PLEASANT VALLEY PEDIATRIC MEDICAL GROUP

Infants Children Adolescents
2486 Ponderosa Dr. N., Suite D-211, Camarillo, CA 93010 805-484-2818
Michael Gold, M.D., F.A.A.P. **Jon D'Andrea, M.D., F.A.A.P.** **Lynn J. Galan, M.D., F.A.A.P.**
William Bocash, M.D., F.A.A.P. **Deborah Marlow-Mejia, M.D., F.A.A.P.**

Date_____ Date. _____ Init. _____/Date._____ Init._____/Date._____ Init._____/Date._____ Init._____

Patient Name:	**Age:**	**Sex:**	**Birth date:**

Home Address: _____ **City:** _____ **Zip:** _____
Home Phone: (_____) _____ **Email Address:** _____

We cannot bill your insurance unless the following section is completed or you will be considered a cash paying patient and will be expected to pay at the time of service

Mother's First and Last Name:	**Birth date:**	**Social Security #:**
Drivers License #:	***Occupation/Employer's Name:***	
Work Phone #: ( )	**Cell phone #: ( )**	**Cell Carrier:**
Home address if different from children:		

Father's First and Last Name:	**Birth date:**	**Social Security #:**
Drivers License #:	**Occupation/Employer's Name:**	
Work Phone #: ( )	**Cell phone #: ( )**	**Cell Carrier:**
Home address if different from children:		

AUTHORIZATION FOR EMERGENCY TREATMENT:

I authorize the physicians of Pleasant Valley Pediatric Medical Group to treat my Child(ren) _____ in case of emergency in the case that I cannot be reached.

Parent/Guardian Signature: _____

Relative or close friend to be contacted in case of emergency: _____

Phone: (___) _____

PLEASE COMPLETE BACK SIDE!

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PVP REQUIRES YOU TO COMPLETE INSURANCE INFORMATION. COPY OF INSURANCE CARD DOES NOT ALWAYS CONTAIN ALL INFORMATION NECESSARY TO BILL. THANK YOU.

Primary Insurance: _____ Cert./ID #_____

Name of Policy Holder: _____ Group #_____

Employer's Name: _____ Effective Date of Coverage: _____

Social Security #_____ Date of Birth: _____

What are your benefits? Copay _____ Deductible _____ Percentage _____

Secondary Insurance: _____ Cert./ID #_____

Name of Policy Holder: _____ Group #_____

Employer's Name: _____ Effective Date of Coverage: _____

Social Security #_____ Date of Birth: _____

What are your benefits? Copay _____ Deductible _____ Percentage _____

I, _____, herby certify that my dependants and I a eligible for
Name of Member/Patient

_____ benefits on or as of _____ through _____.
Insurance Company Name Effective Date Employer Group Name

Please be advised that you are responsible for knowing your benefits and keeping track of your maximum benefits.

Assignment of Benefits

I have chosen PLEASANT VALLEY PEDIATRIC MEDICAL GROUP to be my Medical Provider. I understand that if the above is not true, or if my plan does not pay for services rendered within 45 days, that I will be responsible for all the charges related to service provided to my child(ren). I agree that if it is determined that I am financially responsible, I will pay in full for all services rendered within 30 days of receiving the bill. I authorize payment of medical benefit to the above named physician/medical group or supplier for services rendered to the above named patients. Should I have no insurance coverage or proof of coverage, I will be expected to pay in full for services rendered at the time of service. I also acknowledge that during a physical, should I have questions or receive treatment for other than a physical: an additional charge will be added and billed to my insurance. PVP will only send statements and notices to the address/email address were the child(ren) reside.

_____ _____
Date Signature of responsible party