

ADVANCE BENEFICIARY NOTICE FORM

Pope Paul VI Institute Physicians, PC
6901 Mercy Road Omaha, NE 68106

ANCILLARY SERVICES

I, (Patient's Name) _____ on (Date) _____

understand that the following will apply and be enforced as long as I am a patient at the Pope Paul VI Institute:

Most insurance companies have determine that the following procedures or services provided for you by this office are not deemed medically necessary/non-covered services or are related to infertility or other reproductive issues. Therefore, you are responsible for payment for the following services. These are ranges of prices and are dependent on level or complexity of service provided.

- **Phone Consult \$30.00 - \$90.00** _____ **Patient's Initials**
 - With Physician
 - With Nurse
 - Starting T3 Medication
 - Progesterone Monitoring in Pregnancy – if not delivering with PPVI Physician, Billed by Trimester
 - Initiating IV Antibiotics
 - Postpartum Depressions Treatment, every 2-3 calls
 - Pre-term Labor Monitoring, every 2-3 calls if not delivering with PPVI Physicians
 - Phone calls with treatment recommendations or changes
 - Resuming Care
 - Other: _____
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- **Email with Nurses/Physicians \$35.00 - \$60.00** _____ **Patient's Initials**
 - Cycle Reviews – Brief – Moderate - Complex
 - Emails that result in treatment recommendations or change
 - Frequent/Extensive Emails
 - Other: _____
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- **Nurse Visit \$50.00 - \$60.00** _____ **Patient's Initials**
 - Shot Instructions
 - Face-to-Face Visit with Nurse
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- **Other \$25.00 - \$50.00** _____ **Patient's Initial**
 - Completion of FMLA or Disability Papers
 - Extended Medication Pre-Certification
 - Completion of School, Camp, FMCA, etc. Papers
 - Letter or Documentation requiring Physician Signature
 - No Show Fee (Office Visit or Ultrasound)
 - Other: _____

The services have been explained to me and I agree to be personally and fully responsible for payment. Pre-Payment of these services may be requested. Our staff will work with you to help you know when these are applicable.

Patient's Signature _____ Date _____

Guarantor's Signature (if patient is minor) _____ Date _____

Witness's Signature _____ Date _____