EDD: _____

_____

OB Self-Pay Form

Patient: _____ □ Vaginal □ C-Section

DOB: _____ MRN _____ eCW _____

$ _____ Contracted Rate (Delivery Package)

Paid at NOB Visit: $ _____

Balance After NOB Visit:
$ _____ New Balance
$ 750.00 Anesthesia/Epidural (Pre-Paid discount)
$ 250.00 Pediatrician (Pre-Paid discount)

$ _____ Grand Total

PAYMENT ARRANGEMENTS

Six Monthly Payments of $ _____ Due By: _____

Amount:	Paid Date:	Balance:
$ _____	_____	$ _____
$ _____	_____	$ _____
$ _____	_____	$ _____
$ _____	_____	$ _____
$ _____	_____	$ _____
$ _____	_____	$ _____

Payment Arrangement by Credit Card:

Patient Name: _____ DOB _____

Credit Card Holder's Name: _____

Credit Card# _____ Exp. ___ / ___

CVV _____ Zip Code _____

Signature: _____

Budget payments are to be made monthly. You are responsible for the above schedule. The entire balance must be paid in full by the 32 weeks of your pregnancy. Defaulting on your payment plan may result in having to transfer care elsewhere.

Patient Signature: _____ Date: _____

Comments: _____
_____

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