Advance Pediatrics PLLC
Rakesh Arora, MD.
Sonya Mody, MD.

9836 W Yearling Road F-1300
Peoria, AZ 85383

8232 W Cactus Rd. Ste #124
Peoria, AZ 85381

(PH) 623-328-8664 (FAX) 623-328-9432

Financial Agreement

Please review the financial agreement for our practice. By signing this document, you are agreeing to all the terms in it.

Terms of Financial Agreement with ADVANCE PEDIATRICS, PLLC.

Verification of eligibility and benefits are conducted every time you have an office visit, however, per your insurance carrier, this is not a guarantee of payment. Please be advised that you may be subjected to a deductible, co-insurance amount or co-payment responsibility which we may not be aware of until the claim for the office visit has been processed by your insurance carrier. Should there be a remaining balance due after your insurance has processed the claim, a statement will be sent to you for payment. Also, please be advised that failure to provide correct, new, or additional insurance information in a timely manner may result in additional financial responsibility on your part, this includes any private insurance coverage as well as AHCCCS.

I, _____, the Parent/Guardian of patient, _____, understand that I am obligated to provide payment for any medical services through this office. I understand that while insurance may cover some of my expenses, I will be personally responsible for anything not handled by my insurance.
By signing this document, I am authorizing my insurance to cover any expenses attributed to Advance Pediatrics, PLLC.
I agree to cover any co-pay/ Deductible or Co-insurance at the time of the visit. I will pay any bill received within 30 days time. I understand that any failure to pay will result in a non-refundable late fee charge of $20 and the account will be forwarded to the Collection Agency after 60 days.

Itemized bills can be requested from the office. I understand that it is my responsibility to understand the coverage and limitations of my insurance. By signing this document, I am certifying that all of my billing is correct including my address phone number, and email. I will provide a copy of my insurance card and license/ photo ID when returning this document to the front desk.

_____ (Patient Name) _____ (Patient DOB)

☐ I have read and agree to the Financial Agreement terms stated above.

_____ _____
Parent/ Guardian Name (printed) Parent/Guardian Signature

Date _____