



305 Sunrise Center
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Financial Policy

SonRise Pediatrics & Wellness participates with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know what your particular benefits may be. Therefore, it's important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, by check or by card. Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by our office. Online bill-pay and payment plans are available.

You will be responsible for payment for the following reasons:

1. You do not have insurance.
 2. You are insured by a company or a member of a plan with which SonRise pediatrics is not contracted.
 3. Your child receives a service that is not covered by your policy.
 4. Your insurance company denies your claim for any reason that is not resolvable.
 5. You cannot verify that you have insurance at the time of your appointment.
 6. You did not provide us with updated insurance information resulting in claim denial due to filing deadlines.
- A \$30.00 fee will be applied to your account for all returned checks.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

Divorced/Separated Parents and Custodial Arrangements

SonRise Pediatrics & Wellness does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

I have read and understood the above policy and agree with it.

Signature _____

Date ___/___/_____

Name _____

Relationship to patient _____