Trinitas Regional Medical Center | RWJBarnabas HEALTH

Anesthesia Financial Arrangement

Admitting Office:
225 Williamson Street Elizabeth, NJ 07207

Patient Name: _____

Patient Date of Birth: _____Delivery Date: _____

Payment Agreement-Self Pay Discount

- I agree to pay Trinitas Regional Medical Center the discounted price for the service indicated below.
- I acknowledge that these fees are discounted to the full extent allowed by governing healthcare regulations and guidelines.
- A deposit of 50% is required at the time this agreement is accepted and signed.
- Payment in full must be received prior to discharge unless otherwise indicated and agreed upon in advance.
- If payment in full is not received as agreed upon the discount will be null and void and you will be responsible for list price.
- I understand that the prices shown below are only an estimate of my final bill.
- If for any reason charges are significantly higher than estimated, I agree to pay Trinitas Regional Medical Center the balance.
- Furthermore, I understand that these prices do not include the services of physician(s), anesthesia, testing or any service performed at any time that are not part of typical and routine charges associated with the "Hospital Services Only" listed below. I am solely responsible for the payment of physician(s) or other services for which I will be billed separately.

Delivery Self- Pay Discount for Hospital Services only:

Service	Discounted pricing for Self-Pay Patient	Estimate of List Price
Routine C-Section (includes Newborn)	$ 12,000.00	$50,000.00
Routine Vaginal Delivery (includes Newborn)	$ 8,400.00	$40,000.00
ICN (Intermediate Care Nursery)	$ 1,500.00 per day	$ 3,000.00 per day

Please select your payment option:

_____ (option A) Self Pay discount as outlined above with payment in full prior to discharge.

_____ (option B) Full charges if the Self-Pay discount is not received prior to discharge.

If you <u>do not</u> choose the Self-Pay discount option (option A) you will automatically be defaulted to and responsible for the full charges (option B)

Patient Signature _____Date_____

Witness_____Date_____

Guarantor (if needed) _____

To pre-register and arrange to make payment, contact Janet Hartmann, Director, Patient Access Services at 908 994 5323 or Bob Mendes, Manager at 908 994 5356. ***G:Letters/OBGYN agreement Revised 7/17/15; 7/7/16;9/20/16;9/28/16;8/7/17;1/20/22***