SEBASTIAN MD

MINOR PATIENT REGISTRATION FORM

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SANTA MONICA, CA 90404
(310) 917.4433 TELEPHONE
(310) 917.4432 FAX

Please present your insurance card and your photo identification to the receptionist. A copy will be made and your cards will be returned to you promptly.

MINOR'S INFORMATION (**please print**) Today's Date_____

Name _____ Date of Birth_____
Last *First* *M.I.*

Mailing Address_____
Street *City* *State* *Zip*

Primary Phone _____ What do you prefer to be called?_____

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LEGAL GUARDIAN OR PARENT INFORMATION

Name_____ Date of Birth_____
Last *First*

Mailing Address_____
(If different from above) *Street* *City* *State* *Zip*

Primary Phone_____ E-Mail_____

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INSURANCE INFORMATION

Primary Insurance_____ Policy Holder (Insured) Date of Birth_____

Name of Policy Holder_____
Last *First*

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EMERGENCY CONTACT (In case of emergency, whom should we notify?)

Name_____Relation_____Phone_____
Last *First*

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PREFERRED PHARMACY

Name_____Phone_____City_____

MINOR'S FAMILY DOCTOR OR PEDIATRICIAN

Name_____Phone_____City_____

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May we:

May we leave medical information about the patient on your phone? □ Yes □ No
May we e-mail personal medical information about the patient to you? □ Yes □ No Do you give our office permission to discuss medical information about the patient with other family members? □ Yes □ No
If yes, please provide their name(s) and phone number(s) below:

Name_____Phone_____Relation_____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Parent/Legal Guardian Signature_____**Date**_____

PAYMENT POLICY

The adult/guardian who accompanies the child will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.
You authorize the release of medical information to your primary care or referring physician and consultants if needed and as necessary to process your insurance claims, insurance applications and prescriptions. You hereby assign your insurance benefits to be made directly to your physician for services rendered. Full payment is required for all services at the time they are rendered. Applicable co-payments and deductibles will be collected; this includes our consultation fee for uninsured patients. There is an annual administration fee of **$250 per office visit**, not to exceed **$500 per year**. This is due at the time of visit, and is non-refundable.
You are responsible for knowing your benefits/coverage, and are responsible for any unmet deductible, non-covered services and co-payments. In the event that your account must be turned

over to collections, a $20 collection fee will be added to your account. You attest that the above information is accurate and that you are an eligible member. You will be financially responsible for all charges that are not covered by your insurance company. Your signature below signifies your understanding and willingness to comply with this policy.

- **You have been informed that procedures are billed and coded separately from office visits.**
- **You understand that pathology services are separate from biopsy services, and are billed accordingly. This office does not process pathology billing.**
- **You have the right to refuse any treatment.**
- **You are responsible for knowing your insurance benefits and verifying your eligibility.**
- **You are responsible for making sure you understand the risks and benefits of each procedure prior to it being rendered.**

Patient/Legal Guardian Signature_____**Date**_____