PREMIER PEDIATRICS
beverly hills

PATIENT REGISTRATION FORM

Thank you for completing in full

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 _____ E-MAIL 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 _____ E-MAIL 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

REFERRED BY _____

INSURANCE COMPANY _____

PHARMACY AND PHONE NUMBER _____

ALLERGIES _____

CHILD'S SCHOOL _____

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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 and no other legal guardian is available at the time my child is brought to the office, I authorize in advance that care may be rendered in my absence.

Please list any restrictions to the above statement: _____

Signature _____ Date _____

Relationship _____

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.

Signature _____ Date _____

Relationship _____

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FINANCIAL INFORMATION AND AUTHORIZATION

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 S. Schreiber, MD, Michael K. Sachs, MD
Lisa S. Hauselman, MD, Nicole Nourmand, MD
8907 Wilshire Blvd #250
Beverly Hills, CA 90211

Cancellation Fee Policy

Our goal is to provide your child with excellent 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:

1. I will contact the office 24 hours prior to any appointment I will be unable to keep.

2. 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 _____

* This policy does not apply to same day sick visits.

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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.
- **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.
- **School, camp, athletic and other similar forms** will be assessed a charge of $10 per form, per child. More complicated forms, letters, prescriptions, or authorizations may result in additional charges (a cost estimate will be provided prior to completion). An additional $10 per form will be charged when the document(s) must be completed in less than 48 hours.
- The initial copy of your child's **immunization record** is provided free of charge. However, additional copies will be assessed a charge of $10.
- **Copies of medical records** will be assessed a charge of $20 each per child.
- 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 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.

Susan Schreiber, MD | Michael Sachs, MD | Lisa Hauselman, MD | Nicole Nourmand, 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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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 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: _____

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