PREMIER PEDIATRICS
beverly hills

PATIENT REGISTRATION FORM

PERSONAL DATA DATE ____/____/____

CHILD'S NAME _____ DOB _____ SEX _____

BEST DAYTIME PHONE _____

PARENT #1 _____ DOB _____ SS# _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DRIVER'S LICENSE NUMBER _____ EMAIL ADDRESS _____

OCCUPATION _____

PLACE OF EMPLOYMENT _____

PARENT #2 _____ DOB _____ SS # _____

ADDRESS (if different from above) _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DRIVER'S LICENSE NUMBER _____ EMAIL ADDRESS _____

OCCUPATION _____

PLACE OF EMPLOYMENT _____

EMERGENCY CONTACT **OTHER THAN PARENT** _____

RELATIONSHIP _____ PHONE _____ ALTERNATE PHONE _____

REFERRED TO ☐ SUSAN SCHREIBER, MD ☐ MICHAEL SACHS, MD ☐ LISA HAUSELMAN, MD
☐ NICOLE NOURMAND, MD ☐ LAUREN MEEPOS, MD

REFERRED BY _____

INSURANCE COMPANY _____

PHARMACY & PHONE NUMBER _____

ALLERGIES _____

CHILD'S SCHOOL _____

PREMIER PEDIATRICS
beverly hills

CONSENT FOR TREATMENT

PATIENT'S NAME _____ DATE OF BIRTH _____/_____/_____

Please sign only **one** of the following two statements:

I authorize Drs. Sachs, Schreiber, Hauselman, Nourmand, or a covering doctor to render any medical care necessary to my child. If I am not available**, I authorize in advance that care may be** rendered in my absence with only the people listed below.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please list any restrictions to the above statement: _____

Parent/ Legal Guardian Signature _____ Date _____

I authorize Drs. Sachs, Schreiber, Hauselman, Nourmand or a covering doctor to render any medical care necessary to my child. If I am not available and no other legal guardian is available at the time my child is brought to the office, **I do not authorize in advance that care may be rendered in my absence.** I understand that by signing below the doctors will not see my child unless a parent or legal guardian is present.

Parent/ Legal Guardian Signature _____ Date _____

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

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

PREMIER PEDIATRICS
beverly hills

FINANCIAL POLICY

PATIENT'S NAME _____ DATE OF BIRTH ____/____/____

The doctors at Premier Pediatrics Beverly Hills contract with most insurance PPO plans. However, it is my responsibility to understand the benefits provided in my insurance plan. I am responsible for insurance copayments at the time of my visit, and I am also responsible for any outstanding balance once my insurance claim has been processed.

Signature _____ Date _____

Relationship _____

I authorize release of any medical information to my insurance carrier necessary for processing of claims.

Signature _____ Date _____

Relationship _____

I authorize payment of medical benefits directly from my insurance carrier to the treating physician for services provided.

Signature _____ Date _____

Relationship _____

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

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

PREMIER PEDIATRICS
beverly hills

CANCELLATION FEE POLICY

Our goal is to provide your child with excellence and timely medical care. When a patient does not show up for an appointment or cancels at the last minute, another patient is denied an opportunity for medical attention. In an effort to address this problem, we have decided to institute a cancellation fee. If you are unable to keep your appointment, kindly notify us at least 24 hours in advance.

We appreciate your understanding.

I understand and agree to the following:

- I will contact the office 24 hours prior to any appointment I will be unable to keep.
- I understand that I will be billed **$50** if I miss an appointment or fail to give 24 hours' notice before canceling an appointment.

Patient name _____

Signature _____

Date _____

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

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

PREMIER PEDIATRICS
beverly hills

FINANCIAL POLICY

Thank you for choosing Premier Pediatrics Beverly Hills as your child's medical home. We are committed to providing the highest quality comprehensive care for your child. The purpose of this document is to ensure that you are fully informed regarding our financial policies. Should you have any questions or need any clarification, please do not hesitate to ask a member of our office staff.

Please understand that your insurance policy is a contract between you and your insurance company. As a service to you, we will request payment from your insurance company. This requires having accurate and up-to-date insurance information on file, so please notify us of any changes to your policy. Once your insurance company has processed the claim, you are responsible for any remaining balance. Patient responsibility includes co-payments, co-insurance, and deductible amount and is determined by your contract with the insurance company.

- **Co-pays and any outstanding balances will** be collected at the time of service.
- We will always provide your child with, what we consider the best and most up-to-date medical care, some insurance plans limit coverage of procedures and services in order to control their costs. As a result, certain services we may provide for your child may not be reimbursed by your plan. Except as provided by your insurance contract or by state law, you will be responsible for all **non-covered services**.
- **If you believe your insurance company** has made an error in processing a claim, we ask that you contact your insurance company as soon as possible. If your company determines that an error has been made, please contact our billing staff so that we can resubmit the claim.
- **Outstanding charges** are due upon receipt of the first billing statement. For outstanding charges not paid within 90 days, we reserve the right to discontinue scheduling well visits. Outstanding charges not paid within 120 days will be sent to our collection agency and may be reported to the major credit bureaus. Once an account has been sent to the collection agency, care in our office will be discontinued for all family members.
- **If you are experiencing financial difficulties,** please contact our billing department to discuss installment payments. A regular monthly payment schedule can avoid collection procedures and enable continuation of care in our office.
- **Additional issues** addressed at well check appointments may need to be reported and billed separately. Your company may require that a separate co-payment be paid for additional services provided at the visit.
- There is a $50 **late cancellation/no show** charge for appointments canceled with less than 24-hour notice.
- **Checks returned for insufficient funds** will result in a service charge of $35 being added in addition to the original billed amount.
- **Saturday** appointments will be billed an after-hours fee to cover overtime staffing expenses. If your insurance company does not cover this fee, you will be responsible for payment.
- **Annual Comprehensive Family Plan** will be provided under separate cover.

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

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

PREMIER PEDIATRICS
beverly hills

FINANCIAL POLICY ACKNOWLEDGEMENT

Please be advised that this policy is subject to modification at any time without notice, though we will do our best to keep your family informed of any significant changes.

I acknowledge receipt of the Premier Pediatrics Beverly Hills Financial Policy that went into effect on February 1, 2015.

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

Patient Name(s): _____ DOB: _____

Patient Name(s): _____ DOB: _____

Patient Name(s): _____ DOB: _____

Patient Name(s): _____ DOB: _____

Patient Name(s): _____ DOB: _____

Patient Name(s): _____ DOB: _____

Patient Name(s): _____ DOB: _____

Patient Name(s): _____ DOB: _____

Susan Schreiber, MD | Michael Sachs, MD | Lisa Hauselman, MD | Nicole Nourmand, MD | Karen Hovav, MD | Alison Faber, DO

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

PREMIER PEDIATRICS
beverly hills

CREDIT CARD ON FILE AGREEMENT

Premier Pediatrics now offers the ability for families in our practice to securely store a Credit Card On File (CCOF) which will simplify billing and be used to pay outstanding balances. Once an insurance company has processed and paid their portion of a claim, there is often a patient (parent/guarantor) responsibility for an additional amount due to:

- Deductible not yet being met
- Co-pay or Co-insurance being applied to the charges
- Insurance company deeming a service not a covered benefit
- Insurance policy not being in effect on the date of service
- Newborn or older child not being added to the policy

After the insurance company processes the claim and issues an Explanation of Benefits (EOB), a billing statement will be sent by our office to the postal address of the guarantor on file in our system requesting payment of any unpaid charges. Any outstanding balance remaining three weeks later will be automatically charged to the CCOF and an email receipt sent to the card holder. If you have any questions regarding the balance shown on your EOB please call our billing office before the card is charged. Prior to the card being charged, payment may be made by postal mail, phone, or online at ppbhmd.com/paymybill.

For your convenience, the card on file will also be used to pay for charges not billed to insurance such as for school and camp forms, copying of medical records, and missed appointments. At the time of a visit, your CCOF may also be used to pay your co-pay or deductible due per your insurance contract or you may choose another form of payment accepted by our office.

This agreement does not restrict your right to appeal any charge made to your credit card. Should you feel that an error was made with any charge to your card, you may contact our billing office. Please do not hesitate to ask a member of our staff if you have any questions regarding this policy.

AUTHORIZATION

By signing below, I authorize Premier Pediatrics Beverly Hills' credit card processor to keep a credit card on file that may be used for future payments. Additionally, I authorize Premier Pediatrics Beverly Hills to charge any unpaid balance on my account according to the terms in this agreement. If my billing statement address changes or my credit card is canceled or re-issued with a new account number, I will notify Premier Pediatrics Beverly Hills as soon as possible. If my card is declined I will pay the balance owed on the account through other means.

Parent/Guarantor Name	Signature	Date

Name(s) of Patient(s)

Susan Schreiber, MD | Michael Sachs, MD | Lisa Hauselman, MD | Nicole Nourmand, MD | Karen Hovav, MD | Alison Faber, DO

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