



**CHOPTANK COMMUNITY HEALTH SYSTEM
PATIENT FINANCIAL RESPONSIBILITIES**

Patient 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 90 days will be turned over to a collection agency and it will be reported to a credit bureau.
- 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 you have not made a payment for your health care services in a 4 month period you can be dismissed from Choptank Community Health System. You will receive a letter to inform you that you are in danger of being dismissed and you will have 30 days to make payment.

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 Signature: _____ Date: _____

CCHS Representative: _____ Date: _____