

**The OB Suite**  
**South Carolina Obstetrics & Gynecology Associates, P.A.**

EDC: \_\_\_\_\_  
 NOB1 \_\_\_\_\_

Patient \_\_\_\_\_  
 Chart#: \_\_\_\_\_

Insurance(s): \_\_\_\_\_  
 Deductible: \_\_\_\_\_  
 Co-Insurance \_\_\_\_\_

**OBSTETRICAL DEPOSIT & PAYMENT AGREEMENT**

Below is your OB deposit and payment plan for prenatal care and delivery. This deposit is based on routine prenatal care, delivery, and the postpartum check-up. Your obstetrical deposit does **NOT** include charges for lab work, non-pregnancy related visits, ultrasounds, non-stress tests, circumcision, anesthesia, hospital, or any other tests or exams required for your care and the care of the baby. ***Your OB deposit is based on our global OB delivery fee.*** You will be responsible for the fee difference if you have a C-Section delivery. If your maternity care spans 2 different calendar years, 2 separate deductibles may apply.

Obstetrical Care & Delivery .....	\$ _____	(Enter current OB fee)
Estimated Insurance Payment .....	\$ _____	
* Approximate patient liability after insurance processing	\$ _____	
Initial OB Payment (No Insurance) .....	\$ _____	
Account Balance .....	\$ _____	
* Deposit Due From Patient .....	\$ _____	

\* Amount due after delivery and insurance processing may vary.

**PAYMENT PLAN**

MONTH	PAYMENT	MONTH	PAYMENT	MONTH	PAYMENT	MONTH	PAYMENT
1 <sup>st</sup>		4 <sup>th</sup>		7 <sup>th</sup>			
2 <sup>nd</sup>		5 <sup>th</sup>		8 <sup>th</sup>			
3 <sup>rd</sup>		6 <sup>th</sup>					

**\*\*\* NOTE \*\*\*** The verification of your insurance benefits does NOT include the pre-certification of your pregnancy with your insurance company (You have to do this; They won't let us do it.) You must contact your insurance company so that they will authorize your OB care.

I have read the above financial agreement and understand the payment responsibility for my Obstetrical Care **must** be paid by the 1<sup>st</sup> day of the 8<sup>th</sup> month of pregnancy, which is \_\_\_\_\_, 20\_\_\_. Furthermore, I have contacted my insurance company and informed them of my pregnancy and that I am aware that I am responsible for payment on any service rendered not paid by my insurance.

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Patient's Signature)

**If you have any questions about your OB deposit, please call our Insurance Office at 799-8816.**

**Thank you.**