NAME:

POLICY #: **DOB:**

PID #: **EDD:**

Acct. #: **TERM DATE:**

Effective Date: **DOWN PAYMENT: $**

VALLEYWISE HEALTH MATERNITY PACKAGE PLAN AGREEMENT

Maricopa County Residents

Valleywise Health is pleased to offer you the Maternity Package Plan Agreement. The Plan offers complete prenatal maternity care for one affordable price. The package prices include the physician fees, hospital and clinic charges. If you agree to deliver your baby at Valleywise Health Medical Center (VHMC), sign this Agreement and provide payment in full within 90 days of contract signing or before discharge after delivery, whichever comes first. Should you desire to pay in full at the time of contract signing; the total package price will be discounted. This plan is limited to Maricopa County residents, and does not have any income requirements.

Eligibility Requirements: At the time of signing this Maternity Package Plan Agreement the mother must provide proof of being a fulltime resident of Maricopa County and agree to deliver her baby at Valleywise Health Medical Center (VHMC). This Agreement is not available for patients with any health insurance for maternity care or for patients that are enrolled in AHCCCS.

As part of this Agreement, you may choose to receive the following care and services:

PRENATAL CARE – Please choose one of the clinics below that is convenient to you. To book an appointment, please call 1 (833) VLLYWSE or (1-833-855-9973)

VALLEYWISE COMPREHENSIVE HEALTHCARE CENTER (VCHC) WOMEN'S CLINIC	2525 E. Roosevelt St., Phoenix 85008
WEST MARYVALE FQHC	7808 W. Thomas Rd., Phoenix 85033
SOUTH PHOENIX LAVEEN FQHC	5650 S. 35th Ave., Phoenix 85041
NORTH PHOENIX FQHC	2025 W. Northern Ave., Phoenix, 85021
MESA FQHC	950 E. Main St., Mesa 85203
GUADALUPE FQHC	5825 E Calle Guadalupe, Guadalupe, 85225
SOUTH CENTRAL FQHC	33 W Tamarisk St., Phoenix, AZ 85041

Prenatal Care Services: The following Prenatal Care Services will be provided to you under the Maternity Package Plan:

1. Routine Prenatal Care Visits with a physician/provider and clinic visits with OBGYN providers.
2. Childbirth Education, Breastfeeding and Parenting Classes
3. Obstetrical Ultrasound(s) as needed
4. Vitamin and Iron Supplements
5. One OB TRIAGE visit on Labor and Delivery at Valleywise Health Medical Center
6. ONE oral health exam for the mother with a provider as needed
7. The following Routine Prenatal Care Labs and Radiology Services:

□ CBC (2)	□ STD Testing: Gonorrhea, Chlamydia, HIV, Syphilis
□ Hepatitis B-surface Antigen	□ TB Test (1)
□ Blood Type and Antibody Screen	□ Chest X-Ray (1 if TB test indicates)
□ Rubella Test	□ (AFP Quad Screen: 16 - 18 weeks)
□ Hemoglobin electrophoresis	□ 1 hour glucose tolerance test
□ Urine dip test (every visit)	□ 3 hour GTT (1 if indicated)
□ Pap Smear	□ Beta strep
□ Initial visit urine culture and sensitivity (1)	□ NST fetal monitoring at Antepartum Testing Center
□ Rhogam workup and injections	□ Flu shot (if indicated)
□ Tetanus, Diphtheria and Pertussis injection (if indicated)	

DESCRIPTION OF DELIVERY OPTIONS AND PROGRAMS: Please Initial the Option(s) that you want:

1. NORMAL VAGINAL DELIVERY OPTION (WITH OR WITHOUT) EPIDURAL

This option covers the cost of a normal vaginal delivery and post-partum hospital stay up to two (2) days at VHMC for the mother and baby.
You must pay **$5456** within the next 90 days or before discharge after delivery whichever comes first**.**
_____***(Initial)***

OR

You must pay **$4350** in full now (discount for payment at signing**).** _____ ***(Initial)***

2. NORMAL VAGINAL DELIVERY OPTION with BILATERAL TUBAL LIGATION

This option covers the cost of a normal vaginal delivery and post-partum hospital stay up to two (2) days at VHMC for the mother and baby and the cost of a bilateral tubal ligation for the mother.

You must pay **$5800** within the next 90 days or before discharge after delivery, whichever comes first**.**
_____***(Initial)***

OR

You must pay **$4700** in full now (discount for payment at signing). _____***(Initial)***

***UNPLANNED CESAREAN SECTION DELIVERY**

For those mothers who sign up for a Normal Vaginal Delivery Option (Options #1 or #2 above), you understand that this Maternity Package Plan Agreement does **not** cover an Emergency Cesarean Section if one is required. You will be responsible for the additional cost of an Emergency Cesarean Section delivery and hospital stay up to four (4) days at VHMC for the mother and baby. You must pay in full an additional $**1,750** for your Emergency Cesarean Section within 90 days after you are discharged from delivering your baby at VHMC. _____ ***(Initial)***

3. PLANNED CESAREAN SECTION DELIVERY

This option covers the cost of a planned Cesarean Section delivery and post-partum hospital stay up to four (4) days at VHMC for the mother and baby.

You must pay **$6614** within the next 90 days from the date of signing or before discharge after delivery whichever comes first**.** _____ ***(Initial)***

OR

You must pay **$6050** in full now (discount for payment at signing). _____***(Initial)***

4. BILATERAL TUBAL LIGATION (with Cesarean Section Delivery only) Additional $50

This option adds the cost of bilateral tubal ligation to the amount required for the selected Cesarean Section Delivery Option. (Not eligible for a discount.) _____ ***(Initial)***

5. TWINS

This option adds an additional **$200** if you deliver twins at VHMC. If it is discovered that you will be delivering twins after care has started, then this amount will be added to the cost of your package.
(Not eligible for a discount). _____ ***(Initial)***

POST-PARTUM CARE: The following post-partum care will be provided to you or your baby at no extra charge at the above Valleywise Health locations as part of your signing this Agreement.

Up to two (2) WELL BABY VISITS within the first 30 days with a physician/provider at Valleywise Health.

POST PARTUM CHECKUP FOR MOTHER with a physician/provider to be held within 12 weeks of the delivery if you did not have a C-section

OR

Two (2) Visits with a physician/provider for C-section patient.

I understand that traveling before 4-6 weeks after my baby's delivery is against the medical advice of my physician. _____***(Initial)***

EXCLUSIONS: The Maternity Package Plan does not cover any of the following costs: specialty or high–risk nursery services (NICU), high risk post-partum services for the newborn and/or the mother, preterm, DNA testing, dental services (other than the one oral health exam), multiple births other than twins, circumcisions, X-rays, anesthesia services (other than those needed for delivery or tubal ligation), special care nursery, family planning, birth control (unless administered in hospital), extended hospital stay due to complication medical care and physician consulting outside of the OB/GYN specialty, Amniocentesis, Nuchal Translucency/First Trimester Screening, Genetic Testing, and Lab tests sent outside of Valleywise Health for processing. You will be responsible for any of these extra charges. _____ ***(Initial)***

DESCRIPTION OF CHARGES

DESCRIPTION	IF PAID IN 90 DAYS AFTER SIGNING OR BEFORE YOU HAVE BEEN DISCHARGED AFTER DELIVERY, WHICHEVER COMES FIRST	IF PAID IN FULL TODAY
NORMAL VAGINAL DELIVERY (w/or w/o epidural)	**$5456**	**$4350**
NORMAL VAGINAL DELIVERY W/TUBAL	**$5800**	**$4700**
UNPLANNED / EMERGENCY CESAREAN SECTION DELIVERY	**$1750** additional	NOT APPLICABLE
PLANNED /CESAREAN SECTION DELIVERY	**$6614**	**$6050**
BILATERAL TUBAL LIGATION With Cesarean Section Delivery Only	**$50** additional	**$50** additional
TWINS	**$200** additional	**$200** additional

MATERNITY PACKAGE PLAN AGREEMENT

The PATIENT must read and agree to the following terms to participate in the Maternity Package Plan.

I am a full time resident of Maricopa County._____***(Initial)***

I understand the services covered under this Maternity Package Plan Agreement and that I am eligible to receive the services that I have initialed**.**_____***(Initial)***

I understand that I must pay the full package price within 90 days of signing this Agreement or before discharge after delivery whichever comes first; I further understand that services I have received from Valleywise Health or from DMG, Inc. prior to the date I sign this Agreement are not covered under this Agreement._____***(Initial)***

I understand that if I pay the full package price at the time of signing this Agreement, I will receive a discount off the total package price that is listed above (unless the Agreement says otherwise)**.**_____***(Initial)***

I understand that there are certain services that are not covered under the terms of this Agreement or by the Plan and that they are listed in the paragraph above labeled **EXCLUSIONS**. In addition, any services listed under **EXCLUSIONS,** and any other services not listed on this Agreement are not covered by this Plan, and I will be liable for the full billed charges for such services and I will be billed by Valleywise Health for those services and I will be billed by DMG, Inc. for the physician/provider **professional** services. ***(Initial)***

I understand that I will receive a bill for the hospital charges and a bill for the physician/provider or professional services provided by DMG, Inc. when I or my baby have stayed in the hospital for extra days or days that are not covered by the Delivery Option I have selected. _____ ***(Initial)***

I understand there may be an additional charge for each "well baby" hospital nursery day for each additional baby (or twin) delivered at Valleywise Health Medical Center. I further understand that I will be billed by both Valleywise Health and DMG, Inc. for these services, and the total amount for these services is due within 90 days after the delivery. _____ ***(Initial)***

I understand that if I purchase Normal Vaginal Delivery, Options #1 or #2, I will be responsible for the additional cost of an Emergency Cesarean Section delivery and hospital stay, which may be up to four (4) days at Valleywise Health Medical Center for the mother and baby. I also understand that I must pay in full $1,750 which is the total costs of the Emergency Cesarean Section, within 90 days after I am discharged from delivery at Valleywise Health Medical Center._____***(Initial)***

I understand that if I purchase Delivery Options 1, 2, 3, 4, or 5, that I must then pay the package rate within 90 days of signing this Agreement or before discharge after delivery from Valleywise Health Medical Center and if not, I am liable for full billed charges on file with the Arizona Department of Health Services. I understand that if I fail to pay the full amount I owe Valleywise Health by the day I am discharged there could be additional charges for the hospital services or for the physician/provider professional services, and that I will be responsible to pay these additional charges in full to Valleywise Health and the physician group, DMG, Inc. I understand that if I fail to pay the required amount in full by the date that I am discharged that any payments already made to Valleywise Health or DMG, Inc. will be applied to any outstanding balances I have with Valleywise Health and/or DMG, Inc., but I will still be responsible to Valleywise Health and DMG, Inc. for the remaining balance. _____***(Initial)***

I understand that if I sign up for Option 3, the Planned Cesarean Section, but have a Normal Vaginal Delivery (Option 1 or 2) at VHMC, the terms of the appropriate Normal Vaginal Delivery Option (Option 1 or 2) will take effect, and that any amount I pay to Valleywise Health for the Planned Cesarean Section Option 3 that is in excess of the amount to be charged for Option 1 or 2, will be refunded to me within 90 days after delivery; but I also understand that any excess payments that I made to Valleywise Health will first be applied towards any outstanding balances that I may have with Valleywise Health and/or DMG, Inc._____***(Initial)***

I understand that if there is a miscarriage or a pregnancy loss, the money that I already paid for the Maternity Package will be used to cover the cost of the Valleywise Health and DMG, Inc. services related to the miscarriage or pregnancy loss. I also understand that Valleywise Health's costs related to a miscarriage or pregnancy loss are not part of the Maternity Package and I will be required to pay for those Valleywise Health services as they are high risk inpatient services or high-risk delivery services and high risk postpartum services, as needed; thus, if the Valleywise Health costs for these additional services are more than I already paid for the Maternity Package Plan, I will pay the extra amount. If after the miscarriage or pregnancy loss, it is determined that the amount that I have paid Valleywise Health is more that the Valleywise Health costs related to the miscarriage or pregnancy loss, the excess amount will be refunded to me within 90 days._____***(Initial)***

I agree that if at any time I am advised by Valleywise Health that a member of my family/household may qualify for any medical benefits or health care plan or program, including AHCCCS, I must apply for such benefits and Valleywise Health will assist with that application._____***(Initial)***

I agree that if I require health care services that are not included in the Maternity Package, and I am advised by Valleywise Health that I may qualify for any medical benefits or health care plan or program, including AHCCCS, I must apply for such benefits and Valleywise Health will assist that application. _____***(Initial)***

I understand that if at any time I am eligible for any other medical benefit or health care plan or program that offers similar benefits and I have purchased a Valleywise Health Maternity Package Plan instead, that any payments I made towards the Valleywise Health Maternity Package Plan will be applied first to services rendered by Valleywise Health that are not covered by the other medical benefit or health care plan or program and prior to determining the amount of any refund._____***(Initial)***

I understand that if I qualify for any other medical benefit or health care plan or program and that plan or program does not cover any maternity service I receive at Valleywise Health, that I will be billed by and pay Valleywise Health for the hospital related services and I will be billed by and pay DMG, Inc. for the physician/provider professional related services*.*

_____**(Initial)**

I understand that if I have not paid the amounts that I owe, timely and in full, that I will be dropped from the Valleywise Health Maternity Package Plan Program, that any amounts that I have paid will be kept by Valleywise Health and that I will be billed at full billed charges for any services provided._____ ***(Initial)***

I further understand that before I receive a refund under this Agreement, any overpayment will first be applied to any amounts that I am responsible for at Valleywise Health or to DMG, Inc. _____***(Initial)***

I (we) have read, or have had this Agreement read to me (us), and understand and accept its terms.

_____ _____

Patient/Guarantor's Signature Date Spouse (if any) Date

I HAVE EXPLAINED THE ABOVE FORM TO THE PATIENT IN HIS/HER NATIVE LANGUAGE. HE/SHE HAS HAD AN OPPORTUNITY TO ASK QUESTIONS AND THOSE QUESTIONS HAVE BEEN ANSWERED.

Valleywise Health Representative: _____

(SIGNATURE/TITLE) Date