

Albany Obstetrics & Gynecology, PC
319 Manning Blvd Suite 201 Albany NY 12208
Obstetrical Contract/Information Sheet

Name: _____

Date: _____

Congratulations! We welcome you as an obstetrical patient!

The following will help explain the finances associated with your pregnancy and delivery.

The fee for obstetrical care with a normal vaginal delivery (procedure code 59400) is \$3,000

The fee for obstetrical care with a cesarean delivery (procedure code 59510) is \$3,500

The fee for obstetrical care with VBAC delivery (procedure code 59400-22) is \$3,500

The fee for circumcision of a son (procedure code 54150) is \$200. PLEASE NOTE: If your son is to be circumcised by our doctors, you MUST contact our office with his name within one week of his birth so that we can bill your insurance carrier. Otherwise, you will receive the bill from us and be held financial responsible for the \$200 fee.

There may be extra charges throughout your pregnancy for additional testing that your physician decides is necessary. Some examples are ultrasounds, amniocentesis, blood work and injections. These are not included in the global fees listed above. Services included in the global fee are all routine prenatal care, delivery and care in the hospital and postpartum care for you, including checkups during the six weeks following your delivery. If, however, you are seen during your pregnancy for any condition not related to your pregnancy, there will a separate billable charge.

If you have any change in your insurance coverage during your pregnancy, please notify our office immediately so that we handle the billing correctly and pre certify you for your delivery if your insurance company requires it.

If we participate with your insurance, you will be responsible for any fees that they state are your responsibility.

If we do not participate with your insurance, you will be responsible for the difference between what they pay for your care and our charge. We ask that this difference be paid by the beginning of your 8th month of pregnancy.

Our fee for an expected normal delivery:	\$3000
Less estimated expected payment:	
Balance due:	

Patient agrees to pay the above stated balance in monthly installments beginning on _____ and to be completed by _____. Installment amounts shall be _____. Failure to complete the above stated payment arrangement will result in the referral of your account to collection. Further, it will be assumed that you do not wish to continue as our patient and you will be discharged. If you are unable to fulfill this obligation because of extenuating circumstances, please contact our office and we will try to work with you.

I have read and understood the above.

Patient/Guarantor signature _____