Explanation of Payment Policy

(Payment is due at Check in, at time of Service)

We accept cash , debit card , and credit cards (Visa , MasterCard , Discover , American Express).

All payments for deductibles not met are due at time of service rendered. If incorrect payor information is provided and service is not covered by payor (insurance) , it is the responsibility of parent/guardian to provide payment in full.

All insurance benefits from claims filed by Trinity Pediatrics / Galaxy Pediatrics prior to payment in full are assigned to Trinity Pediatrics / Galaxy Pediatrics. In the event that insurance is canceled , the services rendered are not covered , or partially covered , the undersigned is responsible for full payment of services rendered.

I, ___________________ understand that I am financially responsible for all medical charges incurred by my dependent child for services rendered by Trinity Pediatrics / Galaxy Pediatrics. I understand that all fees required to collect on my account are payable by me. I understand and agree that if it becomes necessary to forward my account to a collection agency , I will be responsible for additional fees by collection agency.

Signature: ____________________________ Patient Name: _______________________
Date: ________________________________