Fort Worth Fertility, PA
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AGREEMENT REGARDING PAYMENT TERMS AND CONDITIONS

Please sign, date, and fax in ALL of the consent forms with the rest of your paperwork. A FWF employee will complete the "Witness" signatures where applicable at the time of your appointment. Thank you.

Payment for professional services are due at the time services are provided.

We accept cash, personal checks and most major credit cards.

INSURANCE

It is your responsibility to know what you insurance covers and does not cover. You are ultimately responsible for all charges not covered by your insurance. Some insurance plans limit the number of procedures they will cover within a treatment cycle, so there may be times when not all procedures done will be covered by your insurance.

If we have received all of your insurance information 48 hours prior to the day of the appointment and we are able to confirm eligibility, we will be happy to file claims on your behalf for covered services. The accuracy of all the information we receive is essential for proper claim filing. We will assist you in estimating your portion of the fee for services; however we cannot guarantee what your insurance company will pay on a claim. Please understand that filing your claims is a courtesy our office provides to our patients, it does not guarantee payment to us. We are providing our professional services to you—not the insurance company. Consequently, you are ultimately responsible for payment of our fees.

For example, if your insurance states that they will cover diagnostic testing only, this means that they will not pay for the midcycle or follicular ultrasound of a treatment cycle. This particular type of ultrasound would be considered self-pay. A treatment cycle is considered a cycle with the intent of assisting a couple conceive. For example any cycle requiring an insemination or use of fertility medications such as clomid other than a clomid challenge test and gonadotropins (example Follistim/Gonal-F)

If your insurance company does not offer treatment benefits we offer treatment cycles at a discounted prepaid price (global fee). You may also pay a fee for service price for each of your visits. In this situation your insurance will not be billed for these services. If you chose to pay a global fee and your cycle is not completed for some reason you may be refunded the balance of that cycle. The balance is calculated on a fee for service charge based on the services provided. For example: if you pay a global fee for an insemination cycle and the cycle is cancelled for some reason after you had two ultrasounds performed, we would calculate the fee for service for the two ultrasounds and office visits and subtract this from your global and refund the difference.

Outstanding balances must be paid otherwise you will not be allowed to initiate a treatment cycle.

If your insurance company pays for only diagnostic testing and you ask them if they cover ultrasounds they may say they cover this service. They will, however not cover this service if it is for treatment of infertility. It is difficult for them to know if this treatment by just the diagnostic code. The charge is billed to your insurance for treatment and you do not have this coverage then this would be considered fraud and we would be liable for excessive fines or other formal actions.

It is this important that you understand your insurance your insurance benefits before starting treatment.

It will be an advantage for you to obtain a copy of your insurance policy and contact your insurance company to determine benefits for infertility and IVF. If you believe you have coverage for IVF treatments it will be your responsibility to obtain written confirmation of benefits covering the treatment (predetermination letter) before you undergo the procedure. If you do not have this letter before you start your cycle (i.e.: lupron start) you will need to pay a global fee or wait for a subsequent cycle start. We have available a form letter you can use for this purpose. We will need a copy of written verification of the predetermination letter before the start of your cycle.

BENEFITS ARE NOT DETERMINED BY OUR OFFICE

You may have noticed that sometimes your medical insurer reimburses you or the doctor at a lower rate than the doctor's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your doctor's fee has exceeded the usual, customary, or reasonable fee (UCR) used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most doctors in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR fee. Frequently, this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20-30% profit.

Unfortunately, insurance companies imply that your doctor is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Once the physician has determined your treatment protocol, FWF at your request, will provide you with a financial visit to discuss the upcoming treatment and identify charges for expected procedures. However, once treatment begins, unique patient situations sometimes require additional procedures. These additional procedures may not be announced to you as "additional" by our clinician, as they are providing you with care based solely upon your individual needs. (These procedures for example may relate to extra ultrasounds and blood tests to monitor effects of medication during ovarian stimulation.)

Unless you have a written agreement with FWF, all prices quoted to you are quoted under a fee-for-service arrangement. Under the fee for service arrangement, you will be charged for all of the services provided by FWF, and you will not be entitled to a refund in the event that, for any reason, the treatment is not successful. This arrangement may not be modified by a verbal agreement.

It is your responsibility to keep track of the services provided to you as you progress in your individual treatment cycles. You will be financially responsible for all services provided, even if such services were not anticipated when you began treatment and are not included in the financial visit. Charges that are the patient's responsibility and remain unpaid after 30 days may be subject to an administrative fee of $15.00 per billing cycle.

I agree to be responsible for all charges incurred by me and to pay my account. If my account is sent to an attorney or collection agency, I agree to pay reasonable attorney's fees and/or collection expenses (currently at 30%). The amount of the attorney's fee shall be established by the Court and not a jury in any court action. A delinquent account may be charged interest at the legal rate.

If I am entitled to benefits of any type whatsoever under any policy of insurance, the benefits are hereby assigned to FWF or to the provider group rendering the service, for application on my bill. However, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL (see attachment). In rendering treatment, FWF is relying on my agreement to pay the account.

A photocopy of this statement is to be considered valid as an original.

I have read and understood FWF payment terms and conditions

Signature:_____

Date: _____

Witness: _____

Consent to Treat

Medical Treatment: The patient consents to the treatment, services, and procedures which may be performed in the office, which may include but are not limited to, multiple visits, laboratory procedures, ultrasound evaluation, x-ray examination, medical and surgical treatment, or procedures, anesthesia, or hospital services rendered under the general or specific instructions of the responsible physician or other healthcare providers. The office may establish certain criteria which will automatically trigger the performance of specific tests which patient agrees may be performed without any further separate consent.

Legal Relationship Between Office and Healthcare Providers: The patient will be treated by his/her attending doctor and healthcare providers and be under his/her care and supervision.

I have read and understand this treatment agreement. I am the patient, the parent of a minor child, or the legal representative of the patient and authorized to act on the patient's behalf to sign this agreement.

Patient: _____ Date: _____

Witness: _____Date: _____

Cancellation Policy

It is our policy to call and confirm appointments prior to the scheduled appointment time. If we are unable to reach you and leave a voice message reminding you of the appointment, we expect a confirmation call back from you the same day the message was left. You can do this by either calling and speaking to one of our office staff or by leaving us a voice message if after hours. If we do not receive a confirmation from you, your appointment slot may be given to someone else.

We understand that sometimes it is impossible for you to keep your scheduled appointment. However, if you know in advance that you will not be able to make it in for your appointment, we do require that you inform us at least 24 hours in advance so that we may schedule another patient in your time slot. Please call us at 817-348-8145 to notify us. We have voice messaging available for weekends and evenings so that you may leave us a message if necessary.

If you do not call to cancel or do not show for your appointment after confirming with us, you will be charged the full amount of your scheduled appointment. This charge is not billable to your insurance company and therefore must be paid by you. This policy helps us serve all our patients more effectively. Thank you for your cooperation in this matter.

I have read, understand and agree to abide by FWF cancellation policy.

Patient:_____Date:_____