STANDARD PRENATAL AGREEMENT
BETWEEN
Florida Health Department of Osceola County

And

Patient Name: _____

The Florida Health Department of Osceola County is pleased to offer a **prenatal** healthcare program to patients who qualify. This program is available to our patients who reside in Osceola County and only those without health insurance benefits.

THE AGREEMENT COVERS

Pregnancy Testing
All Routine Prenatal Care:
Up to 10 prenatal care visits
Up to 1 Primary Care visits (if required)
All Routine Prenatal Lab work :
Urine Culture, Prenatal Profile,
1hr Glucose, 3hr Glucose, Antibody
Screen, Strep B, AFP, HIV testing
Up to 2 sonograms if medically Necessary
Up to 2 Post Partum visits including Pap smear
and Family Planning supply visit

THE AGREEMENT DOES *NOT* COVER

Emergency/Observation Room Visits
Non-Routine Prenatal Lab Testing
Delivery charges including but not limited to:
Hospital, Anesthesia, Pathology, Delivery
Physician Tubal Ligation, Newborn charges
Colposcopy
Fetal Non Stress Test
Fetal Biophysical Profile
High Risk Pregnancy
Hearing Testing for Newborn
Newborn Circumcision

Charges other than what this agreement covers will be the patient responsibility.

PROGRAM COST

1st Trimester- (1- 15 weeks) $1,300.00	$300 deposit / $100 monthly
2nd Trimester-(16- 28 weeks) $1,200.00	$400 deposit / $125 monthly
3rd Trimester-(29- 32* weeks) $1,100.00	$400 deposit / $150 monthly

* Women with 33 weeks of gestation or more would not be eligible for this program.

REQUIREMENTS

- A financial interview and proof of all income, assets, and Osceola County residency will be required.
- Qualified applicants will be required to make a deposit and monthly payments which will satisfy all program charges in full before delivery.

OTHER TERMS AND CONDITIONS

- All prior unpaid balances must be paid in full prior to acceptance to the program.
- If at anytime you become eligible for full Medicaid benefits this contract will become null and void. Any overpaid fees will be refunded or applied to any outstanding balance.

I hereby agree that I have fully read the above information and that it has been explained to my satisfaction**. I realize that failure to abide by program guidelines or failure to follow the payment schedule may result in my termination from the program, at which time all outstanding fees will be due**. This Agreement is subject to approval by the Osceola County Health Department.

_____	_____	_____
Applicant Signature	Date	Witness

PROMISSORY NOTE

For valuable consideration, the undersigned hereby agrees to pay the Osceola County Health Department, which is part of the Florida Department of Health, an Agency of the State of Florida, the principal sum_____, without interest. This will be satisfied by the undersigned making a deposit of $_____ on _____ with subsequent payments of $_____ per month until paid in full. Upon default, Osceola County Health Department will refer to our collection agency which will include an additional fee of 15.5 % of unpaid balance which will be paid by the undersigned. Should it be necessary to collect this note by legal process, court proceedings or by an attorney, the undersigned will pay costs of same along with reasonable attorney fees.

_____	_____	_____
Applicant Signature	Date	Witness

_____	_____	_____
Legal Guardian or Responsible Party	Date	Witness