NORTH PLATTE OB/GYN, PC

OBSTETRICAL CARE FEE DESCRIPTION & CONTRACT

Prenatal care, labor surveillance, normal vaginal delivery and post-partum care are the services included in the complete obstetrical care fee of $4,300.00. Cesarean section is $4,800.00 plus assistant surgeon charges. Hospital services rendered are separate from your obstetrical care fee.

Some services will be billed to you separately; these include ultrasounds, (initial OB ultrasound, 20 week ultrasound, etc.) OB monitoring/non-stress tests, problem visits for illness, nausea, pain, bleeding, etc. The lab tests will be billed separately by the facility providing the services. The tests listed below are examples of separately billed services, there may be additional services not listed.

(Lab fees)

Pre-natal blood work
One-Hour Glucose Tolerance Test (GTT)
Three-Hour Glucose Tolerance Test (if needed)
Quad Screening
Group B Strep Culture

(Additional office fees)

Obstetrical Ultrasounds
Fetal Non-Stress Test
OB Problem Visits

Patients with insurance coverage are required to make necessary co-payments when being seen for ultrasounds, non-stress tests or problem visits as listed above. Should your insurance company pay less than what was anticipated, the patient is responsible for the balance in full within 30 days of the final remittance following delivery.

Patients without insurance coverage are requested to remit the entirety of the complete obstetrical fee by the **end of the 35th week** of your pregnancy. A $500 payment is due at the first visit for care and monthly $500 payments thereafter until the base OB fee is satisfied.

****

Having read the above obstetrical care fee description I request that North Platte OB/GYN care for me during my pregnancy, perform the delivery of my infant, and provide post-partum care. I understand that the physicians share call coverage. I understand the above fee descriptions and billing policies and agree to abide by them. I understand that I am responsible for full payment on my account and will pursue payment by my insurance company and if applicable make payment myself.

Patient's signature_____Date_____