I, (Patient’s Name) __________________________________________ on (Date) _______________________
understand that the following will apply and be enforced as long as I am a patient at the Saint Paul VI Institute:

Most insurance companies have determined 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.

- **Telehealth With Physician (not billed to Insurance)** - $135
- **Phone Consult (not billed to Insurance)**
  - With Physician $120
  - With Nurse:
    - Brief $42 – Moderate $53 – Complex $70
  - Starting T3 Medication $70
  - Progesterone Monitoring in Pregnancy –
    - if not delivering with SPVI Physician,
      - Billed as First Trimester $80
    - 2nd and 3rd $65 ea.
  - Initiating IV Antibiotics $65
  - Postpartum Depressions Treatment, every 2-3 calls $70
  - Pre-term Labor Monitoring, every 2-3 calls if not delivering
    - with SPVI Physicians $70
- Other: _____________________

- **Email with Nurses/Physicians** Brief $42 – Moderate $53 – Complex $70
  Includes cycle reviews, emails resulting in treatment recommendations or change
  Or frequent/extensive emails

- Other: _____________________________

**Surgery Cancellation Fee** $375.00
**Surgery Rescheduling Fee** $150.00
**Comprehensive Management Review** $215.00

- **No Show Fee** (Office Visit or Ultrasound) $50
- **Miscellaneous Charges** $40.00
  - Completion of FMLA or Disability Papers
  - Extended Medication Pre-Certification
  - Completion of School, Camp, FMCA, etc. Papers
  - Letter or Documentation requiring
    - Physician Signature
  - 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 ______________

Revision August 1, 2022