Fertility & Women's
HEALTH CENTER OF LOUISIANA
Helping couples build families.

FINANCIAL POLICY

We appreciate your confidence in our practice and would like to work with you to limit the rising cost of medical care. You can help a great deal by reviewing the following summary of our payment policy. This policy was implemented to reduce paperwork and delays in payment, which in turn decrease the cost of care for everyone.

We will ask to see your insurance card at every visit to ensure there are no changes. We will also ask for a new patient information sheet to be completed every year in order to maintain accurate information in our files. Updating this information regularly will prevent incorrect billing of insurance and will also allow timely receipt of statements and/or refunds when necessary.

ALL PAYMENT IS EXPECTED AT THE TIME IS SERVICE

Payment is required at the time services are rendered. Co-payments are set by the insurance company to off-set the negotiated rate of our charges and will not be billed to the patient. All co-pay amounts must be paid at the time of visit without exception.

Deductible and coinsurance amounts will be calculated based in your insurance contracted rate and will be payable at time of visit. We will make every effort to verify your insurance benefits before or on your appointment date to ensure payment amount expected is as accurate as possible for this service.

Fertility and Women's Health Center accepts cash, personal check, credit, and debit cards.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments or requesting prescription renewals. We realize that people have financial difficulties and we will make every effort to accommodate our patient's needs after a financial evaluation form is completed.

Return Checks:

There will be a $25.00 charge for returned checks. Return checks must be paid in full within 10 days of notification. Checks not paid will be forwarded to the collection agency for final collection and no further checks will be accepted for payment.

Insurance:

We bill participating insurance companies as a courtesy to you. Please verify your insurance 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 have questions, please contact collections coordinator, , between 8:00 AM and 4:30 PM, Monday through Thursday and 8:00 AM to Noon on Friday s, 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 responsible party without a prior request.

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 you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge $50.00 for missed or late-canceled appointments. Two no-shows of scheduled appointments will result in discharge from the practice.

I have read and understand the Fertility & Women's Health Center of Louisiana Practice Financial Policy. I agree to assign insurance benefits to the Fertility & Women's Health Center of Louisiana Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs 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 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 necessary or 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 of insured or authorized representative:

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Date: _____