Obstetric Patient Financial Responsibility

Thank-you for choosing Atlanta Women's Obstetrics & Gynecology, PC for your obstetrical care. We look forward to providing you with prompt, courteous and quality medical care during your pregnancy and beyond.

Obstetrical services are billed in two phases. Phase One is for routine prenatal visits, delivery and postpartum visits. Our fees for those services are: $5,150.00 for a vaginal delivery, $5,400.00 for a high-risk or AMA vaginal delivery, $5,300.00 for a cesarean delivery, and $5,600.00 for a high-risk or AMA cesarean delivery. This does not include charges for the hospital, anesthesiologist, or assistant surgeon (cesarean delivery only). Phase One services are billed to your insurance company after delivery. If you do not have insurance coverage or if your insurance deductible is $1,000.00 or more, monthly payments toward your delivery are required and the last Phase One payment must be received during the sixth (6th) month of pregnancy. All fees are approximate and may vary based upon the nature of presenting medical conditions. All costs are subject to change without prior notice.

It is important that you verify your insurance company's requirements concerning pre-certification as soon as possible. Pre-certification is YOUR responsibility in most cases, and failure to comply will result in reduced insurance benefit payments. Our tax identification number is 58-1520845, if your insurance company requests it.

You will also need to pre-register at Piedmont Hospital to provide them with your demographic and insurance information or make payment arrangements between your 7th and 8th month of pregnancy. If you would like more information regarding hospital fees, you may call Piedmont Hospital at (404) 605-2222.

Phase Two services are ancillary services such as ultrasound, laboratory, amniocentesis, non-stress tests, and Rhogam injections. Our Phase Two service fees vary depending upon the service provided. A ***sample*** list of services is provided below (fees are subject to change without notice).

CPT Code	Description	Charge
36415	Venipuncture	$23.00
54150	Circumcision	$460.00
81003	Urinalysis	$12.00
82947	1 Hour GTT	$23.00
90772	Injection	$35.00
59000	Amniocentesis	$275.00
59025	Fetal Non-Stress Test	$140.00
76811	2nd Trimester Ultrasound	$447.00
76817	1st Trimester Ultrasound	$375.00
90384	Rhogam Full Dose	$150.00
99000	Specimen Handling	$29.00
99213	Problem Visit	$205.00
82105	AFP 1 Lab Test	$92.00
84702	Beta HCG	$117.00
87081/87149	Group B Strep	$80.00
83021	Hemoglobinopathy	$115.00
85014/85018	Hemoglobin & Hematocrit	$34.00
86701	HIV Lab Test	$90.00
Various	Obstetric Lab Panel	$386.00
88175/Q0091	Pap Smear Collection & Cytology	$175.00
87086	Urine C & S Lab Test	$59.00

Phase Two services are billed to your insurance company at the time of service. If you do not have insurance coverage, payment for Phase Two services are due on the day the services are provided unless other arrangements are made in advance. Phase Two services paid in full on the date of service will receive a 20% cash discount.

I have read and understand the above information pertaining to obstetric service fees. I fully understand that payment of the bill is my responsibility in the event that my insurance company fails to make payment or pays a reduced portion of the charges submitted. I understand that where applicable, my last Phase One payment must be received during the sixth (6^{th}) month of pregnancy and that all Phase Two services are billable at the time of service.

Patient Name	Date of Birth
Patient Signature	Date

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Estimated Phase One services or Deductible due from patient:	$ _____
Down-payment received from patient (minimum of 25%)	$ _____
Balance due from patient prior to 6^{th} month of pregnancy	$ _____
Number of months until 6^{th} month of pregnancy	_____
Monthly payment required	$ _____
Day of month payment is due	_____
Information reviewed and coupon book provided to patient by	_____

I have read, understand and agree to the above information pertaining to obstetric service fees. I understand the down payment and monthly payments required for my Phase One services and/or insurance deductible. I further understand that all Phase Two services are due and payable at the time of service and are specifically excluded from the costs estimated above unless otherwise stated. I understand payment for Phase One services must be paid no later than the sixth (6^{th}) month of pregnancy and that unpaid Phase One services will be assessed a 10% finance charge per month.

Patient Name	Date of Birth
Patient Signature	Date