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**Center for Cancer and Blood Disorders  
Patient Financial Responsibility**

This is an agreement between The Center for Cancer and Blood Disorders and the Patient/Guarantor named on this form.

**Insurance:** Insurance is a contract between you and your insurance company. In some cases we are not contracted with your insurance company and therefore we are not part of the contract. CCBD will bill your insurance company as a onetime courtesy and if they do not pay the financial responsibility is yours. In order to properly bill your insurance company we require that you disclose all insurance information including primary, secondary and tertiary insurance information. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If CCBD is not contracted with your insurance company, you agree to pay any portion of the charges above the usual and customary allowance. If insurance you directly, you are responsible for payment and agree to forward the payment to CCBD immediately. If your insurance company requires a referral and/or preauthorization, you are responsible for it and we will assist in the preauthorization process. Failure to obtain the referral and/or preauthorization may result in no payment from the insurance company, and the balance will be your responsibility.

**Payment Options for In-Network Insurance:**

- A. You are required to pay your deductible, co-pay and any out-of-pocket portions at the time of service by cash, check or credit card.
- B. If you choose to pay for all of your treatment in full at the time of service, we will promptly issue a refund for any credit balance when the insurance pays.

**Payment:** Unless we approve other arrangements in writing, the balance on your statement is due upon receipt. Approval is required for an extended payment arrangement. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts.

**Monthly Statement:** If there is a balance on your account you will receive a monthly statement. This statement provides you with a listing of all activity in the billing month in addition to the balance forward and the total amount due.

**Medicare/Medicaid:** We participate with Medicare and Maryland Medicaid. We agree to bill and accept the discounted reimbursement for both programs. There may be services rendered and supplies that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/Guarantor. By signing the ABN, you understand that you are financially responsible for payment of those services and or supplies.

**Missed Appointments:** We require 24 hours notice if you cannot make your appointment. If you are a "No-Show" a fifty dollar (\$50) fee will be billed and must be paid before rescheduling.

**Returned Checks:** A \$35.00 fee will be assessed on any returned checks by the bank.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency you will be responsible for all associated collection fees, lawyer's fees and court cost.

**Finance Charges:** A finance charge of 2% per month (24% APR) will be applied to the unpaid patient due balance of your account.

Patient Name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_