

Ohio Pediatrics, Inc.

1775 Delco Park Drive
Kettering, OH 45420
937-299-2339

7371 Brandt Pike, Suite C
Huber Heights, OH 45424
937-236-5396

Electronic Payment Authorization via Modern Payment

As a medical practice our goal is to provide you with the best, most current medical care available in a positive and supportive environment. As a small business we must constantly strive to reduce and minimize our expenses and cost of doing business.

In an effort to streamline this system and make it more cost effective for everyone, we are asking every patient to provide us with a credit card, HSA debit card, or a voided check at the time of service. This system is exactly like that found in hotels, rental car companies, and your mail order pharmacy. Nothing will be charged to your credit card or checking account until the Explanation of Benefits (EOB) returns from your insurance company and we can enter the contractual write-offs and amount paid by your insurance company into our system. The amount charged to your credit card or checking account will be the PATIENT RESPONSIBILITY portion as defined on your insurance company's EOB. You will receive an E-MAIL notification with the amount charged to your credit card or deducted from your checking or savings account. This will significantly reduce the costs of repeat statements and collection attempts. Thank you for your cooperation and understanding.

If you have questions about this process, you may contact our Billing Department @ 937-299-2587.

AUTHORIZATION TO CHARGE MY CREDIT CARD, HSA DEBIT CARD, CHECKING OR SAVINGS ACCOUNT FOR THE "PATIENT RESPONSIBILITY" OPTION OF MY INSURANCE PAYMENT.

I authorize Ohio Pediatrics, Inc. and Modern Payments, Inc. to charge my credit card, HSA debit card, or my checking or savings account with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB). If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company. I understand that the actual amount of the charge can be disputed only with my insurance company, and any change in the EOB by the insurance company will be reflected as a credit or additional charge on my credit card, HSA debit card, or directly in my checking/savings account.

PARENT
NAME: _____ SIGNATURE: _____

DATE: _____

CHILDREN'S
NAMES'/DOB _____

E MAIL ADDRESS:

****By providing your e-mail address we will be able to e-mail you a statement on the day we charge your patient balance to your credit card, HSA debit card, checking or savings account.**