WASHINGTON FERTILITY CENTER

PIERRE ASMAR, MD, FACOG

ANNANDALE VA, RESTON VA, HAGERSTOWN MD, ROCKVILLE MD

PAYMENT AGREEMENT

Services to be performed are of the Medical nature; (therefore positive results can not be guaranteed). Payment is due and expected at the time of service. Payment can be made either by cash, check or credit card to: Pierre Asmar, MD, PC. T/A Washington Fertility Center, Annandale Surgical Center and Washington Reproductive Laboratories.

Washington Fertility Center will submit claims for payment, for services for these insurance companies with which the Center participates. By doing so, the Center makes no representations that any services performed will be covered by insurance. Patients are responsible for all deductibles, co-payments, and any services not covered by insurance.

In any case where the insurance company is not billed by the center, an itemized statement will be given to the patient for submission to the insurance company.

Verbal or written authorizations from an insurance company are NEVER a guarantee of payment. I understand that my insurance company may deny payment for any or all number of reason. I understand that just because Washington Fertility Center renders services, this does not guarantee that my insurance company will honor the claim and pay the bill.

I understand and agree that I am ultimately responsible for the balance on any account for any professional services rendered. I have read, understand and agree to all of the terms described in the Payment Agreement above.

______________________	______________________	______________________
Patient's Signature	Account #	Date
______________________	______________________	______________________
Partner's Signature	Account #	Date
______________________	______________________	______________________
Washington Fertility Center	County, State	Date

4316 EVERGREEN LANE, ANNANDALE, VA 22003
PHONE: (703) 658-3100 •TOLL FREE: (866) WFC-BABY •FAX: (703) 658-3103
WWW.WASHINGTONFERTILITY.COM
ANNANDALE, VA • RESTON, VA •HAGERSTOWN, MD •ROCKVILLE, MD

Cancellation Policy/No Show Policy for Doctor Appointments and Surgery

1. **Cancellation/ No Show Policy for Doctor Appointment:** We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from filling that slot. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a "fully booked" schedule. If an appointment is not cancelled at least 48 hours in advance you will be charged a one hundred dollar ($100) fee; this is not covered by your insurance company.

2. **Scheduled Appointments:** We understand that delays can happen; however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule this appointment.

3. **Cancellation/ No Show Policy for Surgery:** Due to the large block of time needed for surgery, last minute cancellations can cause problems and add expenses to our practice. If surgery is not cancelled at least 10 days in advance, you will be charged a two hundred fifty dollar ($250) fee; this is not covered by your insurance company.

4. **Account balances:** We will require that patients with self-pay balances to pay their account balances to zero (0) prior to receiving further services by our practice. Patents who have questons about their bills should contact Shaun Singletary at 703-658-3447 and patents who would like to discuss a payment plan opton may call Carol Smith, financial counselor at 703-658-3100. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

In an effort to minimize no shows and late cancellations; we will require a credit card to secure your appointment on all our patients.

Please complete the following section:

Circle one: VISA MasterCard Discover

Credit Card Number: ____________________________________ Exp Date:__________ CCV:______

______________________ ________________________ ____/____/____

Print Name Patient Signature Date

______________________ ________________________ ____/____/____

Print Name Partner Signature Date