Georgia Obstetrics and Gynecology
A division of Atlanta Women's Health Group

OB Financial Policy

Congratulations on your pregnancy! We will go to great lengths to give you and your baby the most diligent care during your pregnancy. With your cooperation and help, you should be able to receive he maximum level of benefits entitled to you by your insurance plan, and we will be able to concentrate on caring for your medical needs.

At your first obstetrical examination and consultation you are responsible for an office co-payment or co-insurance. After this exam we charge a global fee for your prenatal care. The global fee is **$3,056.00** and will be billed as one claim **after** delivery. The global fee includes:

- 15 obstetrical visits
- Unlimited phone calls
- Informed consent session
- Vaginal delivery
- 1 post partum visit

The global fee excludes excessive office visits, diagnostic tests or procedures, laboratory fees and pap smears.

Additional fees are as follow:

- Circumcision $506
- Non stress tests (if necessary) $125
- Ultrasounds $270

These charges are incurred for each visit those services are preformed. Charges will be billed on the date of service.

For high-risk pregnancies (medical complications, prior cesarean deliveries, etc) the adjusted fee will be determined by the services preformed. An assistant in a cesarean section incurs an additional fee (typically 30% of the C-section).

We expect you to pay the difference between our "allowable" charges and any insurance reimbursement. Therefore, we collect the co-insurance amount as a pre-payment for the global fee. This MUST be paid in full by the seventh month of pregnancy. For example: A co-insurance amount of 20% is $600.00, 15% is $450.00 and 10% is $300.00. We will refund any overpayment AFTER delivery. If you do not have valid insurance coverage that can be verified upon your first prenatal visit, we will require a prorated amount of the global charge to be paid monthly. The entire payment amount is DUE by the end of the SEVENTH month of pregnancy.

I understand that I am responsible for compliance with ANY of my insurance plan's requirements for hospitalization, surgery, or diagnostic tests/procedures preformed in this office or elsewhere PRIOR to havening it preformed. This information may be obtained in several ways. For example, calling my insurance company, contacting my human resources department or insurance agent, or referring to my plan's booklet/website. In addition, if I am referred to a location or physician outside this practice, I will ensure the location and/or physician is in my network. If precertification/ preauthorization is required I will contact the bookkeeping department to obtain this prior to the appointment. Failure to do this may result in the reduction of my benefits or denial of my claim.

I understand it is my obligation to notify your office of any change in my insurance and/or financial status, which may result in my being unable to meet my financial obligations.

I have read and understand the office financial policy stated above and agree to accept responsibility as described.

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PRINT NAME & DATE OF BIRTH

_____ _____

SIGN DATE