

CHILD CARE CONSULTANTS, INC.

Practice Limited to Pediatrics

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FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

- BASIC POLICY:** Payment for service is due in full at the same time service is provided in our office.
- FOR PATIENTS WITH INSURANCE:** We bill most insurance carriers for you if proper paperwork is provided to us at the time of service. Co-payments, deductibles and proof of insurance coverage are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If you have a question regarding how your insurance company paid your claim, contact them at the number provided on your card. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
- WELFARE PATIENTS:** All welfare patients must provide a current, valid proof of eligibility card upon each visit before being seen.
- SURGERY FEES:** All co pays, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.
- NONCOVERED SERVICES:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
- PERSONAL INJURY CASES:** This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
- YEARLY HEALTH CHECKS:** Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician. (See **Non-covered Services and Basic Policy** above)
- MISSED APPOINTMENTS:** in fairness to the other patients and the doctor, we require at least 24 hours notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

I hereby authorize payment directly to Child Care Consultants, Inc. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to use and/or disclose any protected health information required to carry out treatment and health care operations and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that consent may be revoked by myself or Child Care Consultants, Inc and I have the right to request that Child Care Consultants, Inc restrict how my protected health information is used or disclosed.

I understand that I may review Child Care Consultants', Inc. Notice of Privacy Practices for a more complete description of it's uses and disclosures of protected health information.

The patient / legal guardian is ultimately responsible for all professional fees.

Signature: _____

Date: _____