The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

Global Maternity Benefits

Patient Name: _____

Account Number: _____ **Insurance Type:** _____

Your **Deductible** is $_____with $_____met.
Once your deductible is met, your Insurance will pay _____% of allowed amount leaving a **co-insurance** (patient responsibility) of _____% up to an **out of pocket maximum** of $_____. Your Global Maternity Package includes 14 antepartum visits and the Delivery of the baby including one post-partum visit.

Lab and ultrasound is billed separately:

Labs and Ultrasounds are covered at _____% with a **Co-pay** of $ _____ after your deductible is met, if applicable.

- During my initial OB interview, I've agreed to the following payment arrangements and I am aware that I am fully responsible for the stated amount.
- Amounts owed are an estimate and may change based on deductible accumulation at the time of delivery.
- This is not a guarantee of payment only an estimate of your benefits.

Payment Plan or Payment in full option (please check):

□ Payment in full: $_____ (based on _____% of deductible being met)

□ Payment plan: Four monthly auto debit installments of $_____ to be processed on credit card on file on _____ day of each month.

_____ _____
Patient Signature Date

**** INNER OFFICE USE****

EDD: _____ **Primary:** _____

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