Payment of Services

Please Read Carefully!

At Reproductive Health Center, we make every effort to contain the cost of specialty fertility care. We recognize that treatment and other procedures are expensive and are often not covered by most insurance plans. Before scheduling any visit or procedure or treatment, we recommend that you contact your insurance company to determine coverage. Insurance coverage varies and, in many cases, treatment of infertility is not covered. Additionally, sometimes "covered services" are more expensive than the cash pay price offered by our office (depending on out of pocket expenses, deductibles and copays). If you choose to have Reproductive Health Center bill your insurance, we cannot offer you the cash pay discounts if the claim is denied. _____***Initial***

If you choose to have us bill your insurance company, make sure that Dr. Hutchison is a contracted provider and that you have verified your coverage. Once we bill your provider, we are obligated to bill you at the contracted rates which may be more than the cash pay pricing for the service.

We will not bill AHCCCS (AHCCCS associated) or Medicare plans for any services as we are not in network.

We accept cash, check, HSA, FSA, American Express, Discover, Visa and MasterCard for payment of services.

If circumstances make it necessary for you to cancel your new patient appointment please **CALL** the office 24 hours prior to your appointment time. Failure to give proper notice of cancellation will result in full billing for the consultation time

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I understand that unless otherwise arranged, all charges are payable at the time of service. If I provided my insurance information to Reproductive Health Center, I have given all insurance information, including primary and secondary insurance. I understand that my health insurance coverage is an agreement between me and my insurance company and I am responsible for payment of fees regardless of coverage. In the event of hospitalization and/or surgery, I authorize my insurance company to make payments directly to Reproductive Health Center and I further authorize Reproductive Health Center to release to my insurance company any information necessary for payment of claims.

Patient Name	Patient Signature	Date

Responsible party (if other than patient)