Account #

Coastal Pediatric Medical Group, Inc.

Pediatric and Adolescent Medicine

451 W. Gonzales Rd., Suite 340
Oxnard, CA 93036
(805) 983-3900

100 N. Brent St., Suite 102
Ventura, CA 93003
(805) 643-9271

Patient Information

Name _____

Home Address _____

City _____

State _____ ZIP _____

Home Phone _____

Date of Birth _____ Age _____

Sex(M/F) _____

Father's Name _____

Address _____

City _____

State _____ ZIP _____

Home Phone _____ Cell Phone _____

Date of Birth _____ SS # _____

Employer _____

Business Address _____

City _____

State _____ ZIP _____

Work Phone _____

Occupation _____

Mother's Name _____

Address _____

City _____

State _____ ZIP _____

Home Phone _____ Cell Phone _____

Date of Birth _____ SS # _____

Employer _____

Business Address _____

City _____

State _____ ZIP _____

Work Phone _____

Occupation _____

Medical Insurance Information For Child

Insurance Company _____

Address _____

Phone Number _____

IPA/Medical Group _____

Subscriber Name _____

I.D. Number _____

Group Number _____

Child's Primary Care M.D. _____

Eff. Date _____ Co-pay _____

List names of siblings (first and last names)

_____

_____

_____

_____

Referred By _____

In Case Of Emergency

Emergency Contact _____

Phone Number _____

Authorization to Pay Benefits to Physician

I hereby authorize payment directly to Coastal Pediatric Medical Group, Inc. for services rendered or supplies provided. I understand that I am responsible for paying any amount not covered by my child's primary insurance.

Coastal Pediatrics does not bill secondary insurances.

Authorization to Release Medical Information

I hereby authorize release of any medical or other information necessary to process any claims.

Payment Terms

Cash payment or proof of insurance is required at time of service. Co-pay must be paid before seeing the doctor.

Signature _____

Date _____

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____ _____ _____ _____ (an adult into whose care the minor has been entrusted) to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of _____ _____ (name of minor) deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code 6910.

Signed: _____ _____ _____

Date: _____

Please specify relationship to minor:

( ) parent with legal custody
( ) guardian with legal custody

COASTAL PEDIATRIC MEDICAL GROUP, INC.

Office Policies and Patient Responsibilities

Patient's Name: _____

CONTRACTED INSURANCE PLANS (HMO, PPO, MANAGED CARE): An insurance card, as proof of coverage, must be presented prior to treatment. If benefits cannot be verified, your payment will be expected at the time of service.

COPAYMENTS are due at the time of service.

If your insurance plan has a **DEDUCTIBLE** you will be asked to pay at the time of service until the deductible amount, set by your insurance carrier, has been met.

Coastal Pediatrics will submit to your insurance carrier a claim for all services rendered by our physicians and staff and will accept their contracted payment for those services. If your insurance carrier does not honor that claim within 45 days you will be advised of this breech of contract.

Payment in full is expected at the time of service for **"non-covered" benefits** of your insurance plan.

CASH OR NON-CONTRACTED INSURANCE PLANS: Payment in full is expected at the time of service unless specific payment arrangements are made with our business office prior to your appointment.

OUR OFFICE SEES PATIENTS BY APPOINTMENT ONLY. Please call our office to schedule an appointment whenever your child needs to be seen by the doctor. If you are more than 15 minutes late for an appointment, it may have to be rescheduled.

MISSED APPOINTMENTS: Always call our office to cancel or reschedule any appointment you cannot keep. **No show appointments will be charged a $20 fee.** If your family account has three missed appointments documented, Coastal Pediatrics reserves the right to discontinue care of your children.

RETURNED CHECK: A $35 fee will be charged for any returned check.

DELINQUENT ACCOUNTS will be reported to a collection agency after 60 days.

RELEASE OF MEDICAL RECORDS: A fee will be charged for the copy and release of a patient's medical record - $15 fee if the records are to be mailed and $10 fee if picked up in one of our offices.

MINOR PATIENTS (UNDER 18 YEARS OF AGE): Per California law, all minors must be accompanied by a parent or guardian for treatment in our office. If the parent cannot be present, written authorization for treatment must be given prior to any appointment.

PRIVACY NOTICE ACKNOWLEDGEMENT: I have received Coastal Pediatrics' Privacy Notice_____ (Please initial)

_____ _____

Parent's Signature Date

COASTAL PEDIATRIC MEDICAL GROUP, INC

Póliza del Consultorio y Responsabilidades del Paciente

Nombre del Paciente _____

PLAN DE SEGURO CONTRATADO (HMO, PPO, CUIDADO DIRIGIDO): Para comprobar su cobertura, debe presentar la tarjeta de seguro antes del tratamiento. Tendrá que pagar al momento que se le provee el servicio si no se pueden verificar sus prestaciones.

PAGOS AUXILIARES se deben entregar al momento de recibir el servicio.

Si su plan de seguro tiene **un DEDUCIBLE** entonces le pediremos a usted que siga pagando en el momento de recibir servicio hasta que cumpla con la cantidad del deducible fijada por parte de su compañía de seguros.

Coastal Pediatrics le presentará a su compañía de seguros primaria un reclamo por todos los servicios desempeñados por parte de nuestros médicos y personal y aceptara el pago acordado por contrato para esos servicios. Si su compañía de seguros no cumple con el reclamo dentro del plazo de tiempo de 45 días se le avisara a usted del incumplimiento de contrato.

Coastal Pediatrics no les cobrara a los seguros auxiliares.

Tendrá que pagar el pago completo al momento de recibir servicio **por "beneficios no cubiertos"** por su plan de seguro.

Coastal Pediatrics actualmente no acepta Medi-Cal.

DINERO EN EFECTIVO O PLANES DE SEGURO SIN CONTRATO: Tendrá que hacer el pago completo al momento de recibir el servicio a menos que arreglos de pago se hagan por adelantado con la oficina antes de su cita.

NUESTRA OFICINA SOLO ACEPTA PACIENTES CON CITA. Por favor comuníquese con nuestra oficina para programar una cita en cualquier momento que su hijo necesite ver al doctor. Si usted llega más de 15 minutos tarde a una cita entonces cabe la posibilidad de que tendremos que citarlo de nuevo.

CITAS PERDIDAS: Siempre llame a nuestra oficina para cancelar o programar cualquier cita a la que usted no pueda presentarse. **Se le cobrara $20 por cada cita a la que no se presenta.** Si la cuenta de su familia muestra tres citas perdidas entonces Coastal Pediatrics tiene el derecho de discontinuar el cuidado de sus hijos.

CHEQUE DEVUELTO: Se le cobrara a usted $35 por cualquier cheque sin fondos que sea devuelto por el banco.

CUENTAS DELINCUENTES serán reportadas a una agencia de cobros después de 60 días.

CONCESIÓN AL ENTREGO DE ARCHIVOS MÉDICOS: Cobraremos por la copia y el entrego de los archivos médicos de un paciente – será una tasa de $15 si los archivos son enviados por correo y $10 si son recogidos en el consultorio.

PACIENTES MENORES DE EDAD (MENOS DE 18 AÑOS): Conforme a la ley de California, todo menor debe ser acompañado por el padre o guardián de tutela para poder recibir tratamiento en nuestro consultorio. Si el padre no puede estar presente con el menor entonces tendrá usted que dar una autorización por escrito antes de la cita.

RECONOCIMIENTO DE AVISO DE PRIVACIDAD: Yo he recibido el Aviso de Privacidad de Coastal Pediatrics _____ (Por favor escriba sus iniciales)

_____ _____

Firma del Padre **Fecha**