LIEVANO - PEREZ
OBSTETRICS & GYNECOLOGY OF MIAMI

8525 SW 92 ST, UNIT D13
Miami, Florida 33156
PH (305) 270-3562 Fax (786)384-5766

OB APPOINTMENT POLICY
PLEASE READ CAREFULLY

As part of your maternity care, it is an *office policy* for **ALL** of our patients to be seen accordingly throughout their pregnancy. It is very important for your maternity care that you be seen as directed by the doctor. Failure to comply with office visit appointments will result in discharge from practice.

We ask for your cooperation and understanding, as this will benefit both you and your little bundle of joy.

Thank you!!

Dr. Guillermo Lievano, Dr. Ileana Perez, & Dr. Erika Collado

Patient Name:___________________________

Patient Signature:________________________

Date:______________

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OB Financial Responsibility

As a courtesy our office will verify your maternity benefits by your 3rd/4th visit. At that time you will be advised of your financial responsibilities for the OB care and delivery for the Physicians part.

Our office will create a payment plan according to what is verified with your insurance to be your out of pocket responsibility. This can include deductible, co-insurance, or copay. The payment plan is for your Total OB care (antepartum, delivery, and postpartum), for Lievano, Perez & Associates OB/GYN only and not the hospital. It does not include any additional charges for testing, ultrasounds or hospitalizations.

Once the claim is submitted and paid by your insurance if there is any remaining balance we will continue to deduct monthly until paid off or if there is an overage you will be refunded.

If your benefits happen to change before your delivery, insurance carrier changes, or you lose your insurance coverage, please contact the office as soon possible.

Failure to make any payments on time or payoff total amount due before 26 weeks of pregnancy will result in your discharge from practice.

Patient Name:________________________

Patient Signature:_____________________

Date:________________

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INSURANCE COVERAGE FOR PREGNANT PATIENTS

If you have insurance coverage, our office will verify your maternity benefits and we will let you know if you have any responsibility. This portion must be paid by your 26th week of pregnancy.

It is your responsibility to inform us if your benefits change during pregnancy, your insurance company changes, or you lose coverage. Failure to inform us may make you responsible for the full see of $6,000.00 for vaginal or Cesarean section delivery.

Please give us a copy of any new insurance card you receive, even if it is from the same company.

I have read this and will inform the office staff of any change in my insurance coverage.

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Si usted tiene seguro medico, nuestra oficina verificara sus beneficios de maternidad y le informara si usted tiene alguna responsabilidad monetaria.

Es su responsabilidad informarnos si es beneficios cambian durante su embarazo, su compañía de seguros cambia, o si termina su contracto con el seguro medico. En no informarnos de algún cambio puede hacerla responsable del costo total del parto ($6,000).

Por favor entréguenos una copia de la tarjeta nueva del seguro aun si es de la misma compañía.

Signature of Patient ____

Printed Name of Patient ____

Date ____________________________________

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Dear Patient:

Our goal is to provide each patient with friendly and convenient service during your visit. For your convenience during this visit, our office will process your blood here in the office and send it to the laboratory.

For this service the office will charge an administrative fee of $20.00 for annual gynecologic patients and a one-time fee of $40.00 for obstetric patients that will cover any blood handling and processing throughout your current pregnancy and, if needed, post-partum visits. This service is provided as a courtesy to those patients who do not wish to go to their primary care physician or the lab.

If you choose to take advantage of this service, the administrative fee is due at the time the blood is processed and handled and is non-refundable. The lab will bill your insurance company for the tests that are ordered.

There is also an administrative fee of $20 for administering any type of injection (Rhogam, progesterone, Depo, etc.)

There is a charge of $30 for any maternity forms or letters and $10 for any type of GYN letter (per letter) *Please allow up to 2 weeks to be completed*

Please indicate if you would like your blood work done today in our office.

YES ___________ NO _____________

Patient Signature ______________________________

Print Name ____________________________________ Date _______________

*Occasionally a test will be ordered that needs special handling or sample tubes that we do not have available. If so, you will be given a requisition to take to the appropriate facility. No fee will be charged.

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NOTICE TO OBSTETRIC PATIENT

(See section 766.316 Florida Statutes)

I have been provided information by the doctor on this letterhead, prepares by the Florida Birth-Related Neurological Injury Compensation Association (NICA), and have been advised that Dr. Lievano is participating in this program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand that I can contact the Florida Birth-Related Neurological Injury Compensation Association, at P.O. Box 14567, Tallahassee, Florida 32317-4567, or by phone at 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATED this ____________________ day of ____________________________, 20____.

Signature of Patient ____

Printed Name of Patient ____

This form is informational only and each person, participating physician or hospital should contact his/her own attorney to ensure compliance with section 66.316, Florida Statutes.

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To our patients:

This form is to advise our obstetrical patients that if you decide to have a cord blood collection there will be a fee of $250.00. This fee is due even if you receive the kit directly from Viacord, Cryocell, CBR, or whichever company you choose.

The collection of cells is done by the doctor at the time of your delivery.

Para nuestros pacientes:

Este formulario es para informale a nuestras pacientes obstetras que si desean guardar sangre del cordón umbilical habrá un cargo de $250. Aun obteniendo el kit directamente de la compañía Viacord, Cryocell , CBR que usted elija.

La muestra de sangre será recolectada por el doctor el día del parto.

Patient Signature ________________________________

Print Name ________________________________

Date ________________________________

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Authorization for Circumcision and Payment

Recently we have experienced great difficulty in getting reimbursed for our circumcisions. The most common reason is that parents forget to **add** their newborn to the policy. *It is your responsibility to do so*. We cannot do that for you.

Although many Insurances claim to cover 100% or a portion of your newborn's circumcision, it is not considered a medically necessary procedure. The doctor will still perform the circumcision at the request of our patients.

Our office will be collecting a circumcision deposit fee of $450.00. In the event the circumcision is applied to the deductible or co-insurance and it exceeds the $450 deposit collected you will be responsible for the difference pending to the office. **________Initial**

If your insurance does pay in full or a portion of the claim you will be reimbursed in full or the difference from what they applied to the procedure.

Thank you

****

I authorize Dr. Lievano/Perez/Collado to perform a circumcision on my newborn child.
Yes________ No_______

I also acknowledge that I am responsible for the payment for my newborn's circumcision in the event that my Insurance carrier does not cover this procedure.

Yes_______ No_______

Signature_______________________________________ Date_____________________

Print______________________________________Witness__________________________________

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GENETIC LAB TESTS

The American College of Obstetrics and Gynecology now recommends that DNA screening for cystic fibrosis, fragile X, and spinal muscular atrophy be made available to our patients.

CF causes the body to produce abnormally thick and sticky mucus that can clog the lungs, leading to repeated infections, as well as digestive and/or breathing problems. It does not affect intelligence. CF occurs when a child inherits a defective gene from each parent. If the child inherits the gene from only one parent, the child will be a carrier.

Fragile X syndrome is one of the most common causes of mental retardation. It causes a range of symptoms with varying degrees of mental retardation.

Spinal muscular atrophy is a hereditary disease that destroys the nerves responsible for controlling muscle movement but does not affect intelligence.

Your physician has recommended that you have these test as recommended by AOCG. These are genetic tests to see if the patient is a carrier. If the test comes back positive, testing will be advised for the partner as well. Genzyme Genetics performs all 3 tests. LabCorp & Quest do not offer spinal muscular atrophy testing.

If you have insurance coverage, the laboratory will submit a bill to your insurance carrier. You could be responsible for costs applied to your deductible and if you do not have maternity coverage, you will be responsible in full for any charges. We advise our patients to call their insurance directly to confirm if these genetic labs are covered under their insurance plan. This form acknowledges that you are aware that genetic tests may not be covered by your insurance company and you may be responsible for the bill.

I wish to have genetic testing for cystic fibrosis: YES ____ NO ____

I wish to have genetic testing for fragile X: YES ____ NO____

I wish to have genetic testing for spinal muscular atrophy: YES ____ NO ____

Signature of Patient ____

Print Name ____

Date ____________________________________

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Self-Pay Fees

Initial Visit : $300
Second Visit: $200
Ultrasound : $250
Vaginal Delivery : $5,500
C-Section : $6,500
Labs: Vary but can range from $25-$800
BTL at time of C-section: $450
Circumcision: $450
Cord Blood: $250
FMLA: $30 per packet

Included in Vaginal/C-Section Fee:
All antepartum visits (after confirmation of pregnancy) up until delivery date, delivery, and post-partum visits.
If for any reason you were originally a Vaginal delivery and C-section was performed you will be responsible for the difference owed.

Excluded in Vaginal/C-Section fee but available at an additional fee:
All ultrasounds, labs or pathologies.

On third visit the **total amount** for delivery will be collected. If for any reason you should decide to leave the practice the amount collected will be adjusted and a refund for the difference of services rendered will be issued.

________________________ ________________________ ____________

Print Name Signature Date

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ATTENTION
PLEASE READ CAREFULLY

As part of your maternity care, it is an *office policy* for **ALL** of our patients to be seen by each of our physicians throughout their pregnancy. You will be seeing your primary OB physician as expected but we require that you also be evaluated throughout your pregnancy by our other physicians.

We would like all our physicians to be involved in your pregnancy in case of an emergency or if your primary OB is not available. We ask for your cooperation and understanding, as this will benefit both you and your little bundle of joy.

Thank you!!

Dr. Guillermo Lievano, Dr. Ileana Perez, & Dr. Erika Collado

Patient Name:___________________________

Patient Signature:________________________

Date:______________