



**West Suburban
Women's Health, Ltd.**

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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 be billed separately for our Bundle for a Bundle package. 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 _____ % _____
The Baby Bundle _____

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.