SONRISE
Pediatrics & Wellness

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

Patient Self Pay Agreement

I,_____(Patient Name), DOB _____

have requested SonRise Pediatrics & Wellness to provide the following services to me and/or my child with the understanding that my physician is not participating with my insurance plan at this time. These services will be provided for charges listed below.

Date of Service(s) _____ Estimated Cost:

□ Wellness Visit	$175.00
□ New Patient office visit	$150.00
□ Established Patient office visit	$125.00
□ Vaccine administration fee	$ 20.00 ($50 for three or more)
□ Vision screen fee	$ 10.00
□ Hearing screen fee	$ 10.00
□ Developmental screen fee	$ 10.00
□ Laboratory tests ordered	See below

□ Glucose	$10	□ Covid 19	$25
□ HGB	$10	□ RSV	$25
□ Pregnancy Test	$10	□ Flu/Covid	$50
□ Rapid Strep	$20	□ Cholesterol	$25
□ UA	$10	□ Flu A-B	$25

I understand that by signing this acknowledgement I will be responsible to pay for all the providers' charges for the services rendered to me and/or my child.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Patient Date of Birth

_____ _____

Print Name of Legal Guardian — Relationship to Patient