OBSTETRICAL BILLING AGREEMENT with Susie N. Chung, M.D., P. A.

120 Sister Pierre Drive, Suite 303 * Towson, Maryland 21204
(Phone) 410-337-9003 * (Fax) 410-337-9005 * www.susienchungmd.com

Our general fees are as follows:

- "Global" fee for prenatal care with standard vaginal delivery (procedure code 59400) $5,075.
- "Global" fee for prenatal care with c-section delivery (procedure code 59510) $5,675.
- Circumcision of newborn son (if desired) $ 444.

The **Global Maternity fee includes**: all of your "routine" prenatal office visits, your delivery & your routine post-partum visit(s). It **may not include**: any lab bills for cultures collected in our office, problem or high risk care (ex. urinary tract infection, hypertension, pre-term labor, diabetes, etc.) routine blood work, sonograms, injections, emergency hospitalizations (aside from your delivery). The global maternity fee is applied when one doctor provides all of your maternity care. Global care begins **after** your initial visit documenting your pregnancy. If however, you receive any portion of your routine care from another doctor or if you change insurance carriers at any time during your pregnancy, we must bill your maternity care in 'pieces" as they occur.

Payment for non-routine charges will be billed to your insurance at the time of service. Once your insurance processes the claim, any patient responsibility is due and will be applied to your card on file.

A note about standard allowed amounts – Insurance companies pay a percentage of what they determine to be a "standard allowed amount". As a participating physician with your insurance company, **Chung agrees to accept the "standard allowed amount" as payment and <u>will not</u> bill you the difference between our fee and your insurance plan's "standard allowed amount".**

Patient financial responsibility may include a deductible and/or co-insurance, and/or co-payment(s) as determined by your insurance plan's customer/ provider service number or website. We do our best to gather accurate insurance coverage information; however, it is our experience that claims sometimes are paid differently than anticipated. Therefore, in any effort to avoid unnecessary payments requiring refunds, we require a credit card on file. See separate *Credit Card on File Policy*). We encourage you to research your insurance benefits and coverage as well so that you can best prepare to meet your financial responsibilities at the time in which they are due.

Please note that all hospital/anesthesia charges are separate. The fees discussed here only pertain to your doctor.

PATIENT ACKNOWLEDGEMENT: I understand and agree to the information provided above. I understand the fees above are based on assumption of an uncomplicated pregnancy and information provided by insurance companies is never guaranteed. **In the event my private insurance terminates or changes, I agree to notify Dr. Chung's office immediately.** I understand that **Dr. Chung does NOT participate with medical assistance plans.** I understand that regardless of insurance, I am ultimately responsible for my entire bill. I understand my balance will be paid with the credit/debit card on file upon the posting of my processed claim.

______________________ ____/____/____ ______________________ __________
Patient's printed name date of birth Patient's Signature Date

For Office Staff: global non-global date checked: __________ Web or Spoke to: ____________________
EDD: ______________
Patient's primary insurance ______________________________ Renews ___________
Patient's Co-insurance ___________ Unmet deductible _____________ OOP _____________
Co-insurance amount ____________ Due by ____________ Paid Date ________________
Other Insurance: Circle: Secondary or Replacement insurance ____________________ Renews _________
Patient's Co-insurance ___________ Unmet deductible _____________ OOP _____________

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CREDIT CARD ON FILE POLICY

We require keeping your credit or debit card on file as a method of payment for the portion of services that your insurance doesn't cover, but for which your explanation of benefits states you are liable.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize *Susie N. Chung, M.D., P.A.* to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number____

Expiration Date _____ / _____ CVV ___ ___ ___

Cardholder Name ____

Signature ____

Billing Address ____

City ____________________ State______ Zip __________

I, the undersigned, authorize and request *Susie N. Chung, M.D., P.A.* to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by *Susie N. Chung, M.D., P.A.*.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to *Susie N. Chung, M.D., P.A.* in writing and the account must be in good standing.

Patient Name (Print):____

Patient Signature:____

Date:_____ / _____ / _____