2023

COLLEGE HILL
Obstetrics and Gynecology

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 with all the necessary information needed to allow you to financially plan for your OB care and delivery.

For your benefit to help you financially plan, we have provided an **ESTIMATE** of your financial responsibility of 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.

Your estimated amount owed will be placed into a payment plan with the first payment due at the first visit.

If you have any questions or concerns, please do call the Billing Department prior to your visit on 316-683-6766.

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

- **59400 - Vaginal Delivery Global:** $3600
  - Additional charges for multiple gestation such as twins etc.
- **59510 - C-Section Delivery Global:** $3800
  - Additional charges for multiple gestation such as twins etc.
- **59610 VBAC Delivery Global:** $3500
  - 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: Most routine lab billed by LabCorp.
- Sonogram: $500 towards radiology services
  - Additional sonograms / Biophysical Profile will incur additional cost.
- Injections (Rhogam): $235

Total Charges (Delivery + Incidental Charges): _____

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

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Self-Pay OB Patient Payment Policy

I, _____MRN: _____, have received the Pregnancy Financial Policy prepared for me by College Hill OB/GYN. I understand the Self-Pay OB Policy. I understand $_____ is only an estimate of what is owed. I understand all charges that exceed the estimated amount are my financial responsibility. I understand additional charges such as sonograms, additional lab and biophysical profiles will incur additional cost, and these will be due prior to the service.

College Hill OB/GYN now offers two (2) OB Financial Payment Plans for your convenience. Please complete and initial your payment option below. FLEX spending cards are not approved as a form of payment.

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 the account is up to date.
_____ I understand that I am responsible for all balances due after my delivery.
_____ I understand $_____ is the estimated amount that I will owe for this delivery.

_____ _____
Patient Signature and DOB Date

_____ _____
Witness Signature Date

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Insured OB Patient Payment Policy

OB Insurance Worksheet

Patient Name: _____ MRN: _____
EDD: _____1st OB Apt: _____DOB: _____
Insurance Name: _____
Policy Year _____ to _____ Will deductible start over before delivery? Y or N

Maternity Co-Pay (due at the first appointment): $_____
Deductible: Individual/ Family $_____
Amount met to date: Individual/ Family $_____
Total Coinsurance amount: $_____
Coinsurance met to date: $_____

Coinsurance: After the 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: _____
Reference#_____

*** Your estimated responsibility is based on charges. The global delivery fee, one ultrasound and initial OB lab work. Complications and optional testing are not included in this estimate and will be additional cost to you.

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. Routinely broken into 6-7 payments based on when care begins. **The 1st payment is due at your first appointment**.)

Please complete and initial.
_____ I understand that I am responsible for 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