TRIANGLE
WELLNESS & RECOVERY

FINANCIAL AGREEMENT

Payment Responsibility

I understand that I am responsible for payment of all charges for services provided to me by any provider at Triangle Wellness & Recovery PLLC. I am responsible for paying the entire charge associated with each visit on or before the day of service.

In Network Details

I understand that Triangle Wellness and Recovery PLLC is an in-network provider for select Blue Cross Blue Shield plans, the North Carolina Blue Cross State Health Plan, and Medicare Part B.

I understand that some Blue Cross Blue Shield plans are out of network (including point of service plans like Blue Home and Medicare Advantage.) I understand that Triangle Wellness & Recovery PLLC is out of network for Medicare Advantage plans.

Triangle Wellness & Recovery PLLC will only submit insurance claims for In Network services.

Out of Network Details

I understand that Triangle Wellness & Recovery PLLC is an out-of-network provider for insurance plans that are not select Blue Cross Blue Shield plans, the North Carolina Blue Cross State Health Plan and Medicare Part B.

I understand that I am responsible for paying the entire charge associated with each visit on or before the day of service.

I understand that Triangle Wellness & Recovery PLLC will not submit my out of network insurance claims for reimbursement, but I may request a “Superbill” from Triangle Wellness & Recovery PLLC, which I may then submit to my insurance carrier.

I understand that the amount of the reimbursement I may receive is dependent on several factors including but not limited to my benefits assignment, my remaining deductible and my eligibility determination. I understand that some or all services may not be eligible for reimbursement.

Card on File

I understand that I am required to keep a card on file with Square Capital, LLC regardless of my chosen method of payment on the day of service.

Fees for Cancellation and Rescheduling

I have read and understand the Triangle Wellness & Recovery PLLC Patient and Client Policies and acknowledge there are fees for cancelling or rescheduling visits with less than 24 hours notice.

I understand that I may withdraw consent in writing. My withdrawal will not be effective for actions already taken or in progress by Triangle Wellness & Recovery PLLC.

I authorize Triangle Wellness & Recovery PLLC to release all records required to act on these requests.

Patient / Authorized Signature Date

Patient Name - Printed Relationship to Patient (if not self)