



NAME:

DOB:

MRN:

EDD:

Effective Date:

TERM DATE:

DOWN PAYMENT: \$

VALLEYWISE HEALTH MATERNITY PACKAGE PLAN AGREEMENT

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.

Eligibility Requirements: This Agreement is not available for patients with any health insurance for maternity care or for patients that are enrolled in AHCCCS.

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. 35 th 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
CHANDLER FQHC	811 S Hamilton St. Chandler, AZ 85225

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

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:

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

DESCRIPTION OF CHARGES

DESCRIPTION	Must be PAID IN FULL PRIOR to delivery
NORMAL VAGINAL DELIVERY (w/or w/o epidural)	\$6500
NORMAL VAGINAL DELIVERY W/TUBAL	\$6900
UNPLANNED / EMERGENCY CESAREAN SECTION DELIVERY	\$1850 additional Due within 90 days of discharge
PLANNED /CESAREAN SECTION DELIVERY	\$7700
BILATERAL TUBAL LIGATION With Cesarean Section Delivery Only	\$75 additional
TWINS	\$350 additional

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 **\$6500** Prior to discharge, after you deliver. _____ **(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 **\$6900** Prior to discharge, after you deliver. _____ **(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 **\$1850** 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 **\$7700** prior to discharge, after you deliver. _____ **(Initial)**

4. BILATERAL TUBAL LIGATION (with Cesarean Section Delivery only) Additional \$75

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 **\$350** 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, Hearing exams, and Lab tests sent outside of Valleywise Health for processing. You will be responsible for any of these extra charges. _____ **(Initial)**

MATERNITY PACKAGE PLAN AGREEMENT

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

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 after delivery. 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 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 \$1,850 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 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 than 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)**

