OBSTETRICS & GYNECOLOGY ASSOCIATES. INC.
Obstetrical Collection Policy

PATIENTS WITHOUT INSURANCE OR MATERNITY BENEFITS:

For patients who do not have insurance or cannot provide proof of insurance, and are less than 28 weeks pregnant, a $500 payment was required today. A payment of $750 was required today for patients joining our practice who do not have insurance or cannot provide proof of insurance, and are 28 weeks pregnant or more. We will calculate the remainder of your estimated charges and set up a payment schedule to ensure resolution of your remaining balance by the 7th month of your pregnancy. You should receive notice of your scheduled payments and a telephone call from our office within 30 days. Payments must be received each month by the date indicated on your payment schedule. If payment has not been received in our office by the scheduled payment date, payment will be expected at the time of your next appointment.

PATIENTS WITH MATERNITY BENEFITS:

After your initial obstetrical visit, we will contact your insurance carrier to verify coverage and benefits. Based on this information, we will estimate your out-of-pocket expenses and set up a payment schedule to ensure resolution of your remaining balance by the 7th month of your pregnancy. If payments are required, you should receive notice of your scheduled payments within 30 days. Payment must be received each month by the date indicated on your payment schedule. If payment has not been received in our office by the scheduled payment date, payment will be expected at the time of your next appointment

After all claims have been processed by your insurance carrier, an outstanding balance may exist which was not included in the monthly out-of-pocket expense payments made throughout your pregnancy. However, following delivery, after all claims are processed by your insurance carrier, and providing an outstanding balance does not exist, we will refund any overpayments made by you.

I, _____, acknowledge this collection
(Please print)
policy has been explained to me, and I should receive a payment schedule to ensure resolution of my remaining balance by the 7th month of my pregnancy.

Signed_____Date_____

Witness_____Date_____

Original: Office
Copy: Patient

Rev. 01/09

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Patients are responsible for co-payments, co-insurance(s), non-covered services, and deductible amounts applied by your insurance company, for which payment is required in full at the time of service or if you do not provide proof of insurance. There will be a $25 charge for co-payments not received at the time of service. In addition, there will be a $45 charge for any check returned by your bank.

After your initial obstetrical visit, we will contact your insurance carrier to verify coverage and benefits. Based on the information received from your insurance carrier, we will estimate your out-of-pocket expenses.

Under our contract with your insurance carrier, we do not require you to make scheduled payments. However, in an effort to assist our patients in resolving any balances, we do offer a payment plan at your request.

- ☐ I request a payment plan during my pregnancy.

  After all claims are processed by your insurance carrier, an outstanding balance may exist which would not be included in your monthly out-of-pocket expense payments. However, following delivery, after all claims have been processed by your insurance carrier, and providing an outstanding balance does not exist, we will refund any overpayments made by you.

- ☐ I decline a payment plan during my pregnancy.

  Balance will be due within 30 days following payment from your insurance carrier. Failure to do so will result in your account being considered for collection.

I, _____, acknowledge this collection
(Please print)
policy has been explained to me and understand I am responsible for all balances on my account.

Signed_____ Date_____

Witness_____ Date_____

Original: Office
Copy: Patient

Rev. 01/09