TRINITY PEDIATRICS, P.A.

6105 WINDCOM COURT, #100 PLANO, TX 75093 PHONE: 972-473-9063 FAX: 972-473-9059

FINANCIAL POLICY

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship. Everyone is treated equally and fairly.

INSURANCE:
Payment for services are due at the time services are rendered, except as outlined below. "Payment" means deductibles, co-insurance and co-pays for participating insurance companies. We accept cash, checks, MC, Visa, Discover and American Express. Outstanding balances are due within 30 days, unless prior arrangements have been made with our billing department. **All personal balances over 90 days will be sent to a collection agency**. Even though we verify coverage, insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to know your insurance policy benefits. NON EMERGENT APPOINTMENTS, i.e. physicals, well child checks, ADD checks, etc. will have to be rescheduled if there are outstanding balances or co-pay is not paid at the time of service. If you are experiencing financial difficulty, please let us know.

BILLING:
We can provide you with an itemized statement each time your child receives services.
A rebilling fee will be charged to you if payment is not made at the time service or if you do not furnish us with correct insurance information.
A fee will be charged for all returned checks, and future payments need to be made by cash, money order or credit card.

The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account. Charges remaining unpaid ninety (90) days after the date of service are considered delinquent and will be sent to a collection agency.

IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY, all services performed in our office and at the hospital will be submitted to your insurance. Do not file your own claim, by contract, we have to do it. All co-pays are due at time of service. Deductibles and co-insurance are your responsibility and will be billed to you by our office as instructed by your insurance's explanation of benefits. Therefore, any balances not covered by insurance and allowed by contract become the responsibility of the patient. Again, payment for services is due at time of service.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge for late, cancelled or missed appointments. Cancellations are requested 24 hours prior to the appointment.

MEDICAL RECORDS:
We use an outside medical service for copying medical records. Please note they will charge you a fee for their service. A chart summary and/or shot record will be provided by our office for a nominal fee.

FORMS AND FEES:
There is a fee for the review and completion of school/day care forms not provided to us at the time of the well child exam. Please complete all demographics and medical history portion before giving the form to our staff.

REFERRALS:
If your insurance plan requires a written referral in order for your child to see a specialist, or for procedures and/or, lab tests, you must allow us five business days to complete the appropriate form(s) prior to obtaining services. Retroactive referrals cannot be written and will not be honored. In general, we will not agree to a referral for a problem we have not been consulted about first. It is important that if questions arise, you contact your insurance company directly for final guidance and clarification.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY TRINITY PEDIATRICS, PA. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO ME.

Signature of Parent and/or Responsible Person: ______________________

Date: ____________________ Witness: _________________