Sy Q Le, M.D.
Board Certified in Reproductive Endocrinology & Infertility

www.ivfmd.net

FINANCIAL POLICY

Thank you for choosing **IVFMD** as your health care provider. We are committed to the success of your treatment. The following form is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Insurance

We may accept assignment of insurance benefits upon your first visit. However, we do require that you pay your portion of the bill at the time of service (ie. co-pay, deductible, etc.). We will do everything reasonably required to facilitate the filing of your insurance claim. You need to provide us with correct insurance information along with all other relevant documents (i.e. secondary insurance, change in insurance plan).

Your insurance is a contract between you and your insurance company. Please be aware that your insurance carrier may deny coverage for services that are in our opinion usual, customary, and medically necessary. Your carrier may declare the treatment as not medically necessary and thus not covered. We charge what is usual and customary for our area. Because the bill is your responsibility, should your insurance not pay, you will be billed for the remaining balance.

Under special circumstances, we offer an extended payment plan with prior approval. If your account becomes 90 days delinquent from the last day of service, please understand that your account will be forwarded to a collection agency.

Missed Appointments

Unless canceled at least **2 business days** in advance, our policy is to charge $30 for any missed appointments, such as, cancellations, rescheduled-appointments, or no-show appointments (subject to extenuating circumstances). Please help us serve you better by keeping scheduled appointments.

Returned Checks

There will be a $25 service charge for returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I understand and agree to this Financial Policy,

Print Patient Name: _____

Signature of Patient: _____ Date: _____

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