PREMIER PEDIATRICS
beverly hills

ANNUAL COMPREHENSIVE FAMILY PLAN 2026

At Premier Pediatrics Beverly Hills we are committed to delivering the highest quality care to our patients. We value the relationship we have with our families and understand the importance of contracting with as many insurance companies as possible. Many of the services we provide unfortunately are not covered by insurance. To ensure quality care, we charge our families an annual administrative fee. This administrative fee is necessary to support our dedicated and hard-working PPBH staff and enable us to continue providing the premier care that our families deserve and expect.

To maintain this level of care, our Annual Comprehensive Family Plan will renew on January 1st, 2026. For families that have already paid, we thank you for your continued support.

The annual cost for the 2026 Premier Pediatrics Comprehensive Family Plan is:

- Families with one child $300.00 per year
- Families with two children $400.00 per year
- Families with three or more children $450.00 per year

We are honored that you have chosen Premier Pediatrics Beverly Hills to be your family's pediatric medical home!

Michael Sachs, MD | Lisa Hauselman, MD | Nicole Nourmand, MD | Lauren Meepos, MD | Susan Schreiber, MD

8907 Wilshire Boulevard, Suite 250, Beverly Hills, California 90211 | ph: 310.247.8687 | fax: 310.859.9131 | www.premierpedsbh.com

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I understand that the Annual Comprehensive Family Plan must be renewed and paid yearly in order to continue receiving the benefits of the Plan.

INITIAL HERE _____

New families and new patients to PPBH will have their Annual Comprehensive Family Plan payment pro-rated. All other established patients will be charged the full fee regardless of when they enroll.

INITIAL HERE _____

I have read the information on the preceding page and understand and agree to the terms of the Premier Pediatrics Annual Comprehensive Family Plan.

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Payment may be made by mailing back this form with a check or credit card information below, through our patient portal, or online at:

www.premierpedsbh.com/paymybill

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER ☐ OTHER:_____

Cardholder's Name: _____

Card Number: _____

CVC Number: _____ (3 or 4 digits on the back)

Expiration Date: _____/_____ Signature: _____ REV 10/25

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