FINANCIAL POLICY FORM

I, (Patient's Name) _____ on (Date)_____ understand that the following will apply and be enforced as long as I am a patient at Caring for Fertility LLC:

I, the patient, will be responsible for payment for the following services. These are ranges of prices that are dependent on complexity of service provided and are subject to change.

Self-Pay rates or items no covered by insurance:

Creighton model only: Initial: $99 (includes cost of start-up materials)
Followups: $59 for routine visits (complex visits may be up to $99)
Additional materials are charged separately.

NaProTECHNOLOGY visits: initial: $199
Followups: $99 for 30min
$139 for 45 min

No show fee: $30 (please provide at least 24 hours notice or no show fee may be applied)

Injections only: $20-30

Phone Counseling: $20-50
- Phone calls with treatment recommendations or changes
- Progesterone Monitoring in Pregnancy

Email with Provider: $20-50
- Cycle Reviews
- Emails that result in treatment recommendations or change
- Frequent/Extensive Emails
- Progesterone Monitoring in Pregnancy

Returned payment fee: $25

Any visits made via My Catholic Doctor will be bill to insurance. Any on site visits at the Hartford office are self-pay at this time. Payment is due at time of service.

The services have been explained to me and I agree to be personally and fully responsible for payment. If service is not listed above, please speak to us directly regarding pricing.

Patient's Signature _____Date _____

If minor, parent/guardian_____Date _____

Witness Signature _____Date_____