# AGOURA-WEST VALLEY PEDIATRIC MEDICAL GROUP

## PATIENT INFORMATION DATA

**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…………………………

**INSURANCE INFORMATION:** Please provide your insurance card to the receptionist

Insurance Company…………………………………………………………………………………...

Address……………………………………………………………………………………………

Insured/Cardholder's Name…………………………………………………DOB……………………………

Relationship to Patient……………………………………………………………………………..

Member ID#………………………………………………………………… Group#………………………………

**FATHER:**

Responsible Party? ☐ Yes ☐ No Legal Guardian? ☐ Yes ☐ No Child's Primary Address? ☐ Yes ☐ No

Name………………………………………………………………………… DOB……………………………

Home Address……………………………………………………………………… Apt……………………………..

City……………………………………………… State………………………….. Zip……………………………...

Home Phone (………)……………………….. Cell (………)…………………………..

Employer's Name/Address…………………………………………………………………………………..

Work Phone (………)………………………….. Ext…………………………… SSN……………………………

**MOTHER:**

Responsible party? ☐ Yes ☐ No Legal Guardian? ☐ Yes ☐ No Child's Primary Address? ☐ Yes ☐ No

Name………………………………………………………………………… DOB……………………………

Home Address……………………………………………………………………… Apt……………………………..

City……………………………………………… State………………………….. Zip……………………………...

Home Phone (………)……………………….. Cell (………)…………………………..

Employer's Name/Address…………………………………………………………………………………..

Work Phone (………)………………………….. Ext…………………………… SSN……………………………

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

Name………………………………………………………… Relationship……………………………………

Home Address……………………………………………………………………… Apt……………………………..

City……………………………………………… State………………………….. Zip……………………………...

Home Phone (………)……………………………..

**Referred by**………………………………………………………………………………………………

**No changes to above information**

Date…………… Date…………… Date…………… Date…………… Date……………

**PLEASE COMPLETE OTHER SIDE**

# AGOURA-WEST VALLEY PEDIATRIC MEDICAL GROUP

## Office Financial Policy

In order 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 may 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. You need only to complete your portion of the insurance claim form, attach our encounter form, and mail to 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, xray, 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. Co-payments 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 payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, please notify the front desk staff to make other arrangements.

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 24 hour prior notification and a $35 charge for missed sick visit appointments.

________________________________________

I understand that any amount due and owing over 60 days may accrue interest and finance charges of 1.5% per month, or 18% per annum.

I, 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 SIDE**

## CONSENT TO TREAT AND FINANCIAL AGREEMENT

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 co-existing 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

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## 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 of the financial responsibility if I have no medical insurance, and all of the financial responsibility required by my insurance company if I do have insurance.

______________________________________ ____________________

Signature Date

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## WAIVER FORM

Please print clearly

***IF YOU ARE INSURED, PLEASE COMPLETE THE FOLLOWING***

Name of Insured…………………………………………………………… SSN……………………………….

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