PRIVATE PAY OBSTETRICAL CONTRACT

NAME: DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Our maternity care and the global OB package have three distinct stages: antepartum care, delivery, and postpartum care. Our global OB package includes a large number of services which are bundled into this global package.

For all of our Private Pay OB Patients and/or our OB Patients that *do not* have maternity coverage through their health insurance carrier, the following details the services that will be provided as part of this Self Pay / Private Pay OB Bundled Package.

The cost for the OB Bundled Package is $3850.00, and includes:

Antepartum Care:

* Monthly visits up to 28 weeks gestation
* Bi-weekly visits up to 36 weeks gestation
* Weekly visits from 36 weeks until delivery
* Up to 4 ultrasounds depending on gestational age and provider discretion (Initial pregnancy dating, 12 weeks nuchal translucency, 20 weeks, 36 weeks)
* Non stress tests (NSTs)

Delivery:

- Management of labor and inpatient hospital visits

- Vaginal delivery or C-Section

- Assistant surgeon (if C-section is necessary)

Postpartum:

* Postpartum office visit at 2 weeks postpartum
* Removal of stitches or staples

The following details the services that *Not Included* in this package and will be charged/billed separately.

* Rhogam Injection (if needed, $200)
* Routine Prenatal Labs, AFP, GBS swab (billed separately by the lab)
* Natera (Panorama) Genetic Screening (if desired)
* Specialist Visits at Perinatologist (if needed)
* Additional Ultrasounds when indicated for complications ($200)
* Hospital charges (billed by the hospital, not our office)
* Anesthesia (billed by the anesthesiologist office, NOT our office)
* Pediatrician

Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 28 Weeks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I will pay the entire balance in full by 28 weeks of pregnancy. I understand that this is not a guarantee of all charges that I may be responsible for. I understand that in the occurrence that I do not complete my prenatal care with Sabella Women’s Health, refunds will be prorated and I will only be reimbursed the difference of the OB prenatal care / visits that I have not completed minus any current balances on my account.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to pay Sabella Women’s Health the total sum of $3850. It will be divided by \_\_\_\_\_\_\_\_\_\_\_installments of $\_\_\_\_\_\_\_\_\_\_\_ until the balance is paid in full.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_