Central Mississippi Civic Improvement Association, Inc.

D/b/a

3502 West Northside Drive
Jackson, Mississippi 39213-4454
Phone: (601) 362-5321 ■ Fax: (601) 364-2600

To Self-Pay and Insurance Pending OB Patients:

Thank you for choosing Jackson-Hinds Comprehensive Health Center (JHCHC) as your health care provider during your pregnancy. We look forward to serving you with quality care during this most important time in your life.

If your insurance (i.e., Medicaid) is pending or you do not have any insurance coverage, JHCHC is more than willing to work with you until your insurance is approved and offer you our sliding fee discount.

Keep in mind JHCHC fees do not include any hospital charges. You must contact the hospital and make financial arrangements with them. We strongly encourage you to apply for Medicaid and/or sliding fee discounts. If eligible, your cost will be substantially lower. We are here to assist you in obtaining or meeting your financial obligations.

Once JHCHC receive your insurance information and it has been verified that you are covered for maternity benefits and the claim has been submitted and paid, all monies paid to JHCHC will be refunded. Please be aware if you have any outstanding balances for other services that you received from JHCHC (i.e., Dental, Adult Medicine, Optometry), JHCHC reserves the right to withhold any money paid by you and apply it to any outstanding balance.

The fees below reflect the cost per slide level and our eight (8) month installment plan. Additional installment plans are available upon request.

Type of Delivery	**Cost**	**Slide A** 30%	**Slide B** 35%	**Slide C** 40%	**Slide D** 60%	**Slide E** 80%	**Slide F** 100%	**Homeless** 30%
OB-Care Vaginal Del	**$3,000**	**$900** $115 per month	**$1050** $130 per month	**$1200** $150 per month	**$1800** $225 per month	**$2850** $356 per month	**$3000** $375 per month	**$900** $115 per month
OB-Care C-Section Del	**$3,500**	**$1050** $130 per month	**$1225** $155 per month	**$1400** $175 per month	**$2100** $262 per month	**$3325** $415 per month	**$3500** $438 per month	**$1050** $130 per month

The fees quoted above are based on the fact you are in your 1st trimester. If you are accepted as a patient beyond your 1st trimester, your monthly fee will increase.

Please sign below acknowledging that you have received this letter and agree to abide by the above financial agreement.

Again, thank you for choosing JHCHC as your healthcare provider.

Print Full Name: ____

Signature: ____________________________________ Date: ______________

Witnessed by JHCHC Staff Member ______________________________Date:______________

NOTE JHCHC STAFF: PLEASE CIRCLE THE COST FOR THE ABOVE MENTIONED PATIENT