Conejo Children's Medical Group
558 N. Ventu Park Road, Suite D
Thousand Oaks, CA 91320
Phone: (805) 499-5525 Fax: (805) 499-5554

Patient Name:____

Please call me at the following phone number,_______________, with the results of any medical tests, appointment confirmations, and any other communication regarding my child's health or medical records.

Check here____to authorize us to leave a message with details of your child's test results. If this is not checked we will leave a message asking for a return phone call.

OTHER THAN THE PARENTS, PLEASE LIST ANY ADDITIONAL LEGAL GUARDIANS FOR THIS PATIENT(S).

Name:_______________________________Phone:_______________________
Address:_____________________________Relationship_____________________

EMERGENCY CONTACT:

In the event of an emergency, who should we contact?

Name:_______________________________Relationship_____________________
Home Phone:__________________________Cell Phone:______________________

AUTHORIZATION AND RELEASE - FINANCIAL AGREEMENT

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care, to third party payors and/or other health practitioners.

Also, I understand that I am financially responsible for all charges whether or not they are covered by insurance. I understand it is my responsibility to verify insurance coverage and/or deductions for any referrals that may be made to outside laboratory and/or x-ray services. Interest, court costs and/or attorney fees may be pursued on delinquent accounts assigned to collections. I understand that cash payment or proof of insurance is required at time of service, and co-payments are due at time of service.

Signature:_________________________________Date:___________