



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:

- \$5564.00 Global Fee (includes delivery, 13 Antepartum visits & Postpartum visit)
- \$225.00 Amniocentesis (at Bayside Office)
- \$150.00 Amnio ultrasound
- \$135.00 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 Chris or x 7016 Pam.

Payment Arrangement: _____

My signature below indicates full responsibility for these services.

Patient Signature

Date

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