Santa Clarita Pediatrics
23823 Valencia Blvd., Suite 120
Valencia, CA 91355
Phone: (661) 253-4971 Fax: (661) 253-4972

Patient Name: ____________________________ Date: _______________________

- I have received a copy of Santa Clarita Pediatrics' Welcome Letter outlining the practices general policies.
- I have received a copy of Santa Clarita Pediatrics Vaccine Policy and in order to remain a patient of Santa Clarita Pediatrics ***I will adhere to the vaccine schedule worked out with my child's doctor***.
- I have received a copy of Santa Clarita Pediatrics' Financial Policy. I understand ***anything applied to my deductable, copay, or coinsurance is determined by my insurance carrier and is my financial responsibility***. I also understand if I do not cancel my appointment within 24 hours Santa Clarita Pediatrics will charge a ***$25.00 missed appointment fee*** per appointment.

Your signature acknowledges that you have received a copy of the forms specified above.

Parent/ Guardian Signature: ____

Santa Clarita Pediatrics
23823 Valencia Blvd., Suite 120
Valencia, CA 91355
Phone: (661) 253-4971 Fax: (661) 253-4972

Patient Name: ____________________________ Date: _______________________

- I have received a copy of Santa Clarita Pediatrics' Welcome Letter outlining the practices general policies.
- I have received a copy of Santa Clarita Pediatrics Vaccine Policy and in order to remain a patient of Santa Clarita Pediatrics ***I will adhere to the vaccine schedule worked out with my child's doctor***.
- I have received a copy of Santa Clarita Pediatrics' Financial Policy. I understand **anything applied to my deductable, copay, or coinsurance is determined by my insurance carrier and is my financial responsibility**. I also understand if I do not cancel my appointment within 24 hours Santa Clarita Pediatrics will charge a ***$25.00 missed appointment fee*** per appointment.

Your signature acknowledges that you have received a copy of the forms specified above.

Parent/ Guardian Signature: ____