AGREEMENT FOR OBSTETRICAL CARE

1.) The following is the anticipated obstetric schedule for patients starting care:

   * Up to 28 weeks of pregnancy, you will be seen approximately every four weeks
   * 28 to 36 weeks of pregnancy, you will be seen approximately every two weeks
   * 36 to your delivery, you will be seen every week.

   Patients who develop a high-risk pregnancy will be followed more frequently as medically necessary.

We ask that you understand the importance of being on time for your appointments. Each patient has a scheduled time and when one patient is late they run into another patient's time, therefore those patients following you are also seen late. Patients arriving fifteen minutes or more after their scheduled appointment time may be asked to reschedule.

Unfortunately, if a patient has missed two or more scheduled appointments we may consider dismissing that patient from the practice and advise her to seek care elsewhere.

If Dr. McCleave or Dr. Ha are delivering a baby or called away to an emergency, your appointment will be re-scheduled, you may see the other provider on staff or you may be given the option to wait for them to return to the office. Every effort will be made to accommodate your needs with respect to appointment scheduling or rescheduling. Please be assured you will receive the same attention if you are the patient in labor or requiring emergency care.

2.) To ensure the best outcome for you and your baby, we perform screening tests that will keep us informed of your status. Laboratory tests and ultrasounds ordered should be performed when requested.

3.) Please make sure we have your updated phone number and address at all times. This is so that we may contact you regarding test results, if needed. (Please note: normal test results are not called to the patient.)

4.) Call Coverage: Dr. McCleave and Dr. HA share evening and weekend call with other OB/GYN Physicians. The other Physicians are, DR. Counts, Cruz, Dekeyser, and Kilby. If you should call or need to be seen on a weeknight or weekend when Dr. McCleave is not on call, one of the Physicians listed above will take your call or if need be, see you.
5.) Pre-Authorization with your insurance company is the responsibility of the patient. If, after you make your initial contact with your insurance carrier, they require a call from our office, please let us know and we will be happy to help you.

6.) Payment is expected at each visit. We will supply you with a superbill consisting of all codes that your insurance company will need to reimburse you directly. As a courtesy, we will bill your insurance company for your delivery and any services rendered in the office, which are more than $300.00. In order to do so, we will need to be supplied with all insurance information and a claim form. You will be requested to pay your insurance co-payment and any remaining deductible balance at the time of service.

By the 28th week of pregnancy, patients who have insurance, which we have not billed, will need to have all necessary information as well as a completed claim form to the business office so we may bill for the delivery. In addition, we request you prepay your insurance co-payment by the 28th week. This is the amount we expect your insurance will not cover for your delivery. A policy, which covers 80% of the delivery, will require an approximate 20% prepayment of $600.00 for a vaginal delivery. A scheduled C-Section is a prepayment of $840.00 will be required. Amounts are higher for twin or VBAC deliveries.

Patients who do not have insurance coverage will be required to prepay their delivery fee by the 28th week of pregnancy. Please ask to talk to the office manager if you have any questions regarding pre-payment.

7.) Patients under the care of Dr. McCleave and/or Dr. Ha must agree with the following:

* Be on time for appointments
* Comply with all orders for lab tests/ultrasounds
* Make prompt payments not allow account to become delinquent
* Not have disruptive children in the office
* Be kind and courteous to staff

I have read and understand the ALASKA OB/GYN CARE office policy. An office representative has answered all my questions. I am to receive a copy of this agreement for my records.

SIGNATURE______________________________________DATE_______________

PRINT NAME______________________________________DATE______________