FINANCIAL POLICY FORM

I, (Patient's Name) ______________________________________ on (Date)________________
understand that the following will apply and be enforced as long as I am a patient at Caring for Fertility LLC:

I, the patient, will be responsible for payment for the following services. These are ranges of prices that are dependent on complexity of service provided and are subject to change. You can also contact My Catholic Doctor Billing department for insurance and most up to date pricing.

Self-Pay rates or items not covered by insurance:

Creighton model only: Initial: $99 (plus cost of start-up materials)
Followups: $59 for routine visits (complex visits may be up to $99)
Additional materials as supplies are charged separately.

NaProTECHNOLOGY visits: initial: $199
Followups: $99 for 30min
$139 for 45 min

No show fee: $30 (please provide at least 24 hours notice or no show fee may be applied)

Injections only: $30

Phone Counseling, emails, and other electronic communication with the Provider: up to $99 depending on length and complexity
-Communication that results in treatment recommendations or changes
- Progesterone Monitoring in Pregnancy
- Cycle Reviews
- Frequent or extensive communication (such as ultrasound series)

The services have been explained to me and I agree to be personally and fully responsible for payment. If service is not listed above, please speak to us directly regarding pricing.

Patient's Signature ____Date _______________

If minor, parent/guardian_______________________________________Date _______________

Witness Signature ____Date________________