SONORAN SKY PEDIATRICS, P.C.
10720 E. Southern Ave., Suite 116
Mesa, Arizona 85209
Phone: (480) 365-0050 – Fax: (480) 365-0049

PAYMENT POLICIES

CO-PAYMENTS
Sonoran Sky Pediatrics, P.C. expects co-payments to be paid at each visit upon check-in. We will also collect any deductible due in accordance with your insurance policy at the time of your visit, unless other prior arrangements have been made. We will make every effort to inform you about co-pays, deductibles or non-covered charges prior to your visit so that you are prepared to make payment before services are rendered. In the event you are unable to make payment, services may be rescheduled or denied, depending on the nature of the appointment.

APPOINTMENT CANCELLATIONS
As a courtesy to other patients and to us, we ask that you give us a 24 hour notice if you are unable to keep your scheduled appointment. However, we understand that may not always be possible, so we would appreciate it if you would inform the office as soon as possible if you need to cancel your appointment. Appointments cancelled with less than a 2 hour notice may be deemed a “no show appointment” if we are unable to fill that appointment slot. If you need to cancel an appointment when our office is closed, you may do so by leaving a message in our general voice mail box.

NO SHOW APPOINTMENTS
Failure to show for a scheduled appointment without notification to our office will be viewed as a “no show” appointment. “No show” appointments are disruptive and costly to our practice. After the second “no show” appointment, we may assess a $25 fee for each failed appointment. Multiple “no show” appointments will not be tolerated and will result in the patient being terminated from our practice. Patients terminated from our practice will be notified via certified mail. If terminated, a patient will have 30 days to find another primary care physician to assume their care. After one year, the patient may reapply to the practice for care. If the patient is accepted, the same criteria mentioned above would apply.

INSURANCE BILLING
Our office is contracted with several health plans and will bill the insurance company for services we render. In the event your insurance deems charges to be non-covered by the policy and applies them to the patient deductible or denies payment, unpaid balances will become your financial responsibility. We make every effort to verify benefits prior to rendering care but it is also your responsibility to know your health insurance benefits. Please help us to help you, and inform us of any changes to your health insurance prior to services being rendered.

Thank you for reviewing our payment policies. For our records, please acknowledge you have read these policies by signing below. If you would like a copy of this document please ask the receptionist.

____ ____________________
Patient Name Date

____ ____________________
Signature of Parent or Guardian Relationship to patient