

Trinity Pediatrics

Payment Policy

Thank you for choosing us as your child's primary care provider. We are committed to providing your children with quality and affordable healthcare. Because some parents have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If your child is not insured by a plan we do business with, payment in full is expected at each visit. If your child is insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your child's coverage. Knowing your child's insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your child's coverage.

2. Co-payments and Deductibles. All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your child's insurance company. Failure on our part to collect co-payments and deductibles from patient's parents / guardian can be considered fraud. Please help us in upholding the law by paying your child's co-payments at each visit.

3. Non-covered services. Please be aware that some of the services your child receive may be non covered or not considered reasonable or necessary by your child's insurer. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patient's parent / guardian must complete our patient information form before seeing the doctor. We must obtain a copy of your child's current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your child's insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your child's claims is your responsibility whether or not your insurance company pays your child's claim. Your child's insurance benefit is a contract between you and your child's insurance company. We are not party to that contract.

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6. Coverage changes. If your child's insurance changes, please notify us before their next visit so we can make the appropriate changes to help your child receive their maximum benefits. If your child's insurance company does not pay your child's claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your child's account is over 30 days past due, you will receive a letter stating that you have 20 days to pay your child's account in full. Partial payments will not be accepted, unless otherwise negotiated. Please contact the office manager for any concerns / questions regarding this matter. Please be aware that if a balance remains unpaid you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

8. Missed appointments. We do not charge for missed appointments but please let us know within 24-48 hours if you would like to cancel or reschedule your child's appointment. Our policy is to terminate patient after 3 no-shows. The purpose of our policy is to protect the practice from loss of unavailability to its patient's population in medical needs. It is your responsibility to update any demographic information with the front desk to ensure that you can be reached to confirm your appointment time and date.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agreed to abide by its guidelines.

Signature of parent / guardian or responsible party

Date