

**REPRODUCTIVE CARE OF INDIANA**

201 Pennsylvania Parkway, Suite 205 \* Indianapolis, IN 46280

**FINANCIAL POLICY**

1. If you **DO NOT** have insurance coverage and are a self-pay patient, or if your insurance does not cover these services you will be required to pay \$200.00 prior to your visit with the doctor. **If you are being seen in one of our satellite offices (Aegis in Bloomington, Women’s Clinic in Lafayette, Clarian Arnett in Lafayette, or AP&S in Terre Haute) you will need to make payment prior to your appointment.** This is an estimate of the charge for your initial visit. Please contact the Indianapolis office at 888-365-3436 to do so. You will be billed for any additional fees generated during your visit. \_\_\_\_\_(Initial)
2. Patients are responsible for obtaining prior authorizations or referrals from their Primary Care Physician (PCP) and/or insurance company. Please bring this authorization with you to your first visit or have your PCP office mail or fax it to us prior to your visit. If you do not have a referral on the date of service, you will be asked to sign a waiver or you will be given the option of rescheduling your appointment. \_\_\_\_\_(Initial)
3. Any services not authorized by your insurance company will be denied and will become your financial responsibility. **Remember that prior authorization does not guarantee benefit payment.** Contact your insurance company for verification of benefits. \_\_\_\_\_(Initial)
4. Co-payments or deductibles and fees for non-covered services will be collected at the time of service. We accept payment by cash, check, Visa, MasterCard or Discover. \_\_\_\_\_(Initial)
5. For patients undergoing fertility treatment, we require that all patient responsibility balances be paid in full prior to beginning a new cycle of treatment. \_\_\_\_\_(Initial)

Please feel free to contact our Billing Manager to answer any questions you may have regarding financial issues.

I have read and fully understand the financial policy listed above. I understand that I will be given a copy of this policy for my records.

Patient’s  
signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

(03/2009)