Patient Payment Policy

Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services**. Please sign below that you have read and agree to this policy.**

Payment Policy:

- We accept cash, check, Visa, and MasterCard, American Express, and Discover cards.
- All fees are based on the type of service provided for your care and related services. Our fees are competitive for this region.
- If the patient is a minor, the parent or guardian is responsible for payment of the account, in accordance with the policies outlined above.
- For elective or uncovered surgical services, all co-pays, deductibles, and co-insurances are due prior to your surgery.
- All accounts are due to be paid in full in 30 days. Accounts past 30 days will be subject to **finance charges of 18% per month**, regardless of non-payment from your insurance company. If your account is overdue longer than 90 days, it will be referred to our collection attorney. **Should it become necessary to place this account with our attorney for collection, I/We agree to be responsible for all cost**, **including 35% attorney fees and interest at 1.5% per month.** This is a last resort, done reluctantly and after we have exhausted efforts for voluntary payment. **If a professional courtesy discount has been applied, then the discount will be reversed before being referred to our collection agency.**

Referrals
It is your responsibility to bring any required referrals or authorizations for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you will be financially responsible for the visit.

Verification of Benefits
Please contact your health insurance to obtain your infertility benefits. The infertility benefits we obtain are not a guarantee of payment from your insurance.

I/We have read, understand, and agree to the above Payment Policy. I/We understand that charges not covered by my insurance company, as well as co-payments, deductibles and coinsurance, are my responsibility.

I/We authorize my insurance benefits paid directly to the Virginia Center for Reproductive Medicine, or its affiliates: Virginia Reproductive Surgery Center, and Virginia Reproductive Labs.

I/We authorize Virginia Center for Reproductive Medicine, Virginia Reproductive Surgery Center, and Virginia Reproductive Labs to release any medical or other information to my insurance company when requested.

_____ _____
Patient Signature Date

_____
Print Name

_____ _____
Spouse/ Partner's Signature Date

_____
Print Name