not be billed to your insurance company. It is the patient's responsibility.

Referrals

It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, you can pay in full at the time of your visit. If you do not pay in full, you must reschedule.

Acknowledgement and Authorization

I have read, understand, and agree to all the terms and conditions set forth in this Financial Responsibility Policy. I understand that I am financially responsible for all fees incurred for my medical treatment.
I authorize and direct that my insurance benefits be paid directly to Midwest Reproductive Center.
I authorize and direct Midwest Reproductive Center to release any medical or other information to my insurance company when requested.
This authorization is in effect for all current and future claims, until I choose to revoke it in writing.

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Patient's Signature (Or Authorized Signature) **Date**

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Printed Name of Patient **Date of Birth** Relationship to patient if not patient

1/30/2024 Revised