



PATIENT REGISTRATION FORM

Thank you for completing in full

Date: _____

PERSONAL DATA

CHILD'S NAME: _____ DOB: ____ / ____ / ____ SEX: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BEST DAYTIME PHONE : _____

PARENT #1 NAME: _____ DOB: ____ / ____ / ____ SS# _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____ CELL PHONE: _____

DRIVERS LICENSE NUMBER: _____ STATE: _____

PARENT #2 NAME: _____ DOB: ____ / ____ / ____ SS# _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____ CELL PHONE: _____

DRIVERS LICENSE NUMBER: _____ STATE: _____

Child's parents are: Married ___ Divorced ___ Never married ___ Separated ___ Widow(er) ___ Other ___

SIBLINGS:

NAME: _____ DOB: ____ / ____ / ____

NAME: _____ DOB: ____ / ____ / ____

NAME: _____ DOB: ____ / ____ / ____

NAME: _____ DOB: ____ / ____ / ____

E-MAIL ADDRESS _____

WOULD YOU LIKE TO RECEIVE MONTHLY STATEMENTS VIA E-MAIL? YES NO

EMERGENCY CONTACT: _____ PHONE: _____

INSURANCE INFORMATION

Name of Insurance Company: _____

Address for submitting claims: _____

Who is the policy holder? _____ DOB: ____ / ____ / ____

Policy ID # _____ Group # _____

PLEASE BE SURE TO HAVE OUR FRONT OFFICE COPY YOUR CURRENT INSURANCE I.D. CARD. IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES. THANK YOU

MEDICAL HISTORY

NAME: _____ DOB: ____ / ____ / ____

PLACE OF BIRTH: _____ BIRTH WEIGHT: _____

ANY PROBLEMS AT BIRTH? (e.g. jaundice, prematurity)

FAMILY HISTORY

Please answer yes/no to the following conditions as related to your immediate family. If you answer yes, please provide any comments and who in the family is affected.

DIABETES YES NO COMMENTS: _____

SEIZURES YES NO COMMENTS: _____

ALLERGIES YES NO COMMENTS: _____

HEART DISEASE YES NO COMMENTS: _____

HIGH BLOOD PRESSURE YES NO COMMENTS: _____

ELEVATED CHOLESTEROL YES NO COMMENTS: _____

CANCER YES NO COMMENTS: _____

ALLERGIES

Allergic to any medications? _____ reaction? _____

other allergies (environmental/food/pets)? _____ reaction? _____

HEALTH AND MEDICAL HISTORY (if applicable)

Please list and describe any important injuries, illnesses, hospitalizations, surgeries or development concerns, and when they occurred:

MEDICATIONS Please list medications your child is currently taking and the reason :

Name of Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



MEDICAL CONSENT and OFFICE POLICIES

HOURS OF OPERATION

Monday through Friday 9:00am - 12:00 noon and 1:00pm - 5:00pm

Our office is located at the corner of Wilshire and Le Doux, one block west of La Cienega. Valet parking is available in the building. You may also park on the street in the surrounding neighborhood. Be sure to read the parking signs carefully. Please allow adequate time to get to your appointment.

If you have a question, we encourage you to call our office during office hours. Our experienced nurses are trained to help you. If you need to speak with your doctor, your call will be returned between patients, during lunch and after 5:00pm. When the office is closed, one of our doctors is always available by phone. Please call the office and listen to the entire message. It will instruct you on how to reach the doctor on call. We appreciate that our patients recognize that when the office is closed, it is our time to spend with family and friends. Thank you for only calling after hours for matters that cannot wait until the next business day.

Please visit our website at www.beverlyhillspediatrics.com. It has helpful hints on common illnesses and standard tables for medications.

FINANCIAL POLICIES

We will bill your insurance company after each visit. It is your responsibility to keep your insurance and personal information current in our files. Copays must be paid at the time of service. This is a contractual agreement that you have with your insurance company. After your visit charges have been reconciled with your insurance, you will receive a billing statement from our office. Any balance remaining on your account for services not covered by your insurance company is your responsibility. The amount on this statement will reflect your balance, and that balance is payable on receipt. We send bills on the third of each month. A \$25.00 late fee will be automatically added to your bill for every 30 days your payment is late.

We do offer an E-Z pay option. You can keep your credit card on file and your balance will be automatically charged to your account on the 15th of the month. You will still receive a statement from our office. Please complete the E-Z Pay Agreement form and give to one of our front office coordinators.

We do not verify insurance coverage. You will need to call your carrier and verify our participation in your network to determine your coverage. We also suggest that you familiarize yourselves with your insurance policy regarding well check-ups as well as all coverage limitations. We are pleased to bill your insurance for you, if your information is current in our system. Please be sure to notify us of any changes in insurance, address or phone numbers. Remember newborns must be added to your insurance plan within the first 30 days after birth.

Beverly Hills Pediatrics Annual Family Fee is due June 1st of each calendar year. This fee will be prorated your first year at the practice. For detailed information please visit our website at www.beverlyhillspediatrics.com

You can reach our billing department Tuesday - Thursday from 7:00am - 5:00pm at 713-896-3131 or at billing@beverlyhillspediatrics.com.

APPOINTMENTS

In order to see all of our patients on time (or even early), we encourage our patients to arrive 15 minutes prior to the scheduled appointment time. Patients who arrive more than 15 minutes late will be rescheduled. In order to receive your preferred date and time for your well-child visits, we ask that you schedule your appointments 4 to 8 weeks in advance. Please give us a minimum of two weeks to complete and return school and camp forms.

All appointments must be scheduled including sick visits. Sick visits can be booked and seen on the same day. There is a \$35.00 charge to be seen without first scheduling an appointment. We have two entrances to our office. Please be sure to enter through the "not so well" entrance door when your child is sick.

Failure to appear for a scheduled well child appointment will result in a \$50.00 charge. Canceling less than 24 hours prior to a scheduled appointment will result in a \$25.00 charge.

If your child is experiencing a life-threatening emergency call 911 or go immediately to your nearest emergency room.



MEDICAL CONSENT AND OFFICE POLICY AGREEMENT

I hereby authorize examination and whatever services deemed necessary by Beverly Hills Pediatrics, Scott Cohen, MD and Bess Raker, MD and Associates.

I have read and understand the office policies. I hereby authorize all insurance benefits to be paid directly to Beverly Hills Pediatrics for services rendered. I understand that I am responsible for charges as designated by my insurance company (e.g. deductibles, coinsurance, and copays). I am also responsible for charges not covered by insurance including but not limited to, the annual family fee, emergency medication administered in the office, telephone management, charges for missed appointments or finance fees occurred on late balance. I authorize Beverly Hills Pediatrics, Scott Cohen, MD, Bess Raker, MD and Associates to release information to my insurance company when requested. I have also received a copy of my privacy notice that describes how medical information about my child may be used and disclosed and how I can access this information.

NOTICE TO CONSUMERS

**Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov**

Name of Parent/ Guardian

Name of Child

Signature

Date



March 2010

I agree to Beverly Hills Pediatrics Administrative Fee. I understand that this fee is for items and services not covered and not reimbursed by my insurance plan.

The cost of the annual administrative fee is:

- Families with 1 child : \$150.00 per year
- Families with 2 children: \$250.00 per year
- Families with 3 or more children: \$300.00 per year

This fee will be paid in full by June 1st of each year, beginning June 1, 2010.

Please list your child/children below.

_____/_____/_____
Child's Name Date of Birth

_____/_____/_____
Child's Name Date of Birth

_____/_____/_____
Child's Name Date of Birth

_____/_____/_____
Child's Name Date of Birth

Enclosed is my payment of \$_____

_____/_____/_____
Printed Name Signature Date

If you would like to pay by credit card, please complete section above.

Please return entire form with your payment.

I have an E-Z pay account. Please charge my credit card on file at the office: _____
Initials

If you choose to decline, Beverly Hills Pediatrics will forward a copy of your medical records to your new pediatrician with your written request. If you should change your mind in the future, you will always be welcomed back. If you need assistance locating another pediatrician in the area, you can call 1-800-CEDARS-1 for referrals or our billing department can provide you with names of other pediatricians.



Dear Parents,

We are pleased to offer automatic debit services to easily pay your statements at Beverly Hills Pediatrics. If you elect to use this service, just complete this form and return to our office. Your family statements will continue to be mailed to you monthly, but we will automatically charge your balance to your credit card on the 15th of each month.

We hope this new service will be beneficial. **Please complete form and fax to 310-854-0440.**

PATIENT EASY PAY CONSENT FORM

I AUTHORIZE Beverly Hills Pediatrics to charge the below listed credit card for balances not paid or covered by my insurance carrier. My family balance will be charged on the 15th of each month to this card beginning the 15th after my dated signature.

I understand that this authorization will be valid thru the expiration of my credit card, unless I cancel this authorization through written notice.

Cardholder Name

Billing Address

Billing Zip

_____ MC VISA
Account Number

Expiration Date

CVV (three digits located on back of card at signature)

My children at Beverly Hills Pediatrics are listed below

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Cardholders Authorized Signature

____/____/____
Date

FOR OFFICE USE ONLY

Scanned to billing department - _____ initials/date

Scanned into children's chart - _____ initials/date