Welcome to Cary Rheumatology & Arthritis Associates, PA

We are pleased to have you as a patient and are committed to providing you with the best medical care possible. To help you receive the maximum benefits from your insurance, we kindly ask you to review and sign this statement. Please note that as your healthcare provider, our relationship is with you, not your insurance carrier.We appreciate your understanding and the opportunity to serve you!

Important Update: Financial Policy Changes for 2025

Co-Payment Policy

- If your insurance requires a co-payment, it must be paid at the time of service, prior to your appointment.
- Failure to pay your co-pay may result in your appointment being rescheduled.
- For assistance determining your co-pay amount, please contact your insurance company directly.

Other Fees

- **No-Show Fee:** $75 (applies if the appointment is not canceled at least 24 hours in advance).
- **Returned Check Fee:** $50.
- **Prior Approval Fee: Our office will be charging a $50 fee for all Biologic prior approval, it will be billed to the patient as a fee that will be applied on the next upcoming in-office appointment. This fee will be applied only once a year for all new prior approvals or prior approval renewals.**
- **No-Show for New Patient Appointment:** $100.
- **No-Show for Infusion Appointment:** $100.

Self-Pay Patients

- If you are uninsured or self-pay, payment in full is required at the time of service.
- If payment cannot be made, your appointment may need to be rescheduled.

Non-Covered Services

- You are responsible for paying any services or treatments not covered by your insurance at the time of service.
- Outstanding balances must be paid in full. If needed, our billing office can assist with setting up a payment plan to clear the balance within 3 months.
- Unpaid balances may restrict future appointments.

If you have questions about your bill or this policy, please contact our Billing Department at **(919) 344-0180, Ext. 3**.

Acknowledgment of Financial Policy

By signing below, I certify that I have read and understand the policies outlined above. I acknowledge my responsibility for all charges not covered by insurance at the time they are incurred.

Print Name: ____**Signature:** ____________________________

Date of Birth: ___________________________ **Today's Date:** ___________________________