

Patient Agreement



Suite 301
46 S. Glebe Rd.
Arlington, VA 22204

Authorization Agreement Office Policy on Payment Name

Patient Name _____ Date _____

Please print

- 1. Payment for services rendered** by Dominion Fertility is due and payable in full at the time services are rendered, unless prior arrangements have been specifically made.
- 2. Any balance unpaid after 60 days** from the date services were rendered will be subject to interest at the annual percentage rate of 18% percent with a \$2.00 minimum.
- 3. In the event** the Patient submits payment by check and that check is returned for any reasons by the Bank, Dominion Fertility will add \$25 to the balance owed by the Patient or Responsible Party.
- 4. For patients with insurance:** Any cost sharing, such as co-payments, coinsurance and/or deductibles are the responsibility of the Patient and/or Responsible Party. In the event that services rendered are not covered or are deemed as not medically necessary, Patient and/or Responsible Party shall be responsible for payment in full for those services.
- 5. No statement by an employee** or agent of Dominion Fertility will contradict, void or nullify this Agreement, nor shall the patient rely on any statements or opinions made by Dominion Fertility that Patient's insurance carrier will pay the bill.

Authorization is hereby given to Dominion Fertility to submit my claim directly to my insurance company on my behalf. I understand that by signing this form, my signature is not needed each time a claim is submitted on my behalf. I further authorize my insurance carrier to forward payment directly to Dominion Fertility.

Authorization for release of medical records

I hereby authorize Dominion Fertility to release all medical and billing information necessary to secure payment from any insurance carrier, on my behalf.

I have read and fully understand all the above conditions. By signing this Agreement I accept that I am responsible for all payments, charges, and if necessary, costs of collection as stated above.

I acknowledge receipt of a copy of this agreement.

Patient's signature _____ Date _____

Responsible Party _____ Date _____

Please print

Signature

Relationship to Patient (spouse, parent, other) _____

Witness _____ Date _____

Please print

Signature

Continued on back