Triangle Arthritis & Rheumatology Associates
FINANCIAL POLICY

I understand that I may be responsible for the payment of services rendered if the services are not covered by my insurance. T.A.R.A. physicians participate with BCBS and United Healthcare insurance plans. I understand that it will be my responsibility to verify with my insurance plan the participation status of my physician prior to any service being rendered. Insurance will be billed according to the guidelines of my primary insurance. It is my responsibility to update the T.A.R.A. staff of any new insurance plans or any changes in insurance and failure to do so may result in charges being denied and transferred to me.

SELF-PAY: All payments are due at the time of service.

PAYMENT AGREEMENT: Your insurance contract is an agreement between you and your insurance company, as the subscriber, you are responsible for the terms of that agreement. I understand I am responsible for all applicable co-payments, co-insurances, deductibles, non-covered services (including pre-existing conditions), missed appointment fees and other services denied by insurance are my responsibility. T.A.R.A. accepts, cash, personal checks (in-state only), VISA, MasterCard and Discover. Accounts are due in full within **30 DAYS** unless otherwise determined by my insurance plan. T.A.R.A. will make 3 separate attempts to collect the balance after the original 30 days. If I do not abide by this payment agreement, and my balance is more than 120 days delinquent, I understand that my account will be turned over to a collections agency and I will be responsible for all fees associated with the collection process as well as the original debt. At this point I may be in jeopardy of being dismissed from the practice for non compliance. If I have any questions or concerns, I may contact T.A.R.A billing department at 919-881-8272 ext. 112 or the practice manager at ext. 106.

RETURNED CHECKS: There is a $35.00 fee for all checks returned by the bank. I will be responsible for the original debt plus the returned check fee. This debt must be paid by cash, cashiers check or credit card. Going forward a check will not be accepted.

MISSED APPOINTMENTS/CANCELLATION FEE: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. I understand that if I fail to give a 24 hour notice of cancellation or fail to show up for my appointment I will be charged $50.00 for the FIRST offense, $75.00 for the SECOND offense and $100.00 for the THIRD offense. After the third offense I will be DISMISSED from the practice. I understand that this fee is non-negotiable and cannot be filed to insurance. ALL FEES MUST BE PAID PRIOR TO MY NEXT APPOINTMENT**.** I also understand that I will not be able to schedule further appointments until all frees are paid in full.

I have read and understand the Triangle Arthritis & Rheumatology Associates Financial Policy. I agree to all terms and conditions contained herein and understand this agreement will be effective immediately.

Patient Signature: _____ ***Date:*** _____
(Responsible Party)