Pregnancy Financial Policy
Self-Pay & Insured Patients

Congratulations! We are delighted you have chosen our physicians at College Hill OB/GYN for your obstetrical care during this very special time in your life.

We are committed to providing you with excellent medical care from our expertly trained and caring team of physicians and staff as well as providing you all the necessary information needed to allow you to financially plan for your OB care and delivery.

We have provided an **ESTIMATE** of your financial responsibility for your portion of the total OB care and delivery charges. Because we do not know what the actual charges will be until your delivery, please remember this is only an **ESTIMATE.** Charges and patient balances may change depending on the type of delivery, your insurance charges and insurance payments when applicable.

GLOBAL CHARGES (Includes all prenatal care / physician hospital care / delivery / postpartum care) *

- **59400 - Vaginal Delivery Global:** $3200
  - Additional charges for multiple gestation such as twins etc.
- **59510 - C-Section Delivery Global:** $3500
  - Additional charges for multiple gestation such as twins etc.
- **59610 VBAC Delivery Global:** $3300
  - Additional charges for multiple gestation such as twins etc.
- **58611 Tubal with C-Section Delivery**: $625

* If you have an insurance change or leave the practice, global billing will no longer apply and charges will be billed out according to number of visits and specific services rendered.

Incidental Charges

- Obstetric Lab / Glucose Test: Billed by LabCorp
- Sonogram (1 per pregnancy): $385
  - Additional sonograms / Biophysical Profile will incur additional cost.
- Injections (Rhogam): $235

Total Charges (Delivery + Incidental Charges): _____

****Please note**: you may incur extra charges from your delivery that are separate from College Hill OB/GYN. You should expect to see bills from the hospital, anesthesia, radiology, pediatrics, laboratory, etc.

COLLEGE HILL
Obstetrics & Gynecology

Self-Pay OB Patient Payment Policy

I, _____, have received the Pregnancy Financial Policy prepared for me by College Hill OB/GYN. I understand the Self-Pay OB Policy.

College Hill OB/GYN now offers two (2) OB Financial Payment Plans for you convenience. Please complete and initial your payment option below.

1. _____ I would like to receive a 30% discount, therefore will pay in full the estimated prepayment of $_____ at my first appointment on _____.

OR

2. _____ I would like to receive a 20% discount, therefore understand my responsibility for payment on my account and I will start my 4 installment payments of $_____ on _____. (1st or 28th of the month / credit card will be kept on file and billed automatically.) These are due on the 1st and 4th OB office visit.
    a. $ _____ 1st OB Visit
    b. $ _____ 2nd OB Visit.
    c. $ _____ 3rd OB Visit
    d. $ _____ 4th OB Visit.

    Name on CC: _____
    CC Type: _____ Exp. date: _____
    CC#: _____ Security Code#: _____

Please complete and initial.

_____ I understand if I have not met the requirement of this agreement and payments are not paid timely, I will not be seen by the provider until account is up to date.
_____ I understand that I am responsible for any and all balances due after my delivery.
_____ I understand $_____ is the estimated amount that I will owe for this delivery.
_____ I understand that my account balance will be paid in full no later than _____.

_____ _____
Patient Signature and DOB Date

_____ _____

Witness Signature Date

Insured OB Patient Payment Policy

OB Insurance Worksheet

Patient Name: _____

EDD: _____DOB: _____

Insurance, Policy Holder name, & Policy #: _____

Policy Year _____ to _____. Will deductible start over before delivery? Y or N

Deductible: Individual/ Family $_____

Amount met to date: Individual/ Family $_____

Total Coinsurance amount: $_____

Coinsurance met to date: $_____

Coinsurance: After deductible is met, insurance will pay _____% of the allowed charges and you will be responsible for the remaining _____% of the allowed charges until your coinsurance or out of pocket expense of $_____ has been met.

Information obtained by: _____

Spoke to:_____

Date and Time: _____

Reference#_____

Estimated Global and Incidental charges: $ _____

Estimated Patient Responsibility (deductible, co-ins): $ _____

Number of months of care based on EDD: _____

Monthly pre-payment amount: **$**_____

(Estimated responsibility by number of months of care)

Please complete and initial.

_____ I understand if I have not met the requirement of this agreement and payments are not paid timely, I will not be seen by the provider until account is up to date.

_____ I understand that I am responsible for any and all balances due after my delivery.

_____ I understand $_____ is the estimated amount that I will owe for this delivery.

_____ I understand that my account balance will be paid in full no later than _____.

_____	_____
Patient Signature and DOB	Date
_____	_____
Witness Signature	Date