Dear Patient,

We are pleased that you have chosen our services for your Obstetrical care. We would like to familiarize you with our Obstetrical services as well as our billing policy. Please visit our website at www.womenobgyn.net.

The following forms will be included on this side of the packet:

1. Billing Policy & Maternity Insurance Form
2. Baby Boy Circumcision Form
3. Cord Blood Banking Policy
4. FMLA/Disability Paperwork Processing Fee Form
5. NWH/Prentice Registration Packet

Please complete the necessary forms and return them at your next office visit. Your prompt attention to this matter is greatly appreciated and will enable us to complete the insurance verification process in an expedient fashion. **As always, please feel free to clarify any questions and concerns you may have by contacting Stephanie Wengert: 312.440.3810 ext. 7287|email: OBcoordinator@womenobgyn.net and/or any billing representative at 312-440-3810.**

Billing Policy: Total OB Care and Delivery

1. All patients with medical insurance for maternity coverage will have their policy verified by our patient representative.
2. Our fees for global obstetrical care range from ($5,670-$6,280), depending upon your individual needs. The fee includes:
   a. 13-antepartum office visits
   b. Physician delivery charge
   c. One postpartum visit (does not include pap smear)
3. The following services are NOT included in the ($5,670-$6,280) fee and are payable at time of service:
   a. Prenatal lab fee
   b. Tay-Sachs screening/Jewish Panel
   c. Any lab tests (alpha-fetoprotein, glucose tolerance, cultures, pap, etc.)
   d. Postpartum PAP
   e. Any visits or procedures that do not pertain to the pregnancy (sore throat, yeast infection, urinary tract infection, colposcopy, etc.)

   f. Any visits for complications 90 days after delivery
   g. Any hospital admission before delivery
4. The following services may be required during your OB care and are NOT included in the Global fee. They are billed separately by the hospital or by us:
   a. Ultrasounds
   b. Non-Stress Test (NST)
      i. NST Belt Fee-$13.00
   c. Genetic Testing
   d. Amniocentesis
   e. CVS
   f. Any tests or procedures done at the hospital
5. Any services provided by physician specialist, i.e. anesthesiologist, neonatologist, will be billed separately by that physician. Hospital services will be billed separately and are not included in our fees.

<u>If Your Insurance Changes</u>

If your insurance changes from a managed care HMO, PPO or POS to a commercial plan you will be required to pay a deposit. You are required to notify the OB Coordinator immediately when your insurance company and/or plan changes. The deposit amount will be determined once the benefit verification has been completed.

<u>Note: Pre-Certification</u>

It is your responsibility to either call or have someone call your insurance company when you are admitted to the hospital. The usual length of stay is two overnights after a normal vaginal delivery, and 3-4 overnights after a cesarean section delivery. If more days need to be approved, the doctor's office will then notify the pre-certifications department of the medical necessity for the additional day(s).

<u>Credit Card Policy</u>

We require a credit card number on file for all patients. Our internal office policy will now include as a courtesy to our patients to automatically process ALL OB Deposit monthly payments with your Preferred Credit Card on file.

<u>OB Deposit</u>

All patients with verified **COMMERCIAL** are required to pay an OB deposit based on their insurance benefits. The OB deposit is due in full upon receipt of the formalized financial plan, or you may set up a payment plan at the time of receipt of the financial plan. After you deliver, the office will bill your insurance for the physician's delivery charge. Whatever amount your insurance does not pay, we will use your deposit to pay off your account and then refund any necessary balance.

All patients that are **SELF PAY** are required to pay in full $5,670.00 for a vaginal delivery. This fee is subject to increase in the event of a C-section delivery. This can be broken down into four installments. The first payment of $1,417.50 is required at your second visit. The balance is to be paid in three subsequent installments of $1,417.50, which will be set up by an automatic monthly payment plan charged to your credit card on file.

Moving Prior to Delivery

If you know you will be moving before your due date, please speak to our business office regarding your billing. The total number of visits will be billed to you or to your insurance company. All lab charges are in addition to these visit charges. If you are not in one of our managed care HMO/POS/PPO provider networks, payment is required at time of service. You are responsible for submitting the claim to your insurance company. If you have paid your OB deposit, we will apply that money to the number of visits you had at our practice. If there is a balance due, you will be billed. A new printout of your account will be sent to you to submit to your insurance.

Routine Tests for OB Care

Fee for initial visit	The cost of this visit will not be applied to the deposit
Prenatal Profile	Includes complete blood count, serology, blood type, Rh factor, antibody titer, rubella titer, hepatitis surface antigen, urine culture, urinalysis and Chlamydia culture
Pap Smear	
Quad Screen	Optional
Alpha-fetoprotein	Between 15-18 weeks
Diabetic Screening	One hour blood sugar test-between 24-28 weeks
Antibody Screening	Only if you are Rh negative-24 weeks
RhoGam Injection	Required at 28 weeks if you are Rh negative
CBC	Complete blood count-check for anemia
Hemoglobin A1C	Hemoglobin A1C
NST	Non Stress Test
Injection & Venipuncture Fees	

Cystic Fibrosis Testing (Optional)

Cystic Fibrosis is a genetic disorder. It caused by an abnormal gene that is passed from parent to child. It does not affect a person's looks or mental ability. Despite their physical problems, many people with CF attend school, have careers, and lead full lives. This blood test is optional and is offered to our patients based on family history. **PLEASE NOTE:** PATIENTS THAT HAVE BLUE CROSS BLUE SHIELD INSURANCE THIS TEST NEEDS TO BE PRECERTIFIED WITH YOUR INSURANCE COMPANY.

Maternity Insurance

Date: ________________________ Account #: ____

Patient Name: ____

Insurance Company Name: ____

Insurance Company Phone #: ____

Policy #: ____ Group #: ________________

Policy Holder's Name (if other than patient): ____

Policy Holder's relationship to the patient (circle one): Self Spouse Parent

Policy Holder's Employer: ____

Expected Delivery (circle one): Normal C-Section Previous C-Section

Expected Date of Delivery: ____

Have you had maternity care for this pregnancy with another doctor: _____________________

Are you considering having your tubes tied (sterilization) after delivery: ___________________

Are you considering circumcision for your child: ______________________________________?

Call your insurance company for maternity benefits for the global doctor's fee; not-hospital charges.

1. Effective date of Maternity coverage: ____
   a. Will you have maternity coverage by your due date: ________________________
2. Deductible amount: ___________________ Deductible met up to date: _____________
   a. Maximum out of pocket: _____________ Is deductible included: _____________
3. What is your percentage of the global doctor fee covered by insurance: _____________
4. What is your percentage of Lab & Routine Ultrasounds are paid: ____________________
5. Is a hospital Pre-certification or Pre-Admission review required: ____________________
   a. If Yes, please request the telephone number to call pre-cert: _________________
   b. Person's name you spoke with: ____
   c. Pre-Certification #: ____
   d. If no, please write the person's name you spoke with and the date: ___________
6. Do you have coverage for sterilization: ____
7. Do you have coverage for genetic testing: _______________________________________
   Is precertification required? Yes or No
   What is the phone number for precertification:___________________________________
8. Do you have coverage for circumcision: ____

Your insurance company may impose a penalty or deny payment if you do not properly complete the pre-certification process.

Patient Responsibility

I understand that my policy may exclude certain routine services that are considered to be not medically necessary or not covered. The physicians at The Women's Group of Northwestern routinely perform test or procedures that we consider to be invaluable in the management of patient care. I choose to have the services rendered and agree to be responsible for payment of these services.

_____________________________________ _____________________________________

Signature Date