235 Plain Street
Providence, RI
Ph: (401) 421-1710
Fax: (401) 861-2164

NEW OB INSURANCE & PATIENT RESPONSIBILITY FORM

Patient's Name_____

Account #_____Insurance Policy #_____

Insurance Co. Name_____

Insurance Co. Phone #_____

Deductible/Copayment_____

Employer's Name _____

Estimated Charges:

- $3000 Global Fee (includes delivery, 13 antepartum visits & Postpartum visit)
- $225 Amniocentesis (at Bayside Office)
- $150 Amnio ultrasound
- $135 Full OB ultrasound

PAYMENT IN FULL BY THE 36TH WEEK OF PREGNANCY.

Our financial coordinators will be happy to assist you; they can be reached at 421-1710 x7010 Kathy or x 7016 Pam.

Payment Arrangement:_____
_____

My signature below indicates full responsibility for these services.

_____ _____

Patient Signature Date

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Please fill out the top portion of this form and mail it back before your visit. Thank You.