AGOURA-WEST VALLEY PEDIATRIC MEDICAL GROUP

FAMILY NAME……DATE……

Children: 1……M F Birthdate……..
2…….. M F Birthdate……..
3……..……..M F Birthdate…….....
4…… ...M F Birthdate……..
5……... M F Birthdate……..
6……...… M F Birthdate……..

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

PARENT #1: M F EMAIL: ……...
Responsible Party? Yes No Legal Guardian? Yes No Child's Primary Address? Yes No
Name…….D.O.B……..
Home Address……..Apt……..
City……. State……. Zip……..
Primary Phone (.....)..... SSN……..
Employer's Name/Address……..
Work Phone (.....)..... Ext…….

PARENT #2: M F EMAIL: ……...
Responsible Party? Yes No Legal Guardian? Yes No Child's Primary Address? Yes No
Name…….D.O.B……..
Home Address……..Apt……..
City……. State……. Zip……..
Primary Phone (.....)..... SSN……..
Employer's Name/Address……..
Work Phone (.....)..... Ext…….

Person to contact, in lieu of parents, in case of emergency

Name……... Relationship……
Home Address……..Apt……..
City……. State……. Zip……..
Primary Phone (.....).....
Referred By…….

No changes to above information

Date…… Date…… Date…… Date…… Date……

PLEASE COMPLETE OTHER PAGES ⅕

Agoura West valley pediatric medical group

All prescriptions are now sent electronically. Please give us your preferred pharmacy information for your child's future medications.

Pharmacy Name…….

Pharmacy Address…….

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Pharmacy Phone Number……...

PLEASE COMPLETE OTHER PAGES ⅖

Office Financial Policy

To accommodate the needs and requests of our patients, we have enrolled in numerous insurance plans. It is your responsibility to present your child's updated health insurance card at each visit if asked. If you do not have your child's health insurance card, or if another physician's name appears on the card, you will be asked to remit payment at the time of the visit. If we do not participate in your insurance plan, we ask that you pay in full at the time of service. We will provide you with a form suitable for filing a claim with your insurance company.

There is tremendous variation both between and within insurance plans regarding how often services can be rendered, as well as where and by whom they can be rendered. While we often know which facilities can be used by a health plan, it is nonetheless the patient's responsibility to know which hospitals, laboratories, and radiology facilities he/she may use. Unfortunately, if you do not inform us of any special requirements in your contract, and we subsequently order lab, x-ray, or hospitalization that is not covered with the selected provider by your plan, we or the selected facility will have no choice but to bill you directly for those charges. Payment for those services is then solely your responsibility.

You are responsible for deductibles, co-payments, non-covered services (including non-covered immunizations), coinsurance, and items considered "not medically necessary" by your insurance company. Copayments and coinsurance will be collected at the time of service. You agree to pay the remaining balance within one month of notice from the insurance company. If you or your insurance company makes a payment exceeding your balance, reimbursement will be remitted.

For those families in which parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible for payment, co-payment, or coinsurance at the time of service. If the divorce decree requires that the parent not-present pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Agoura-West Valley Pediatric Medical Group will not act as a mediator in collecting these payments.

There will be a charge of $50 for missed physical examination or extended-visit appointments without a 24-hour prior notification and a $35 charge for missed sick visit appointments.

If your child had a physical within one year, we will complete a school form and you will be charged $10 per form.

I understand that any amount due and owing over 30 days may accrue interest and finance charges monthly.

The undersigned, hereby agree to the office financial policy as stated above, and agree furthermore that in the event of default in the payment of any amount due, if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the costs of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

I have read and agree to the financial policy and release of information paragraphs stated above.

Patient or Responsible Party Signature…….. Date……..

PLEASE COMPLETE OTHER PAGES ⅗

CONSENT TO TREAT AND FINANCIAL AGREEMENT

Agoura-West Valley Pediatric Medical Group

I hereby consent to and authorize the performance of all treatments, surgery, and medical services by the physicians and staff which they may deem advisable and agree to pay all charges incurred by reason thereof. I also hereby authorize the release of information requested by my insurance company and/or its representatives. I fully understand that this agreement and consent will continue until canceled by me in writing. I hereby agree to disclose all coexisting medical insurance coverages and authorize my insurance companies to pay the Agoura West Valley Pediatric Medical Group directly any Medical, Surgical, or Major Medical benefits due to me for services rendered. A Photostat copy of this authorization is as legally acceptable as the original.

Signature…….. Date…….

TREATMENT AUTHORIZATION

I hereby authorize the physicians of Agoura-West Valley Pediatric Medical Group to administer medical treatment to my child(ren) in my absence. I agree to assume all the financial responsibility if I have no medical insurance, and all the financial responsibility required by my insurance company If I do have insurance.

Signature…….. Date……..

WAIVER FORM

Please print clearly

IF YOU ARE INSURED, PLEASE COMPLETE THE FOLLOWING

This is to certify that I am eligible for coverage with …….insurance company with an effective date of ……/……/…….I understand that if the above is not true, or if I am not eligible under the above plan, or if I fail to provide a current insurance card, I will be liable for all charges for services rendered.

Signature…….. Date……..

PLEASE COMPLETE OTHER PAGES ⅘

Acknowledgment of Receipt of Notice of Privacy Practices

Agoura-West Valley Pediatric Medical Group

I Hereby acknowledge that I received a copy of this medical practice's notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Print Name: .....Date: .....

Signature: ……Telephone: ……

If not signed by the patient, please indicate:

Relationship:

- Parent or Guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of patient(s):

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PLEASE COMPLETE OTHER PAGES 5/5