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FINANCIAL POLICY

We are dedicated to providing the best possible care and services to you and your complete understanding of your financial responsibilities and privacy rights is an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health coverage provider, payment is due at the time of service. For your convenience we will accept Visa, MasterCard and Discover.

Your insurance policy is a contract between you and your insurance company. We have made prior arrangements with many health plans to accept assignment of benefits. We will bill those plans for which we have arrangement and will only require you to pay the authorized copayment at the time of service. All out-of-pocket expenses will be collected at the time of service.

As a courtesy to you, we will submit your claim to the insurance company. The insurance company does not pay within 60 days, you will be held responsible for payment. If your coverage is with a plan that we do not have a prior assignment with, the charges for your care and treatment are due in full on the day of the service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered” you will be responsible for the complete charge. Payment is due at the time of service.

For all services rendered to minors, we require the adult accompanying the patient and the custodial parent or guardian for the payment.

In order to provide the best possible service and availability to our patients, we ask that you call us 24 hours prior to your scheduled appointment if you know that you will need to reschedule. Please notify us of any extenuating circumstances.

There will be a \$20 fee charged to you for all NSF checks.

Disputed balances: please check your statement carefully. We work hard to avoid errors, but if one should occur, please notify our billing department at 330-494-9797.

By utilizing the services of Canton Pediatrics, Inc., I agree to be bound by the terms of this policy. I also understand and agree that such terms may be amended from time to time. I have read and understand the financial policy of the practice and agree to be bound by its terms. I understand a copy of the privacy notice is available to me upon request. I have even read the policy article interviewed at this time.

Signature _____ Date _____