MARIMÓN
PEDIATRICS

DATE OF BIRTH SOCIAL SECURITY #

FATHER/LEGAL GUARDIAN_____ ____/____/____ _____
MOTHER/LEGAL GUARDIAN_____ ____/____/____ _____
BILLING ADDRESS: STREET_____
CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME _____
FATHER'S WORK _____
MOTHER'S WORK _____
FATHER'S CELL _____
MOTHER'S CELL _____

EMAIL: FATHER _____
MOTHER_____

WITH WHOM DO CHILDREN RESIDE: ☐ BOTH PARENTS ☐ MOTHER ONLY ☐ FATHER ONLY
CHILDREN'S ADDRESS: STREET_____
CITY _____ STATE _____ ZIP_____

HOW DID YOU HEAR ABOUT US?
PHYSICIAN _____ FRIEND/RELATIVE _____
ADVERTISEMENT _____ OTHER _____

NAME/ADDRESS/PHONE # OF YOUR PREFERRED PHARMACY:
_____
_____

AUTHORIZATION FOR TREATMENT:

With my signature below, I hereby authorize Marimón Pediatrics to render medical treatment, which in his or her judgment may be deemed necessary, for the care of the following **children**:

CHILD'S FIRST NAME, MI, LAST NAME	SEX M F	DATE OF BIRTH MO DAY YR	SOCIAL SECURITY #
1._____	☐ ☐	_____/_____/_____	_____
2._____	☐ ☐	_____/_____/_____	_____
3._____	☐ ☐	_____/_____/_____	_____
4._____	☐ ☐	_____/_____/_____	_____

SIGNATURE OF PARENT OR GUARDIAN

_____ DATE _____

(continued on the other side)

MARIMÓN
PEDIATRICS

INSURANCE CO NAME:_____
CLAIMS ADDRESS:_____
INSURANCE CO TELEPHONE # _____ REFERRAL REQUIRED? ☐ YES ☐ NO
POLICY HOLDER'S NAME: _____
BIRTHDATE _____/_____/_____ SOCIAL SECURITY # _____
POLICY HOLDER'S EMPLOYER_____
ID # OF POLICY _____ GROUP # _____

PATIENT FINANCIAL RESPONSIBILITY:

You understand that you will be financially responsible for the medical services provided to you or your children. As a courtesy to its patients, Marimón Pediatrics, verifies your benefits with your insurance company. You are responsible for keeping your insurance information with us up to date. If you are covered by health insurance, we will be happy to bill your insurance, on your behalf, for the medical services rendered. If your insurance determines a service to be "not payable" or "not covered," you will be responsible for the charge and you agree to pay the costs of such services. If you are "self-pay" or uninsured, you agree to pay for the medical services rendered to you or to your children at time of service.

It is the policy of Marimón Pediatrics that payment is due at the time of service unless other financial arrangements are made in advance. This may include your deductible, co-pay, coinsurance payment, and/or any prior patient account balances, and will be due at the beginning of each visit. It is also our policy that the parent or guardian who requests treatment for the child or children is responsible for all charges for medical services rendered. The office manager will be happy to explain to you this information prior to your first visit and also answer any other questions you may have about these policies. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

By your signature below, you hereby authorize and direct payment of your medical benefits to Marimón Pediatrics on your behalf for any services furnished to you or your children by Marimón Pediatrics.

AUTHORIZATION TO RELEASE RECORDS:

By your signature below, you hereby authorize Marimón Pediatrics to release to your insurer, governmental agencies, or any other entity financially responsible for your medical care, all information, including diagnosis and the records of any treatment or examination rendered to you, which are necessary to substantiate payment for such medical services, as well any information required for precertification, authorization or referral to another medical provider.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

SIGNATURE OF PARENT OR GUARDIAN

_____ DATE _____