CHOPTANK community health
see how healthy you can be!

PATIENT FINANCIAL RESPONSIBILITIES

Thank you for choosing Choptank Community Health System as your healthcare provider. We are committed to providing you with high quality care and ask that you read and sign this form to acknowledge your understanding of our patient financial responsibilities.

Patients Name: **Date of Birth:**

- Please be on time for appointments. If you are more than 10 minutes late, it may be necessary to reschedule your appointment.
- Please give us 24-hour notice if you need to cancel or re-schedule an appointment.
- If you miss three (3) appointments in a twelve (12) month period without notifying our office, you will lose your ability to schedule appointments in advance.
- It is your responsibility to contact us as soon as you change your insurance, name, address or phone number.
- Be knowledgeable of your insurance and pay any applicable co-payment upon arrival. If co-payments are not received upon arrival you will be asked to reschedule your appointment.
- All unpaid balances that are the guarantor's responsibility and are due upon receipt of the bill and due within 30 days unless special payment arrangements have been made with our billing office.
- Any account remaining unpaid after 120 days will be turned over to a collection agency and it will be reported to a credit bureau. The collection agency fee of 35% and attorney fees will be the responsibility of the patient and/or guarantor.
- If you are uninsured, please ask the receptionist for our sliding fee program package which may qualify you for services at a discounted rate. You may also qualify for Medicaid. In addition, Maryland also has a program for uninsured children. If you qualify for the sliding fee program, income verification is needed at the time of the appointment. If we do not receive the required documentation, you will be required to pay a $95 **deposit**. If you provide proof of income within 30 days, you may be eligible for a refund.
- If payment is made by check and it is returned or declined, your account will be charged a return check fee (service charge) of $25.00.

If you have any questions regarding the above patient responsibilities, please feel free to contact our Accounts Receivable Manager at (410) 479-9100 or toll free at (877) 745-2455.

Guarantor_____Date:

CCHS Representative:_____Date: