



FINANCIAL POLICY

Thank you for choosing the CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A.. We are committed to providing you with the highest quality of care possible. CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. is a participating provider for Blue Cross/Blue Shield, Medicare and several other insurance companies, PPO'S, POS'S and some HMO's. A complete list is available at the front desk. Being aware that insurance companies and their plans frequently merge or change their names, however, it is not always possible for our office to ascertain with 100% certainty whether or not CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. is a participating provider with your insurance plan. Therefore, even though we will assist you, it is your responsibility to verify that CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. is a participating provider with your plan. If we know that CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. is not participating provider with your insurance company, full payment is due at the time of service. We accept Visa, MasterCard, Debit card, money orders and checks.

For patients enrolled in the insurance plans in which CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. participates, the insurance company's fees for services will be accepted. With most of these plans, patients are still responsible for their co-payment, co-insurance and/or deductible. Certain services may not be covered and will be the patient's responsibility. Therefore we ask that you pay the charge(s) at the time of service.

I understand that I have a personal and a primary obligation to pay for all medical services when due and I agree to pay all bills promptly. I understand that if my insurance plan requires a referral for specialty care services, I am responsible for obtaining that referral prior to my scheduled appointment, and I will present that referral at the time of service. I am aware that if I fail to submit my referral, my insurance company may not pay for these services, and I will be responsible for payment. I further understand that although CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. may submit a bill to my insurance company for payment as a service to me, that service does not relieve me of my personal responsibility to ensure that the insurance company makes payment according to the terms of my policy.

I further understand that insurance coverage varies widely among insurers and that it is my responsibility to know which services are covered by my policy and which are my responsibility. I am aware that insurance payment/reimbursement may not cover the total balance due for the medical services I received. I agree to pay any outstanding balance on my account when due. I also agree to pay any and all office and legal expenses and fees incurred for the purpose of collecting payment for an outstanding balance on my account if such action is deemed necessary. In addition, I agree to pay interest (at 1 ½ % per month) on my outstanding account balance plus any collection fees and/or costs including court cost incurred in order to collect payments on my account if the balance is outstanding beyond 120 days, including attorney's fees in the amount of 50% the balance due. I waive my right under the Maryland's statute of limitations should reconciliation of my account extend beyond 3 years from the date of service. I certify that the information I have reported with regard to my insurance coverage is correct and promise to update CENTER FOR RHEUMATIC DISEASES AND OSTEOPOROSIS, P.A. with any changes to my insurance company, address, phone number, etc:

ACKNOWLEDGEMENT & UNDERSTANDING OF FINANCIAL POLICY: I have read and understand the financial policy of Center for Rheumatic Diseases and Osteoporosis, P.A.

Patient/Responsible Party Signature

Print Name

Date