AVIVA D. BIEDERMAN, M.D.
RICHARD E. MILLER, M.D.
JENNIFER N. OUCHI, M.D.
INFANTS - CHILDREN - ADOLESCENTS
8635 WEST THIRD STREET, SUITE 260-W
LOS ANGELES, CA 90048

PATIENT'S NAME_____ DATE OF BIRTH_____

SOCIAL SECURITY NUMBER_____ MALE_____ FEMALE_____

REFERRED TO THIS OFFICE BY_____

HOME ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ ALTERNATE PHONE_____

FATHER'S NAME_____ OCCUPATION_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

EMPLOYER_____ BUSINESS PHONE_____

ADDRESS_____

INSURANCE_____ POLICY_____ GROUP_____

MOTHER'S NAME_____ OCCUPATION_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

EMPLOYER_____ BUSINESS PHONE_____

ADDRESS_____

INSURANCE_____ POLICY_____ GROUP_____

IN CASE OF EMERGENCY, NEAREST RELATIVE TO CONTACT:

NAME_____ ADDRESS_____

PHONE_____ RELATIONSHIP_____

IN MY ABSENCE, I AUTHORIZE AVIVA D. BIEDERMAN, M.D. AND/OR HER ASSOCIATES TO PROVIDE ALL MEDICAL CARE NECSSARY FOR THE WELFARE OF MY CHILDREN. IT IS THE POLICY OF THIS OFFICE THAT THE PARENT PRESENTING THE CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF THE CO-PAYMENT AT THE TIME OF SERVICE AS WELL AS ANY CHARGES DEEMED PAYABLE BY THE INSURANCE COMPANY. INFORMED CONSENT IS HEREBY GIVEN FOR ANY AND ALL PROCEDURES NECESSARY FOR TREATMENT IN WHICH THERE MAY BE UN-FORESEEN EFFECTS.

I HAVE READ AND UNDERSTAND THE ABOVE.

PARENT OR LEGAL GUARDIAN_____ DATE_____

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FOR INSURANCE PURPOSES, PLEASE SIGN BELOW

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I AUTHORIZE PAYMENT OF BENEFITS TO AVIVA D. BIEDERMAN, M.D. A MEDICAL CORPORATION FOR MEDICAL SERVICES RENDERED.

AUTHORIZED OR INSURED'S SIGNATURE:

_____ DATE _____

PAYMENT OF SERVICES:

I REALIZE THAT IF INSURANCE PAYMENT(S) DO NOT REPRESENT THE FULL PAYMENT ALLOWED FOR SERVICES RENDERED, I AM RESPONSIBLE FOR ANY BALANCE DUE.

AUTHORIZED OR INSURED'S SIGNATURE:

_____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE AVIVA D. BIEDERMAN, M.D. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY CHILD'S EXAMINATION, IF REQUESTED BY MY INSURANCE COMPANY.

AUTHORIZED OR INSURED'S SIGNATURE:

_____ DATE _____

PATIENT FINANCIAL POLICY

Dear Valued Patient:

We would like to share our financial policies with you, so that you understand your responsibility regarding charges for our services.

Our practice participates with MOST commercial U.S. insurance plans. We will gladly bill your primary and secondary insurance carriers. We can only bill international plans which have a United States billing address. Please bring your child's insurance card with you to each visit.

THE FOLLOWING ARE PAYABLE AT THE TIME OF SERVICE BY THE PARENT WHO BRINGS THE CHILD IN FOR CARE:

A. **The annual deductible**
B. **Co-payments, per your insurance plan**
C. **Charges for non-covered services (forms completion, ear piercing, etc.)**

Most insurance companies restrict routine well care on the basis of number of visits, dollar amount per year, or age of the patient. Our recommended schedule of well care examinations and vaccines may not conform to the restrictions of your insurance plan. Please understand all the provisions and limitations of your particular plan.

Charges for vaccines or laboratory services may require a **"co-insurance"** amount, in addition to any office co-payment you may have. You will be billed for these amounts once we receive the explanation of benefits from your insurance carrier for these services. Our contract with your insurance carrier requires that we discount our fees to their allowable amounts. It also prohibits us from offering further discounts. We are required to collect all deductibles and co-payments in full.

Your insurance policy is a contract between you and your carrier. We cannot make changes to that contract. We cannot enroll your child for you, or change your primary care physician for you. Once you have received an explanation of benefits from your insurance carrier, if you have questions about how your insurance carrier has processed our claims, or what services are covered by your particular policy, we recommend you contact the Member Services Department of your carrier by calling the toll free number on your insurance card.

If you need to cancel a scheduled physical exam, we need at least 24 hours notice in order to fill the appointment from our waiting list. A cancellation fee of $25 is charged when an appointment is cancelled with less than 24 hours notice, or when an appointment is not kept without notice.

We send statements on a monthly basis. Patient balances are due in full within 30 days of receipt of our statement. Our accountant will not allow us to carry patient balances beyond 60 days.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ _____

Responsible Party Signature Date

Patient Name:_____