OBSTETRICAL FINANCIAL POLICY

All obstetrical (OB) balances will be given to you after your initial Prenatal Visit. We obtain these balances as an estimate from your insurance company for your Global Care. Global care consists of all routine visits for your pregnancy after your prenatal visit. These balances will be given to you at your 3rd visit. These balances are due by your 28th week OB appointment. If balances are not paid in full by 28 weeks, we will have to give you a reference sheet to other doctors and terminate care.

We ask that you start making payments on these balances after we give you the estimate owed to us to eliminate some of the bills that will come after delivery. These are deposits. Anything remaining at the end of the postpartum care will be refunded back to you.

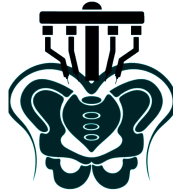
By signing this form you understand that payments towards your OB balance will need to be paid in full by the 28th week of your pregnancy and Reston Pelvic Surgery Associates will hold no responsibility if the balance is not paid by this time and is sent to collections.

Patient Signature: ______________________________________ Date: __________________

Witness:____

EXPLANATION OF PRENATAL CARE

This is a brief description of your prenatal care. The first two visits up to your initial prenatal visit, there will be co-pays per your insurance plan.



Reston Pelvic Surgery Associates

Every routine return obstetric appointment thereafter should be (depending on your insurance plan) covered until after postpartum care. These services are included in the Maternity Global Package. This global care includes your routine prenatal visits. This is NOT a guarantee of coverage by your insurance plan.

Insurance carriers DO NOT cover visits during pregnancy for illness, pain, falling, bleeding, etc. under the maternity global package. Any services or treatments outside of the routine visit is billed differently, copays, deductibles, and coinsurances may apply per your insurance plan.

By signing below, you understand the services generally covered and not covered under the Maternity Global Package.

_______________________________________ ________________

Patient Signature Date

____

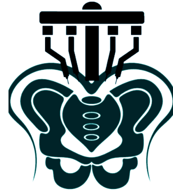
Witness

PAYMENT AGREEMENT

Patient name:______________________ Date:_________________

Account No.:______________________

Balance Due:______________________


Reston Pelvic Surgery Associates

I hereby agree to this payment agreement for obstetrical (OB) balances at Reston Pelvic Surgery Associates (RPSA). The balance due is a predetermined amount by your insurance carrier. The total amount may include your copays, deductible, and/or coinsurance amounts. Below is the breakdown for payments expected at each visit until the balance is paid in full.

Payment due at each visit: ______________