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 level or complexity of service provided.

- **Telehealth With Physician** *(not billed to Insurance)* - **$125**
- **Phone Consult** *(not billed to Insurance)*
- With Physician **$125**
- With Nurse:
  Brief **$45** – Moderate **$55** – Complex **$75**
- Starting T3 Medication **$75**
- Progesterone Monitoring in Pregnancy –
  if not delivering with SPVI Physician,
  Entire Pregnancy **$250**
- Initiating IV Antibiotics **$70**
- Postpartum Depressions Treatment,
  every 2-3 calls **$75**
- Pre-term Labor Monitoring,
  every 2-3 calls if not delivering
  with SPVI Physicians **$75**
- Other: _____

- **Email with Nurses/Physicians Brief $45 – Moderate $55 – Complex $75**
  Includes cycle reviews, emails resulting in treatment recommendations or change
  Or frequent/extensive emails

- Other: _____

Surgery Cancellation Fee $315.00
Surgery Rescheduling Fee $150.00
Comprehensive Management Review $220.00

- **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 _____