WALNUT CREEK PEDIATRICS MEDICAL GROUP, INC.

1822 SAN MIGUEL DRIVE WALNUT CREEK, CA 94596

TEL: (925) 945-3580 | FAX: (925) 934-0471 | EMAIL: WCPEDIATRICS@PM.ME

MONTGOMERY KONG, M.D.	**DIANA NAM, M.D.**
BO ESPINOSA-SETCHKO, M.D.	**KEVIN HOANG, M.D.**

FINANCIAL POLICY

The staff of Walnut Creek Pediatrics is committed to providing your children with quality health care. Our billing office will assist you in receiving the maximum benefits from your health insurance.

Please remember that private health insurance is a contract between you and your insurance company. You are responsible for payment of services provided by our office and your insurance company is responsible to you. As a courtesy, our office will bill your insurance company. **Services provided by our office may or may not be covered benefits of your insurance; it is the insured's responsibility to know the benefits and/or limitations of their own insurance.**

Patients covered by HMO, POS, and PPO insurance plans must make their co-payments at the time of service. Any claim that is denied by your insurance company will become the responsibility of the insured and will be the insured's responsibility to resolve with their insurance company.

In order to process your insurance claims we ask that you present your insurance card at each visit. It is the insured's responsibility to notify our office of any change in their insurance coverage such as a plan, medical group, or coverage.

HMO. POS, and PPO plans must present a card for each family member stating the patient's name. Primary Care Physician (PCP) and medical group affiliation.

Returned checks will be subject to a $25 fee. After two no-show appointments, patients will be charged $25 per occurrence thereafter. Effective February 01, 2014 there will be a $5.00 finance charge for all delinquent account balances past 30 days. There will be a fee for transfer of records, medical forms, and letters.

By signing below, I/we agree to the terms and conditions as stated above and will assume all financial responsibility for charges incurred by our child(ren) at Walnut Creek Pediatrics.

We also acknowledge by signing below that we have read and agree to the Walnut Creek Pediatric Medical Group, Inc's Notice or Privacy Practices.

PATIENT(S) NAME: _____	
SIGNATURE:	**DATE:**
RELATIONSHIP TO PATIENT(S):	

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KINDLY FILL OUT THIS FORM FOR INSURANCE PURPOSES AND TO ASSIST US IN OFFERING THE BEST POSSIBLE SERVICE AT ALL TIMES.

DATE: _____

PATIENT NAME:	**DATE OF BIRTH:**

LEGAL GUARDIAN: _____ **DATE OF BIRTH:** _____

RELATIONSHIP TO PATIENT: _____ **EMAIL:** _____

LEGAL GUARDIAN: _____ **DATE OF BIRTH:** _____

RELATIONSHIP TO PATIENT: _____ **EMAIL:** _____

SIBLINGS	**DATE OF BIRTH**	**GENDER**

HOME/BILLING ADDRESS:	
PRIMARY PHONE:	**SECONDARY PHONE:**

GUARDIAN RESPONSIBLE FOR PAYMENT: _____
NAME OF INSURANCE: _____
NAME OF INSURED: _____ **RELATION:** _____

EMERGENCY CONTACT: _____ **RELATION:** _____
PHONE NUMBER: _____

WHO REFERRED YOU TO OUR OFFICE? _____

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PATIENT NAME:	**DATE OF BIRTH:**

A. PREGNANCY & BIRTH:

1. Baby born at _____ weeks.
2. Any issues during pregnancy? YES / NO
   If yes, explain: _____
3. Any issues for the baby while in the hospital? YES / NO
   If yes, explain: _____

B. ALLERGIES:

1. Please list any food or drug allergies and the reaction: _____
2. Circle if your child has had: eczema wheezing/asthma constant congestion

C. FAMILY HISTORY:

List any medical problems that this child's parents, aunts, uncles or grandparents have had:

Mother's Side: _____

Father's Side: _____

List names, ages and general health of siblings: _____

D. PATIENT PAST MEDICAL HISTORY:

List any hospitalizations, major illnesses, and ongoing concerns (physical/behavioral):