Acct. #____________
Recp. Int __________

Los Robles Pediatric Medical Group, Inc

299 W. Hillcrest Drive, Suite 100
Thousand Oaks, CA 91360
Telephone: (805) 497-7888   Fax: (805) 494-3498

Today's Date____________________ Insurance Effective Date____________________

Primary Ins. Co. ______________________________________ Copay Amount:______

Group # ______________________________________

Policy # ______________________________________

Subscriber: ________________________ SS#____________________ Birth Date____________

Subscriber relationship to patient: ______________________________

Secondary Ins. Co ____

Group # ______________________________________

Policy # ______________________________________

Subscriber: ________________________ SS#____________________ Birth Date____________

Subscriber relationship to patient: ______________________________

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I hereby authorize **LOS ROBLES PEDIATRIC MEDICAL GROUP, INC**. to bill my insurance company on my behalf and to collect direct payment of the benefits otherwise payable to me. Insurance companies may not reimburse for all medically indicated items that LRPMG physicians consider medically necessary. I understand that knowledge of my policy is my responsibility and agree to pay incurred charges as indicated. ______ (Initial)

I agree to pay finance charges of 1.5% per month* (18% annually) on any patient balance due over 30 days.*Minimum finance charge $1.00 per statement. _____ (Initial)

I agree to pay a fee for any collection letter mailed to me due to lack of payment or for a returned check. The current charge is $15.00. ______ (Initial)

I agree to pay a fee for missed appointments, or cancelled appointments with inadequate notice (24hrs). The current charges are $25.00 to $75.00. _____ (Initial)

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I hereby acknowledge that I have read, understand and agree to abide by the terms stated above.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322, www.mbc.ca.gov

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PATIENT/PARENT/GUARDIAN SIGNATURE