Associates for Women's Medicine
generations of compassionate care

PATIENT OBSTETRICAL FINANCIAL AGREEMENT

Patient Name: _____ DOB: ____/____/____ EDD: ____/____/____

This agreement is to inform you of anticipated fees, which may be acquired during the course of your pregnancy. Unlike other types of services, prenatal care and delivery are billed globally and will be billed at the end of your pregnancy. We call and review your obstetrical benefits with your insurance carrier after your first visit once we confirm your pregnancy. Our OB benefit specialist will then call you to review your benefits and anticipated costs. AWM does require any estimated patient responsibility for the **delivery** to be paid by your due date.

An initial payment of 25% of your estimated balance due will be required on or before the 18th week of pregnancy. Subsequent payments must be made in monthly installments with the balance PAID IN FULL on or before your due date.

A refund will be issued to you if your insurance company pays more than what was originally estimated. **Estimates given by your insurance company are not a guarantee of payment. Any difference between quoted amounts and amounts actually owed will be the responsibility of the patient.**

During your pregnancy, physicians may order labs, ultrasounds, or non-stress tests. These services will be billed to your insurance at the time of the service, and are not included in the global delivery fee. Additionally, if you are seen for any problem or condition unrelated to your pregnancy, we are required to bill for the office visit. Your responsibility for these services will be determined by your contract with your insurance company.

Our billing department will contact you to be set up for a payment plan based on your insurance benefits.

Should you have a change in insurance coverage, it is your responsibility to notify us immediately. Any delays could result in additional out-of-pocket expenses or denied claims.

Any unpaid or remaining balances on the patient's account after your insurance has made payment may be considered for collection and/or discharge if not paid promptly upon receiving a statement.

Our office accepts Cash, Bank Card, Visa, MasterCard and Discover.

PLEASE NOTE THIS IS FOR PHYSICIAN SERVICES ONLY. FACILITY SERVICES ARE BILLED SEPARATELY BY ST JOSEPH'S HOSPITAL.

25% of Estimated Delivery Responsibility due by 18th Week of pregnancy $_____

Remaining Estimated Delivery Balance due by Delivery Due Date $_____

Patient/Guarantor: _____ Date: _____/_____/_____

Staff Witness: _____

If you have any questions, please contact our Billing Office at 315.423.9722