TRIANGLE FAMILY CARE, P.A.
106-A Ridgeview Drive
Cary, NC 27511
(919) 319-6363
Fax (919) 319-1331

Insurance Policy

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to track all of the individual requirements and benefits of the various plans. Each one has different stipulations regarding what services can be rendered and how often services can be provided. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide only the care your insurance contract guidelines allow, but you must let us know at EACH visit, exactly what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently provide services or order lab work that are not covered, we will have no choice but to bill you directly for those charges denied by your insurance company. Payment for those charges is then your responsibility.

We send bills to our patients only after we have filed the claims with the insurance companies. If you receive a bill, this is your portion of the claim and is due within 14 days of receipt of the bill.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

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I have read and understand the insurance policy stated above and agree to accept responsibility as described.

_____ _____
Signature of Patient/Legal Guardian Date

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Sign below **only** if you **do not** have your current insurance card with you.

I understand that my eligibility for coverage by my insurance company cannot be confirmed at this time. I wish to receive medical service from Triangle Family Care, P.A. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

_____ _____
Signature of Patient/Legal Guardian Date