West Suburban
Women's Health, Ltd.

Dr. Joan Cardone
Dr. Carla Carpenter
Dr. Lindsey Malone
Dr. Susan Murrey
Dr. Katrina Porter
Dr. Sophia Rodriguez
Karen Barr, CNM

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 the obstetrical estimate for your prenatal care and delivery. This estimate is for the *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.

Allowed Amount by Insurance	_____
Unmet Deductible	_____
Unmet Out of Pocket	_____
Co-insurance based on _____%	_____
Current Account Balance at WSWH	_____
Estimated Patient Responsibility of Global OB	_____

NOTE: *The verification of your insurance benefits does NOT include the pre-certification of your pregnancy with your insurance company. You must contact your insurance company so that they will authorize your OB care. Also, please verify the insurance information our office verified is correct. If there are any corrections or there may be a change in your insurance coverage, please let us know immediately.*

Agreement

I have read the Obstetrical Estimate and understand my benefits. I am aware that this document is an estimate of my insurance payment 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.