VALLEY PEDIATRIC MEDICAL GROUP, Inc.

Patient Registration Form

Primary Physician:_____

Patient: _____Date of Birth:____/____/____ Sex: M F

Patient: _____Date of Birth:____/____/____ Sex: M F

Patient: _____Date of Birth:____/____/____ Sex: M F

Patient: _____Date of Birth:____/____/____ Sex: M F

Mailing Address:

Street:_____City:_____State:___ Zip:____

Primary Contact:_____Phone Number: (____) ____-____

Parent 1: Name:_____Relation to Patient:_____

Lives with patient? Yes No Date of Birth:____/____/____ SSN#_____

Street:_____City:_____State:___ Zip:____

Cell Phone: (____) ____-____ Work Phone: (____) ____-____

Email Address:_____

Employer:_____Occupation:_____

Parent 2: Name:_____Relation to Patient:_____

Lives with patient? Yes No Date of Birth:____/____/____ SSN#_____

Street:_____City:_____State:___ Zip:____

Cell Phone: (____) ____-____ Work Phone: (____) ____-____

Email Address:_____

Employer:_____Occupation:_____

Emergency Contact (other than parents) Name & Relationship:

Name:_____

Street:_____City:_____State:___ Zip:____

Phone Number: (____) ____-____Relation to Patient:_____

Insurance Information

Payment of copays and/or deductible is due at the time service is rendered.

Primary Policy Holder's Name:_____SSN#_____

Policy Holder's Date of Birth:____/____/____ Policy Holder's Sex: M F

Insurance Carrier:_____

ID#_____ Group#_____

Secondary Policy Holder's Name:_____SSN#_____

Policy Holder's Date of Birth:____/____/____ Policy Holder's Sex: M F

Insurance Carrier:_____

ID#_____ Group#_____

Authorization for Treatment and Assignment of Insurance Benefits.

I. the undersigned hereby authorize the Doctors and staff at Valley Pediatric Medical Group, Inc. to treat the medical condition(s) of my child(ren), and further authorize my signature below for use on any and all insurance claims submitted on our behalf for such services. I. hereby irrevocably accept financial responsibility for all medical and related services received while under medical care and assign any and all insurance benefits otherwise payable by the insurance company for said services. I. the undersigned understand that I am financially responsible for any and all charges not covered by insurance, and further understand that payment for services received are due at the time service are rendered.

Signature of Parent or Guardian:_____ Date:_____

How would you prefer to be contacted regarding (circle one):

Medical Issues': *Mail Address/Home Phone/ Work Phone/ Cell Phone/ Text to Cell/ Home Email*

Appointment Reminders: *Home Phone/ Work Phone/ Cell Phone/ Text to Cell/ Home Email*

Recall Notices: *Mail Address/Home Phone/ Work Phone/ Cell Phone/ Text to Cell/ Home Email*

Billing Statements: *Mail Address/ Home Email/ Work Email*

General Practice Notices: *Mail Address/Home Phone/ Cell Phone/ Text to Cell/ Home Email*

Patient Portal Notifications: *Text to Cell/ Home Email/ Work Email*

Contact Privacy Restraints:

OK to send: Text Messages/ Email/ Fax Yes/ No

Referred By:_____

VALLEY PEDIATRIC MEDICAL GROUP

5353 Balboa Boulevard
Suite 104
Encino, CA 91316
Telephone: (818) 789-7181
Fax: (818) 986-8322

Peter R. Shulman, M.D., F.A.A.P.
Marie T. Medawar, M.D., F.A.A.P.
Lynn S. Osher, M.D., F.A.A.P.
Louay Keilani, M.D., F.A.A.P.

WHO MAY WE SHARE MEDICAL INFORMATION WITH ON BEHALF OF YOUR CHILD?

CHILD'S NAME: _____ DOB: _____

PARENT(S) NAME: _____

SIBLING(S) NAME: _____

GRANDPARENT(S) NAME: _____

NANNY'S/BABYSITTER'S NAME: _____

SCHOOL: _____

(Indication of school specifically allows us to disclose medical information regarding immunizations/shots/and/or medications allowed to be administered during the school day).

OTHER: _____

OTHER: _____

WHERE MAY WE LEAVE MEDICAL INFORMATION REGARDING YOUR CHILD NAMED ABOVE?

HOME PHONE ANSWERING MACHING: **Y** OR **N** PHONE #_____

OFFICE VOICE MAIL: **Y** OR **N** PHONE #_____

CELL PHONE VOICE MAIL: **Y** OR **N** PHONE #_____

PARENT SIGNATURE: _____ DATE: _____

Valley Pediatric Medical Group

5353 Balboa Blvd. Suite 104

Encino, CA 91316

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 a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

☐ Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

_____

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

VALLEY PEDIATRIC MEDICAL GROUP, INC.

FINANCIAL POLICY

Welcome to Valley Pediatric Medical Group! We are glad you have chosen us as your child's pediatrician and we strive to give your children the best in medical care. We understand that in addition in needing to feel comfortable with your child's s physician, many parents have concerns about the financial policies of the practice. This information is designed to answer frequently asked questions.

- Valley Pediatric Medical group is contracted with most PPO insurance plans.
- Please bring your insurance card with you at each visit. Notify the office if your insurance has changed.
- As courtesy to you, we will file your child's insurance claim for you.
- All co-payments, co-insurance, deductible, etc. must be paid at the time of service.
- It is your responsibility to know your insurance benefits.
- Any services provided to a parent, grandparent, or any adult are collected in full at the time of service. We will not bill your insurance, but will provide you with a form suitable for filing with your insurance.
- To avoid a $50.00 dollar no-show fee, it is required that you cancel appointments 24 hours in advance.
- We charge $25.00 to copy medical records.
- Valley Pediatric Medical Group is happy to complete any camp/school forms if your child has had a physical in the last 12 months. Non urgent forms will be completed within 3-5 business days and are $5.00 to complete. Urgent forms can be completed on the same day for $15.00.
- If during a well-child physical a diagnosis is identified that requires further management and treatment, there will be an additional fee for the service.
- We do perform certain lab tests in our office. If your pediatrician orders a lab test that is not done in our office, you will receive a separate bill from the lab chosen.

For your convenience, we accept cash, check, and all major credit cards. Our business office staff will be happy to answer any questions that you have, please call (818) 788-1716. Non-compliance with this policy may result in transfer of care to another practice.

I understand and agree to the above financial policy.

Date_____

Signature of responsible Parent/Guardian_____

Child/Children's name_____