



**BW Arthritis & Rheumatology**  
Healthy Joints, Healthy Bones

## **Insurance and Payment Policy**

We are committed to providing you with high quality medical care. We will facilitate the handling of your medical claims by completing insurance forms for you and accepting direct payment from your primary and or secondary insurance carrier. Any balance remaining after primary and secondary payment is the responsibility of the patient. We will not bill to tertiary plans/pension plans/indemnity plans- this is the responsibility of the patient.

Please realize that:

- 1.) We cannot guarantee that your insurance will pay your claims. **It is your responsibility to know your coverage based on your insurance plan. If your plan requires a referral from your primary doctor, it is your responsibility to provide the referral.**
- 2.) You are expected to provide complete and accurate information; this includes your full name, address, contact number, date of birth, photo ID, and most up to date insurance card. Our staff is fully compliant with all the Health Information Portability and Accountability Act (HIPPA) regulations.
- 3.) You will receive a billing statement from our office, which will indicate any deductibles and/or co-pay amounts not covered by your carrier. Deductibles, co-pays and non-covered services are the patient responsibility. Any outstanding balances are due within 30 days of receiving your statement. Non-payment of balances will result in discharge from the practice and the account will be sent to collections and reported to a credit bureau. The patient will be responsible for any collection fees incurred.
- 4.) We require that you pay your co-pay at the time of your appointment. For your convenience, we accept cash, personal check, Visa and MasterCard.
- 5.) There will be a \$25.00 charge for all returned checks.
- 6.) We reserve the right to charge the patient a \$30.00 fee for appointments and \$50.00 fee for procedures canceled with less than 24 hour notice.

**Filing of insurance claims is a courtesy that we extend to our patients. All charges are your responsibility from the date the services are rendered. If payment problems arise, we encourage you to contact our billing department- MTBC.**

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

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

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