SONRISE
Pediatrics & Wellness

305 Sunrise Center
PO Box 2852
Zanesville OH 43701
P: 740-562-6868
F: 740-205-8661

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 are 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. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by our office. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so.

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. For example, some plans do not cover certain immunizations.
4. Your insurance company denies your claim for any reason that is not resolvable.
5. You cannot verify that you have insurance a 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.

Credit Card on File[i]

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email or mail.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

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Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time-of-service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit.

Health Forms

We will provide your child with one health form free of charge at their annual wellness visit (daycare, camp, sports physical forms, etc.). Forms requested to be completed outside of a scheduled visit will be assessed an administrative fee of $15.00 per form.

No-Show Fee

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of **at least 1 business day** for all cancellations A $25 no-show fee will be charged for any missed appointments. Repeated no-shows will result in the family being advised to transfer care out of the practice.

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 to it.

Signature _____ Date ___/___/_____

Name _____

Relationship to patient _____

[i] **This policy does not apply to patients with Medicaid and Medicaid HMO insurance**