The CHILD NEUROLOGY GROUP
of Community Care Physicians

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Richard Simmons, MD
Karen Powers, MD
Steven Hicks, PA-C

PATIENT NAME: _____
DOB: _____
APPOINTMENT DATE: _____
APPOINTMENT TIME: _____
ADDRESS: _____
_____

Dear Parent/Guardian of _____,
Thank you for choosing The Child Neurology Group of CCP. We look forward to seeing your son/daughter on _____.
Please remember to bring your child's insurance card, a form of ID for yourself, and the completed forms to the appointment.

Appointment Policy:
We require 24-hour notice if you are unable to make your scheduled appointment. We reserve the right to charge you if you fail to contact our office in a timely manner. We have a $50.00 no show fee for office visits and $100.00 for procedures. Please be advised that these charges are not covered by insurance companies. If you have to cancel or reschedule the appointment, please be sure to give us a call so you can avoid being charged a no-show fee.

For initial appointments please arrive 15 minutes prior to your scheduled appointment.
For established patients, please arrive a few minutes early to your appointment. This will help with the check in process. Please note that after two (2) no show or cancelations, the practice has the right to release you from our care and refuse any further medication refills.

While we do understand there are sometimes extenuating circumstances, if you are late to your appointment we reserve the right to reschedule you as this delay affects not only the providers but also other patients that may come after you.

If you are unable to reach us during regular business hours, you may leave a message with our exchange 24/7.

We look forward to seeing you,

The Child Neurology Group of CCP
Richard J. Simmons, MD
Karen Powers, MD
Steven Hicks, RPA-C