

OBSTETRICAL FINANCIAL POLICY

Patient Name: _____ Acct #: _____ EDC: _____

Charges:

Delivery and OB Care \$ _____ (Allowable) Office Fee: \$ _____

Co-Insurance: \$ _____ (Percentage Due: _____%)

Deductible: \$ _____ (Portion Not Met)

Total Balance

Due: \$ _____ (Patient Responsibility)

Monthly payments of _____ for _____ beginning _____, 200 ____.

THE FOLLOWING CHARGES ARE NOT INCLUDED IN THE ABOVE GLOBAL CARE PACKAGE:

Any labs, sonograms, injections, non-obstetrical related office visits, circumcisions, tubal ligations, assistant surgeon's fee for C-section delivery, hospital and anesthesia charges.

THE FOLLOWING TASKS ARE THE RESPONSIBILITY OF THE PATIENT DURING PREGNANCY OR AFTER DELIVERY:

Notify the insurance company after delivery within 24 hours, adding the new baby to your insurance policy prior to leaving the hospital (see 8 month reminder), notify the office of any change of insurance during your pregnancy, if you meet any significant portion of the deductible we have collected from you outside this office please provide an insurance EOB and we can adjust your financial policy accordingly.

PLEASE NOTE:

*If you have a Cesarean section delivery there will be an assistant surgeon charge. We will bill your insurance company for this service and you will be billed for any remaining balance they do not cover.

*If you are going to have a tubal ligation with your C-section, we will collect your portion for that procedure prior to your delivery.

*The charges quoted above are only **ESTIMATES** based on the information received from your insurance company prior to your delivery. The actual payment by your insurance plan may be different than originally quoted. Please note that precertification of your delivery does not guarantee payment of benefits.

*All prepayments are due by your 20th week of pregnancy. Failure to comply with this financial plan may potentially cause dismissal from this practice. If you have any situation that arises that will not allow you to make timely payments, please contact our OB insurance coordinator immediately so that we may bring an equitable resolution to the problem.

I, the undersigned, have discussed this financial policy with the OB coordinator at Comprehensive Women's Healthcare and understand the estimated costs associated with my obstetrical care and delivery. I have read the above policy and agree to the terms:

Patient Signature/Date Signed