# Omni Medical Center for Women
# Payment Arrangement Plan

| | | |
|---|---|---|
| Patients Name: | DOB: | SSN: |
| Address: | | |
| Self Pay: | EDD: | MRN: |
| Insurance: | Insurance Phone #: | ID/Policy #: |

**Additional services NOT included in the global OB Budget Agreement:**

- Sonograms
- Amniocentesis
- HMLA paperwork
- Physician Consult
- Cystic Fibrosis
- Tubl Ligation
- Assistant Surgeon
- MFM services related to High Risk Pregnancy
- NIPT Testing
- Diabetic Services
- Women's Care Oncology Services

## OB Budget Viginal:___ C-Section:___

$_____ Co-pay

$_____ Deductible

$_____ Coinsurance

$_____ NIPT (processed as coinsurance if applicable)

$_____ WCF Laboratory – All other labs, IF applicable

$_____ Grand Total

$_____ Grand Total without NIPT

| Credit/Debit Card Information | Credit Card type : |
|---|---|
| Cardholder Name (as shown on card): | |
| Card Number: | |
| Expiration Date (MMYY): | CVV (3-digit code in back): |
| Card holder's Zip Code (from credit card billing address): | |

Omni Medical Center for Women does understand that temporary financial problems may occur. To better manage your financial obligations, we have 2 payment arrangement options, for you to choose from.

**Option 1**- is dividing your balance due in three equal payments. You will be responsible for the calculated amounts due below, as scheduled by using your credit card/debit card.

**Option 2** - is dividing your balance due in 6 equal payments, by using your credit card/ debit card. We will run the amount due on the scheduled dates below this option is available to OB patients and patients who have a responsibility of greater than $900.

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**Please be advised if a payment date falls on weekend, our office will run the payment on the Friday prior.**

| Payment Schedule | |
|---|---|
| Balance Due : _____ | As of today's date : _____ |
| 1st Payment Date:_____/_____/_____ | Amount Due:_____ |
| 2nd Payment Date:_____/_____/_____ | Amount Due: _____ |
| 3rd Payment Date:_____/_____/_____ | Amount Due: _____ |
| 4th Payment Date:_____/_____/_____ | Amount Due: _____ |
| 5th Payment Date:_____/_____/_____ | Amount Due: _____ |
| 6th Payment Date:_____/_____/_____ | Amount Due: _____ |

Budget payments are to be made monthly. You are responsible for remitting payments according to the above schedule. All balances must be paid in full by the 30th week of pregnancy or by the time balance must be paid in full by the last visit or your pregnancy.
Deflating on payment plan may result in inability to be seen.

By **signing this agreement**, you acknowledge that it is a legally binding contract and that the amounts listed below are due according to the scheduled payment plan. You **authorize us to charge your credit card** for the **amounts and on the dates specified**. The amounts listed are based on the balance due as of today's date and may be subject to finance charges accruing at **18% annually**. If payments are not made as agreed, your account may be referred to a **collection agency** for further processing. If you have any questions regarding the management of your account, please contact the billing department at **(813) 251-2000**.

Your financial responsibility has been calculated based on the information provided by your insurance company and is **only an estimate**. The final amount may be higher or lower depending on the actual processing of your claims. You may also be responsible for **deductibles and co-pays**. If your pregnancy extends beyond your insurance plan year, you may be responsible for **two deductibles**. Additionally, if you are covered under a **group policy that renews before your delivery**, any changes resulting from the renewal may affect this agreement and your financial responsibility.

_____ _____
Patient or responsible Party's Signature Date