ADVANCE BENEFICIARY NOTICE FORM

Saint 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 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 the level or complexity of service provided.

- **Phone Consult**
  - With Physician $100
  - With Nurse:
    - Brief $40 – Moderate $50 – Complex $65
    - Starting T3 Medication $65
  - Progesterone Monitoring in Pregnancy – if not delivering with SPVI Physician,
    - 1st Trimester $75,
    - 2nd and 3rd Trimesters $60 ea.
  - Initiating IV Antibiotics $60
  - Postpartum Depressions Treatment, every 2-3 calls $65
  - Preterm Labor Monitoring, every 2-3 calls if not delivering with SPVI Physicians $65

- **Other: ________________________________**

- **Email with Nurses/Physicians**
  - Brief $40 – Moderate $50 – Complex $65
  - Includes cycle reviews, emails resulting in treatment recommendations or change, or frequent/extensive emails.

- **Surgery Cancellation Fee $300**
- **Comprehensive Management Review $200**
- **Miscellaneous Charges $40**
  - 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 ___________

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