

**Women's Healthcare Center
Pre-payment Plan for OB Care:**

Patient Name:

Due Date:

I agree to make monthly payments in the amount of \$ _____ to cover my expenses during my pregnancy, delivery and post partum care. Payments will begin: _____. I understand that the cost of my Global OB care and delivery is due prior to my due date. I also understand that if I am unable to keep up with my payments I need to contact the Women's Healthcare Center immediately to make further arrangements to prevent my account from being turned over to a collection agency.

59400 Global OB & Vaginal Delivery includes: \$

Est. 13 Prenatal Visits.

1 Ultrasound (around 20 weeks)

Vaginal Delivery

1-2 Postpartum Visits within 8 weeks of delivery.

59510 Global Ob & Cesarean Delivery includes: \$

Est. 13 Prenatal Visits

1 Ultrasound (around 20 weeks)

Cesarean Delivery

1-3 Postpartum Visits within 8 weeks of delivery

Date:

Signature: