Alpharetta Office
3180 North Point Parkway
Building 200, Suite 205
Alpharetta, GA 30005
Phone: 770-777-4933
Fax: 770-777-4934

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 at 1000 Johnson Ferry Road, Sandy Springs, GA 30342 is **$3200.00.**

I agree to pay $400.00 on the first visit and $560 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 28th week*. I understand if I have obtained late prenatal care, or miss payments my monthly payments will be increased so $3200.00 is paid by the 28th week of my pregnancy.*

I understand the $3,200.00 fee includes:

1. The initial confirmation of pregnancy visit/" new ob" visit to include an ultrasound, prenatal labs, a pap smear (image guided only—if history of abnormal pap or HPV, additional lab fees apply.)
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. Normal/standard prenatal labs to 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.
5. In office labs: Hemoglobin/Hematocrit and Glucose Tolerance Test at ~28 weeks, and 3 Hour Glucose Tolerance Test if necessary.
6. Two non-stress tests if medically indicated.
7. Tubal ligation at time of Cesarean Section. Only if pre-planned and consents signed 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 $85, Colposcopy for abnormal pap smear is $110). 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 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 card 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 $110.

I also understand the hospital charges, anesthesiologist, hospital lab, etc. are not part of the OB service fee for our physicians/practice and will be billed separately 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