

**Alpharetta Office**  
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Building 200, Suite 205  
Alpharetta, GA 30005  
Phone: 770-777-4933  
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**Northside Tower Office**  
5670 Peachtree Dunwoody Rd., NE  
Suite 1240  
Sandy Springs, GA 30342  
Phone: 404-303-1167  
Fax: 404-303-1126

**OBSTETRICAL PRIVATE PAY FINANCIAL AGREEMENT**

I understand the OB service fee for prenatal care rendered at Alliance Ob/Gyn and subsequent delivery at Northside Hospital (NSH) at 1000 Johnson Ferry Road, Sandy Springs, GA 30342 is **\$3000.00**.

I agree to pay \$400.00 on the first visit and \$520 on the first of each month (for five months) even if I do not have appointment. This will have my account paid in full by the 28<sup>th</sup> week. I understand if I have obtained late prenatal care or miss payments my monthly payments will be increased so \$3000.00 is paid by the 28<sup>th</sup> week of my pregnancy.

**\*\*I understand all outside lab testing costs will be billed directly to me** by the processing laboratory which has offered discounted billing to uninsured patients. I understand the approximate/estimated cost of these discounted, normal prenatal labs with normal results throughout a pregnancy is ~ \$385. Normal/standard prenatal labs include, prenatal profile (Hepatitis B screen, Rubella antibody, blood typing, antibody screen and CBC), image guided pap smear, chlamydia/gonorrhea testing, HIV test, and urine culture (at initial visit.) An AFP Tetra/Quad screen at ~16 weeks. A repeat HIV and Syphilis at ~28 weeks, and a Group Beta Strep Screen at ~ 35 weeks.\*\* Lab costs are subject to change by processing lab without notice.

**I understand the \$3,000.00 fee includes:**

1. The initial confirmation of pregnancy visit/"new ob" visit to include an ultrasound, pregnancy test and urine dipstick.
2. Routine prenatal visits (Scheduled monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery.)
3. Ultrasounds at the initial visit, ~12 week visit, ~20 week visit and ~ 32 week visit. (Up to four at prescribed intervals.)
4. In office labs: Urine dipstick at every visit, Hemoglobin/Hematocrit and Glucose Tolerance Test at ~28 weeks, and 3 Hour Glucose Tolerance Test if necessary.
5. Two non-stress tests if medically indicated.
6. Tubal ligation at time of Cesarean Section. Only if pre-planned and consents signed 30 days prior to hospitalization.

I understand there may be additional fees for labs or treatments my medical condition requires. (i.e. Rhogam injection for Rh negative patients is \$90, Colposcopy for abnormal pap smear is \$115, antepartum hospital admissions.) I understand these additional fees are due at the time of service. The staff at Alliance Ob/Gyn will do their best to inform me of these additional services and fees at the time of service. I realize that any service performed outside routine prenatal care is medically necessary due to my medical condition.

I understand if I apply for and receive Emergency Medicaid for the delivery or circumcision (or any other insurance at any time), it is my responsibility to provide this information to the Alliance Ob/Gyn Billing Manager immediately upon receipt of coverage. I understand if I do not provide insurance coverage immediately upon receipt, **I will not** receive a refund if timely filing limits are exceeded or required prior authorizations are unable to be obtained. I understand I will receive an \$800.00 refund for the delivery only IF Medicaid/insurance pays the delivery fee. I also understand if I have a baby boy who is circumcised by an Alliance Ob/Gyn physician, I am responsible for supplying the Alliance Ob/Gyn Billing Manager with the Medicaid/insurance information as soon as I receive it. If I do not provide this information within 30 days of delivery, I will pay Alliance Ob/Gyn, P.C. the discounted rate of \$120.

**Further, I understand that hospital facility, anesthesiology, hospital lab charges, etc. are not part of the OB service fee for our physicians or practice and will be billed separately to you by these providers.**

PRINTED NAME: \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

We appreciate your confidence in Alliance Ob/Gyn and look forward to assisting you in any way possible.

Sincerely,

Alliance Ob/Gyn Group, LLC  
10/15/18