SOUTH SHORE WOMEN'S HEALTH
90 Libbey Parkway, Suite 105
Post Office Box 188
South Weymouth, MA 02190-0188

To Our Obstetrical Patients:

In order to avoid any misunderstanding in regard to our obstetrical fees, we have prepared this information for you. We ask that you sign in the space provided and return this letter to the office, keeping one copy to refer to if any questions arise. We hope that this agreement regarding our fees and policies will be helpful to you and through mutual understanding, will lead to a happy pregnancy and delivery.

The charge for normal prenatal care, delivery and six week checkup after delivery is **$4,800.00 / $5,000.00**. If there is any major complication of pregnancy, there may be additional professional charges. Fetal monitoring, ultrasound, injections, emergency room visits, hospitalizations or any treatment unrelated to the pregnancy, are not considered normal prenatal care and will be in addition to the above quoted fees. In addition, the fees discussed in this letter are completely separate from the hospital charges, pediatrician, anesthesiologist, assistant surgeon fee, and lab fees.

All insurance coverage will be verified upon your first visit. It is your responsibility to be aware of your insurance company's requirements regarding referrals, co-payments, deductibles, etc. You may contact our billing office at 339-201-4127 with any insurance questions.

If you do not remain as our patient through delivery we will adjust our fees to a rate of **$300.00** for the initial visit and **$220.00** for each visit thereafter.

When it becomes necessary to call us after office hours for emergencies, call our Weymouth office at 339-201-4120 and our answering service will contact the doctor or midwife on duty. Anytime you may feel it necessary for us to call your druggist for a prescription, please have the pharmacy phone number available as this is very helpful to us.

Do not go to the hospital until contacting the doctor or midwife first, either at the office or through the answering service.

If you request an IUD, diaphragm fitting and/or diaphragm at your post-partum visit, there will be a charge for these services as they are not included under a regular post-partum exam. You may need a referral from your insurance company for this service.

Thank you for your cooperation.

By: South Shore Women's Health

Patient: _____ Date:_____

SOUTH SHORE WOMEN'S HEALTH

OBSTETRICS • GYNECOLOGY • WELL WOMAN CARE

DARLYNE A. JOHNSON, M.D.
JULIANNE ARENA, M.D.
CHRISTINE D. HIRSEMANN, M.D.
KAREN M. TOUJOUSE, M.D.
CAROLYN M. McNULTY, D.O.
TIMOTHY JOHNSON, D.O.
HOLLY LEEMAN, M.D.
OLEG DOLGHI, M.D.

CYNTHIA MacLACHLAN, N.P.
DEBRA PALFREY, P.A.-C
DONNA TOCCI, P.A.-C
JANELLE MURPHY, N.P.
KRISTEN ADAMS, P.A.-C
DIANE RUTAN, N.P.
KATHLEEN ALEXANDER, N.P.

JESS F. ORRICK, ADMINISTRATION

Dear Patient:

Please be aware that all fetal abnormalities cannot be detected by ultrasound. Please discuss any concerns with your provider.

Thank you.

Signed:_____

Date: _____

90 LIBBEY PARKWAY, SUITE 105
POST OFFICE BOX 188
SOUTH WEMOUTH, MA 02190-0188
339-201-4120

118 LONG POND ROAD
SUITE 200
PLYMOUTH, MA 02360
774-773-9976

689 BEDFORD STREET
WHITMAN, MA 02382
781-447-4001

WWW.SOUTHSHOREWOMENSHEALTH.COM

South Shore Women's Health
Family Medical Leave Act (FMLA) Release

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Maiden Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

☐ I hereby authorize South Shore Women's Health to disclose the following health information to: **PLACE OF EMPLOYMENT**

_____

Specific Information to be released:

1. Information to be disclosed:

☐ Medical record from this date _____ and will expire one year from this date.

Comments: _____

_____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do NOT permit information of this type, if it exists, to be released. I understand that if I do not check the box, South Shore Women's Health will release such information.

☐ HIV / AIDS Infection
☐ Sexually transmitted diseases
☐ Genetic Information
☐ Treatment for alcohol and/or drug abuse
☐ Mental Health

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying South Shore Women's Health. I understand that any previously disclosed information would not be subject to my revocation request.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here:

_____

_____

This form must be fully complete before signing.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Print Patient's Name

_____ _____
Print Name of Legal Representative (If applicable) Relationship to Patient

90 Libbey Parkway, Suite #105
Weymouth, MA 02189
339-201-4120 Fax 339-201-4122

689 Bedford Street
Whitman, MA 02382
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118 Long Pond Road, Suite #200
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