



Date \_\_\_\_\_

Dear \_\_\_\_\_,

The scheduling for your surgery is complete for a: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

with (Surgeon) Dr. \_\_\_\_\_ at (hospital) \_\_\_\_\_

***\*Please bring a list of all medications you are taking to your pre-op visit.***

Your pre-operative appointment with Dr. \_\_\_\_\_  
will be on \_\_\_\_\_ at \_\_\_\_\_ am pm. ***If you cannot make it to this appointment, you must call and reschedule because if you miss this appointment, your surgery will be cancelled.***

Your pre-admission appointment at \_\_\_\_\_ hospital will be on  
\_\_\_\_\_ at \_\_\_\_\_ am pm. The date of your surgery is  
\_\_\_\_\_ and your arrival time the day of the surgery should be  
at: \_\_\_\_\_ am pm

**FINANCIAL ARRANGEMENTS**

***The total cost of your surgery services performed by OB/GYN Associates is estimated to be \$\_\_\_\_\_. After contacting your insurance carrier about benefits, your estimated out-of-pocket cost is \$\_\_\_\_\_. 50% of this amount is due at your PreOp appointment \$\_\_\_\_\_. The remaining balance on your account is due within 60 days of your surgery. Please note that you will also receive a bill from the hospital for surgery expenses, as well as other entities involved in your care (i.e. anesthesia, x-ray, etc). Thank you.***

I have read and understand the above information and agree that I am responsible for any charges due the practice for services rendered regardless of insurance coverage.

***Signature*** \_\_\_\_\_ ***Date*** \_\_\_\_\_

***Patient Printed Name*** \_\_\_\_\_ ***Account #*** \_\_\_\_\_

If you have any questions, call \_\_\_\_\_ at **454-2035**. We hope your surgery experience is a positive one and we will look forward to seeing you at your post-operative visit. Your surgeon will instruct you after your surgery when to return for a post-operative visit. *Best wishes for a speedy recovery.*

Sincerely,  
OB/GYN Associates

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