West Suburban Women's Health, Ltd.

Dr. Carla Carpenter
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Obstetrical Estimate

Patient Name: _____ DOB: _____ Date: _____

Acct#:_____ LMP: _____ Due Date: _____ Next Appointment: _____

Insurance: _____ Policy # _____Insurance Verified: _____

Thank you for choosing our providers at West Suburban Women's Health for your OB care.

Below is your insurance benefits related to your *OB Global Fee* which includes routine prenatal care, delivery, and your 6 week post-partum visit. There may be separate charges for your 2 week post partum visit, ultrasounds, non-stress tests, non-routine OB visits, circumcisions or labs. You will also be billed separately from the hospital, the anesthesiology group, and your pediatrician.

Unmet Deductible	_____
Unmet Out of Pocket	_____
Co-insurance based on _____%	_____

PLEASE NOTE:

We ask that you notify our office immediately if there are ANY changes to your insurance policy during your pregnancy

Agreement

I have read the Obstetrical Estimate and understand my benefits. I am aware that this document is an estimate of my insurance benefits and I am responsible for any balance that is not paid by my insurance company.

Patient Signature:_____Date:_____

If you have any questions, please call our office at 630-654-2229, and request to speak with a billing specialist.