

Summit Ob Gyn LLC
331 Summit Ave
Hackensack, NJ 07601
Dr. Roohi Kamal

Maternity Financial Policy

This letter is to inform you about our office policy concerning your pregnancy and your insurance coverage. Unlike other types of services, prenatal care is billed at the end of your pregnancy, after you have delivered. Therefore, we do not collect co-pays for most prenatal visits, there are some exceptions.

- Ultrasounds
- Fetal Non-Stress Tests
- Problem Related Visits
- Labor and Delivery/Out Patient Hospital Visits
- Insurance Changes during Pregnancy

If the insurance reduces the doctor's reimbursement by a co-pay, it will be your responsibility to pay the co-pay at your next scheduled visit.

In addition you must also be aware of the cost of the delivery. **Some insurance companies require the patient to pay part of the delivery charge, as a co-insurance and/or a deductible. The coinsurance/deductible is considered part of the total reimbursement to the doctor.** Our office will contact your insurance company to determine if you have a deductible or coinsurance for the delivery. We will send you a statement with your balance if not paid in full; we will take the necessary steps to collect this debt. If we send your accounts to collections you agree to pay all the collection costs which are incurred.

It is your responsibility to inform this office of any changes in your insurance during your pregnancy. If your insurance changes during your pregnancy, it is imperative that you contact the front desk or the billing department as soon as possible. Our office needs to obtain maternity pre-certification so the delivery will be covered by the new insurance. If we are not notified and the pre-certification is not received you are responsible for the cost of the entire delivery.

Newborns must be added to your insurance policy within thirty days of their birth. Male infant will have an additional charge for a circumcision, if you choose to have this procedure performed. If the child has no insurance coverage you are required to pay us for the circumcision.

Your signature below indicates you have read this letter and agree to the terms. If you have any questions, you may speak to the billing supervisor or your insurance policy directly.

Name of Patient

Signature

Responsible Party (if not the patient)

Date