Fertility Center of Dallas
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Reproductive Endocrinology and Infertility
Advanced Gynecologic Endoscopy

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

All patients must complete our Information and Insurance Form before seeing the doctor. All patients must have a signed Payment Agreement on file prior to treatment.

FULL PAYMENT IS DUE ATTIME OF SERVICE
WE ACCEPT CASH, CHECK, OR VISA/MASTERCARD/DISCOVER, AMERICAN EXPRESS

REGARDING INSURANCE

We may accept assignment of insurance benefits. However, we do require all co-pays and deductibles be paid at the time of service. The balance Is your responsibility whether your insurance company pays or not. We cannot bill your insurance carrier unless you. Give us complete insurance information your insurance company requires a referral for treatment. it is your responsibility to obtain the referral from your primary care physician prior to treatment. If your insurance company has not paid your account in full within45 days, the balance will be due in full. Please be aware that some and perhaps all of the services provided may be non-covered service and not considered reasonable and necessary and are the patient's responsibility.

Regarding Insurance plans with which we are a participating provider must have insurance information prior to treatment in order to verify coverage. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating provider’s benefits are denied because they are not covered under your plan, refer to the above paragraph.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns. I have read the financial policy. I understand and agree to this policy.

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Signature of Patient or Responsible Party Date:

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Signature of Co-Responsible Party Date: