HOLY CROSS HEALTH PARTNERS
at Asbury Methodist Village

201 Russell Avenue
Administration Building
Gaithersburg, MD 20877
301-557-2110
TTY: 301-754-7406
HolyCrossHealth.org

FINANCIAL AGREEMENT

I, _____ have requested treatment from one of the above providers; I have read and understand the following:

1. I am responsible for all co-payments, deductibles and co-insurances as per the terms of contract with my insurance carrier.
2. **All co-payments must be paid at the time of service.** This includes multiple co-payments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e. for injections).
3. I am responsible for **all non-covered** services. The office will do its best to inform me of any services that may not be covered. However, I understand that benefits are not determined by my insurance carrier until ***after*** the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
4. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
5. The office is restricted to a **"timely filing period"** per determined by my insurance carrier. I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be processed. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.
6. I agree to pay a fee of $50 if I do not notify the office of cancellation 24 hours in advance.

PATIENT/GUARDIAN SIGNATURE DATE PRINTED NAME