The Christ Hospital Health Network

REPRODUCTIVE HEALTH PRE-PAYMENT AGREEMENT

DATE:

PATIENT NAME: ______________________________

MAILING ADDRESS: ______________________________

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PATIENT NAME: ____________________ Account #: ____________________ Dr. __________

DATE OF SERVICE:

FROM: _____ / _____ / _____ _____ TO: _____ / _____ / _____

CPT CODES/SERVICES: ______________________________

OR CONFIRMATION: ______________________________

SERVICE/PROCEDURE DESCRIPTION	CHARGE AMOUNT
LAPAROSCOPY ONLY (CPT CODES 49320) Includes up to 60 minutes of Operating Room time	**$2,400**
HYSTEROSCOPY/LAPAROSCOPY (CPT CODES 49320 / 58555) Includes up to 75 minutes of Operating Room time	**$2,925**
MICROSURGICAL TUBAL ANASTAMOSIS (CPT CODE 58750) Includes up to 180 minutes of Operating Room time Includes one overnight stay	**$5,060**
ADDITIONAL OVERNIGHT STAY	**$585 per day (semi private)**

Initial below

__________The above referenced patient has agreed to enter into this Agreement with The Christ Hospital for the above self-referred services and has declined to have the Hospital submit these services to their health plan. The signing of this Agreement commits the above referenced patient to payment of all Hospital charges for the services provided under this Agreement. Waiver by The Christ Hospital hereof to enforce any provisions of this Agreement shall not operate to bar The Christ Hospital's rights to enforce any provisions of this agreement at any later time or for any later default.

__________In the event legal action is brought by The Christ Hospital to recover payment under this Agreement or to enforce any term of this Agreement, The Christ Hospital shall be entitled to such legal fees, costs, and expenses of such action.

Additional Terms

1.	A history and physical is required before surgery. Additional charges may be incurred from the physician performing this service. Any additional charges are the responsibility of the patient.
2.	Additional charges may be incurred for anesthesia, pathology, radiology, and cardiology services directly from the physician(s) or midlevel(s) performing these services. Payment arrangement(s) are the responsibility of the patient.
3.	Due to general lack of insurance coverage for noncovered reproductive health procedures, Hospital will not bill insurance payers.
4.	Payment in full for The Christ Hospital Health services must be received seven (7) business days prior to the procedure being performed or the procedure will be cancelled.
5.	Extended Recovery: In the event the patient is not able to be discharged from hospital within four (4) hours post-surgery, a room charge will be assessed at the current rate. The Christ Hospital cannot reserve or otherwise guarantee private room accommodations.
6.	In the event that you need to cancel your procedure; 48-hour notice must be given and 72 hours if holiday related. A late notice cancellation fee of Two hundred fifty dollars ($450.00) will be assessed for appointments that are cancelled within 48 hours of the schedule date and 72 hours if holiday related.

Continued on page 2.

By my signature on this Agreement, I certify, attest, and represent that I have received, read, understood, and will abide by the terms of the Agreement.

PATIENT SIGNATURE	DATE	FINANCIAL COUNSELOR SIGNATURE	DATE

METHOD OF PAYMENT

CARD TYPE:		CARD HOLDER NAME:			
CARD #		EXP. DATE:		CVV CODE:	
BANK:		ROUTING NUMBER:		ACCOUNT NUMBER:	

To Pay by Credit Card, Call: (513) 585-2302

Payment should be mailed to:

The Christ Hospital
ATTN: Financial Counselor, C Level Registration
2139 Auburn Ave.
Cincinnati, Ohio 45219
(513) 585-2302

PHYSICIAN OFFICE AGREEMENT

I have reasonably estimated the expected surgical time required for this surgical visit and have advised patient. I understand that in the event that surgical time exceeds the above listed time by ten (10) minutes, then each additional 15-minute increment will be the responsibility of the surgeon. The surgical time is based on time from when the patient is taken into surgical suite until the time patient is transferred to the Recovery Room (PACU).

Physician Signature	**Date**	**Time**