
Obstetrical Financial Agreement



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Patient Name: _____ DOB: _____ EDD: _____

This agreement is to inform you of anticipated fees, which may be acquired during the course of your pregnancy. Unlike other types of services, prenatal care and delivery are billed globally. Our outside billing office will call and review your obstetrical benefits with your insurance carrier the day prior to your first visit. In house office staff will then call you to review your benefits and anticipated costs. San Martin OB/GYN does require any estimated patient responsibility for the delivery to be paid in full by the **32nd week of gestation**.

Payment can be made in full or in monthly installments with a zero balance by the 32nd week of gestation. A refund will be issued to you if your insurance company pays more than what was originally estimated. Estimates given by your insurance company are not a guarantee of payment. Any difference between quoted amounts and amounts actually owed will be the responsibility of the patient.

During your pregnancy, Dr. San Martin may order labs, ultrasounds, biophysical profiles or non-stress tests. These services will be billed to your insurance at the time of the service, and are not included in the global delivery fee. Additionally, if you are seen for any problem or condition unrelated to your pregnancy, we are required to bill for the office visit. Your responsibility for these services will be determined by your contract with your insurance company. These particular charges are to be paid in full at the time services are rendered.

If San Martin OB/GYN is not contracted with your insurance company you are personally responsible for all fees incurred with your prenatal care and delivery services.

Should you have a change in insurance coverage, it is your responsibility to notify us immediately. Any delays could result in additional out of pocket expenses or denied claims.

Any unpaid or remaining balances on the patient's account after your insurance has made payment may be considered for collection and/or dismissal from the practice if not paid promptly upon receiving a statement.

Please note this is for physician services only. Facility services are billed separately by the hospital attended.

We will do our best to help you with your insurance questions. Feel free to contact your member services line with your insurance company or your human resources department with your employer to learn about your coverage and benefits.

Estimated delivery responsibility due by 32nd week of pregnancy \$_____ Monthly Installments:

Patient:	Date:
Staff Witness:	Date:

HIV Consent

The Texas Legislature passed a law making it mandatory for health care providers attending pregnant patients to order two HIV tests – one at the first prenatal visit and one at the time of delivery, unless patients specifically refuse. This law mandates HIV testing of pregnant patients for children’s sake. Recent research has shown that maternal to fetal transmission of HIV, transmission from mother to the baby, can be significantly reduced following a three-step protocol administering Zidovudine (AZT). In a nationwide study conducted by the AIDS clinical trial group, maternal to fetal transmission of HIV was reduced by two-thirds in cases where women were treated orally with AZT during pregnancy, intravenously during labor and delivery and when their newborns were treated orally for six weeks after birth. This benefits child of patients whose HIV positive status is known because AZT must be administered during pregnancy to reduce the chances of transmission to the baby.

Three important points regarding HIV testing are:

1. Testing is a routine part of this practice.
 2. Testing is routine because the latency period for HIV infection can be as long as 15 years.
 3. However unlikely HIV infection is, if you are positive, you can greatly reduce the chance of transmitting it to your baby with AZT treatment.
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Prior to testing, I have been advised that the results of the test are confidential but not anonymous. The Texas Statute governing HIV information allows confidentiality to be broken in order to release the results to the health department and/or a local health authority for reporting purposes; to the physician who ordered the test or a healthcare provider who has a legitimate need to know the test results in order to provide for his/her own protection and to provide for the patient’s health and welfare. Additionally, HIV test results may be released to a spouse if the results are positive. You may also voluntarily release or disclose test results to any other person and such authorization must be in writing and signed by you.

YES: I request that blood be drawn for HIV testing. I understand the reasons for this test.

Signature	Date
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NO: I refuse HIV testing. I understand and accept the consequences of this decision.

Signature	Date
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Ultrasound Consent

My doctor has recommended an ultrasound. I understand that this ultrasound is to be performed to check fetal growth, fetal number, dating of my pregnancy, as well as other information that will be helpful in following my pregnancy. I understand that a routine ultrasound is not performed to detect congenital defects, although occasionally certain large defects may be identified. I also understand that ultrasounds are only 75% accurate in determining the sex of my baby and are not specifically performed for this purpose.

By signing this form, I acknowledge that I have been given all the information I desire concerning this procedure and have had all my questions answered.

Signature	Date
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Obstetrical Laboratory Service Agreement

You are responsible to know which laboratory your insurance is contracted with. Our office acts strictly as a "drawing station". Your labs will be sent to the laboratory designated by your insurance. If at any time during pregnancy your insurance changes, please notify us immediately so that we may send your lab work to the appropriate laboratory.

We cannot control whether or not you receive a bill from the lab for services rendered. If you have any questions regarding your bill, please contact the laboratory or your insurance company. Please be aware that you will be billed directly by the laboratory for your lab work if you do not have insurance.

Additional testing may be needed that is not recognized by your insurance carrier as usual and customary and is required in order to provide quality obstetrical care. You may get a statement from the laboratory specifying that this is a non-covered service and you may receive a bill.

Patient:	Date
Staff Witness:	Date

Obstetrical Testing Schedule

Laboratory/ Antenatal Testing

This is a schedule of the routine tests that will be ordered throughout your pregnancy.

10 Weeks Gestation

Non-invasive Genetic Testing: blood is drawn from your arm to calculate your risk of carrying a baby with Down's Syndrome or Trisomy

12 Weeks Gestation

CBC: a blood test that screens for anemia, infection and platelet problems

Blood Type and Antibody Titer: a blood test to determine your blood type and if your antibodies may become a problem

Serology: a blood test for syphilis

Rubella: a blood test for immunity to German Measles

HIV: a blood test for the AIDS Virus.

Gonorrhea/Chlamydia Cultures: a urine test for sexually transmitted diseases

Urinalysis/ Urine Culture: a urine test to determine if you have a urinary tract infection

CF: a blood test that screens for cystic fibrosis

16 Weeks Gestation

Quad Screen: a blood test that lets us know if further testing is needed to look for birth defects such as Down's Syndrome, Spina Bifida or Trisomy 18. An abnormal result of this test does not mean that there is a problem. Further testing will be performed.

AFP: a blood test that screens for neural tube defects. If Non-invasive genetic testing is performed the Quad screen testing is eliminated and only AFP is performed.

18-20 Week Gestation

Level II Ultrasound: this is a detailed ultrasound of the baby performed by either an imaging facility or Maternal Fetal Medicine specialist.

24-28 Weeks Gestation

Glucose Tolerance Test: a blood test for gestational diabetes

CBC: a blood test that screens for anemia, infection and platelet problems

Rh Negative Patients: will receive Rhogam injection in the office

34 Weeks Gestation

Group B Strep Culture: a swab culture that detects bacteria

Informed Consent for Maternal Serum Screening

Non-Invasive Genetic Testing: I understand that the purpose of the test is to screen the fetus for chromosomal abnormalities: Trisomy 21, Trisomy 18, Trisomy 13, Monosomy X and Triploidy. Gender of fetus can be obtained as well. I understand the purpose of the Non-Invasive Genetic Testing is to help identify chromosomal abnormalities in the fetus.

YES: I request that blood be drawn for the Non-Invasive Genetic screening test. I understand the reasons for this test.

Signature	Date
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NO: I do not want the Non-Invasive Genetic test. I understand and accept the consequences of this decision.

Signature	Date
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Cystic Fibrosis: I understand that the purpose of the test is to determine whether I am a carrier of one of the common CF mutations. CF is one of the most common inherited genetic diseases that can affect the lungs, pancreas, gastrointestinal tract as well as the reproductive system. I understand the purpose of the CF test is to help identify if I am a carrier of a CF mutation.

YES: I request that blood be drawn for the CF screening test. I understand the reasons for this test.

Signature	Date
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NO: I do not want the CF test. I understand and accept the consequences of this decision.

Signature	Date
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AFP: I understand that maternal serum screening may detect neural tube defects such as spina bifida, anencephaly, abdominal wall defects and Down's Syndrome. I understand that a normal test does not guarantee my baby is normal. I understand that some infants may be born with serious birth defects. I understand the purpose of the AFP test is to help identify some of the effected fetuses.

YES: I request that blood be drawn for the AFP screening test. I understand the reasons for this test.

Signature	Date
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NO: I do not want the AFP test. I understand and accept the consequences of this decision.

Signature	Date
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ROUTINE OBSTETRICAL LABORATORY TESTS:

Please before scheduling your testing call your insurance to verify if the test will be covered. Provide them with the codes underlined on the left side of this page.

First Trimester:

After week 10

81507 Genetic Test Self-pay price up to (\$299)

Diagnosis Codes: Z13.79, Z36.0

*Advance Maternal Age (35yrs and older): all of the above plus O09.511

Quest Diagnostics or LABCORP:

Week 12

81220 CysticFibrosis

80081 Obstetric Panel with HIV

87086 Urine Culture

87491, 87591 Chlamydia, Gonorrhoeae

Diagnosis codes: Z36.0, Z36.89, Z36.9, Z36.2

Second Trimester:

Between 16-19 weeks

82105, 82677, 84702, 86336, 81511 AFP Quad Screen

82105 AFP Screen (If Genetic Test was done)

Diagnosis Codes: Z36.0, Z36.2, Z36.89, Z36.9

Between 24-28 week

82950 One hr. Glucose, gestational screen

85025 CBC w/ Differential and Platelets

Diagnosis Codes: Z36.2, Z36.89, Z36.9

Third Trimester:

After week 34

87081 Group B strep culture

Diagnosis Codes: Z36.85

Two of pregnancy's more common complications are gestational diabetes and preeclampsia, both of which have markers that show up in your urine (Glucose and Protein). That's why at each and every prenatal visit we will need for you to give us a urine sample. (CPT code 81000)

*If indicated, depending on patient's condition and at the doctor's discretion there may be other testing needed. (e.g. vaginal infections, urinary tract infection, pre-eclampsia, etc.)

MEDICATIONS USED IN PREGNANCY AND BREASTFEEDING

Náusea/Vomiting

Dramamine	Fec Vitamin B6 (50mg up to 4 times a day)
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Indigestión/Gas

Maalox	Mylanta/Mylanta Gas
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Mylicon	Gas-X Roloids
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Tums	Prevacid 15-30mg
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Pepcid	Prilosec OTC
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Cold/Flu/Sinus/Allergies

Acetamenophen 500mg	Any Tylenol Cold product
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Sudafed	Benadryl
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Robitussin D.M.	Claritin (not during breastfeeding)
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Normal Saline Nasal Spray	Mucinex (not during breastfeeding)
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Zyrtec (not during breastfeeding)	
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Sore Throat

Sucrets	Chloraseptic spray/lozenges
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Cepacol	
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Headaches/Pain Reliever/Fever Reducer

Acetaminophen 500mg	Tylenol (any Tylenol product)
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Hemorrhoids

Preparation H	Tucks Pads
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Constipation

Milk of Magnesia	Metamucil Colace (docusate)
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Miralax	
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Diarrhea

Immodium AD	Kaopectate
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