NEW PATIENT INFORMATION SHEET

Thank you for your interest in Columbia Fertility Associates. Your appointment with Dr. ______________________________ has been scheduled for ________________ at ______________. We have Financial Counselors on staff that will work closely with you to help you understand your insurance benefits or self-pay responsibility. Please allow an additional 15 minutes to meet with your Financial Counselor after your consultation if needed.

Address:

1005 N Glebe Road Arlington, VA 22201. The phone number is 703-525-4776.

Medical Information:

Please complete the enclosed forms and bring them with you at the time of your visit. Please bring any previous medical records with you to your appointment. You may also have your referring physician send the records directly to our office or fax them to 703-525-8013.

Insurance and Payment:

You are required to pay all co-payments and deductibles at the time of service. If your insurance does not cover your office visit, we will ask for payment in full at the time of service. Charges for diagnostic and/or laboratory tests are NOT included in the office visit fee. Information on all fees is available. We accept cash, personal checks, Visa, MasterCard, Discover, and American Express.

Due to the specialized nature of our practice, our fees sometimes exceed the amount allowed by your insurance company. You are responsible for any balance that may accrue. We ask that you be familiar with your particular health plan and coverage.

Many insurance companies will honor an assignment of benefits and make payments directly to your physician. If you are covered by one of these plans, as a courtesy to you, our billing department can submit your claim. You will still be responsible for any services not covered by your insurance plan. If your outstanding balance is assigned to a collection agency, you will be responsible for all reasonable recovery costs including attorney's fees.

CFA will charge a $50.00 fee for any appointment cancelled or broken without 24 hours advanced notice. We also charge a $50 fee for all returned checks.

I have read and agree to the above policies:

____________________________________ ________________

Signature **Date**