DATE OF BIRTH SOCIAL SECURITY #

FATHER/LEGAL GUARDIAN_____ ____/____/____ _____

MOTHER/LEGAL GUARDIAN_____ ____/____/____ _____

BILLING ADDRESS: STREET_____

CITY _____ STATE _____ ZIP _____

TELEPHONE:

_____ FATHER'S CELL

_____ MOTHER'S CELL

_____ FATHER'S WORK

_____ MOTHER'S WORK

_____ HOME

EMAIL:

_____ FATHER

_____ MOTHER

WITH WHOM DO CHILDREN RESIDE: ☐ BOTH PARENTS ☐ MOTHER ONLY ☐ FATHER ONLY

CHILDREN'S ADDRESS: ☐ SAME AS ABOVE

STREET_____

CITY _____ STATE _____ ZIP_____

HOW DID YOU HEAR ABOUT US?

_____ PHYSICIAN REFERRAL

_____ ADVERTISEMENT

_____ FRIEND/RELATIVE

_____ _____ 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)

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:

Thank you for choosing Marimón Pediatrics as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE.
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT.
Methods of payment that we accept include: Cash, Check, Visa, Mastercard, Discover, and American Express

PROOF OF INSURANCE: All patients must complete this patient registration form in full prior to your appointment with the physician. We must also obtain a copy of your photo identification as well as your current valid insurance card as to provide proof of insurance, unless you are self-pay. If you fail to provide us with the correct insurance information or do not do so in a timely fashion, you may be responsible for the balance of a claim in part or in full. We are in network with most major insurance carriers. However, it is your responsibility to verify that we are a participating provider of your insurance plan. It is also your responsibility to know and understand the requirements of your insurance plan. As part of the contract we hold with your insurance company, all co-payments, co-insurances, and deductibles must be paid at the time of service. Failure on our part to collect such payments can be considered fraud. If you are self-pay or do not have insurance, you agree to pay for the medical services rendered to you or to your children at the time of service.

HMO/REFERRALS: It is your responsibility to obtain a referral form from us if your insurance carrier requires it. Please allow up to 3 business days for processing referrals.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, you may be charged a fee for missed appointments (no show). Please help us serve you better by keeping your scheduled appointments.

NONCOVERED SERVICES: Please be aware that some, and perhaps all, of the services you receive may be noncovered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of your visit.

RETURNED CHECKS: Any check returned to us for non-sufficient funds will be subject to bank fees (fees our bank charges us for the returned check) as well as a NSF (non-sufficient funds) fee of no less than $25 from our office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including, but not limited to, collection agency fees, court costs, interest, and legal fees. All unpaid accounts will be reported to the credit bureaus.

CONVENIENCE FEES: Please be aware there may be other fees not described above that may be added to your account. These fees may include, but are not limited to, fees for filling out forms, convenience fees for having blood drawn in our office, or fees for walk-in appointments.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS: Please be aware the most insurance carriers submit payment directly to us for services provided. 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.

By your signature below, you hereby indicate that you have read, fully understand, and that all of your questions regarding this policy have been answered. You further agree to render payment in accordance with the provisions of this Patient Financial Responsibility Form.

SIGNATURE OF PARENT OR GUARDIAN

_____ DATE _____

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.

SIGNATURE OF PARENT OR GUARDIAN

_____ DATE _____

NOTICE OF PRIVACY ACKNOWLEDGEMENT:

You understand that under the Health Insurance Portability and Accountability Act (HIPAA), you have certain rights to privacy regarding my protected health information. You also understand that this practice has the right to change our Notice of Privacy Practices and that you may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices**. By your signature below, you acknowledge that you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.**

SIGNATURE OF PARENT OR GUARDIAN

_____ DATE _____

NOTICE OF NONDISCRIMINATION AND PATIENT BILL OF RIGHTS ACKNOWLEDGEMENT:

Our practice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We also comply with Florida statutes which require us to recognize your rights when you are receiving medical care and that you respect our right to expect certain behavior on your part. **By your signature below, you acknowledge that you have received or have been given the opportunity to receive a copy of our Notice of Nondiscrimination and the Patient Bill of Rights.**

SIGNATURE OF PARENT OR GUARDIAN

_____ DATE _____

CONSENT TO THE USE OF E-MAIL:

RISKS OF USING E-MAIL TO COMMUNICATE WITH YOUR PHYSICIAN: Please be aware that there are inherent risks to transmitting patient information by e-mail which include, but are not limited to: ease of circulation, forwarding, broadcasting, misdirecting (sent to an incorrect e-mail address), copying/backing up, falsification, or using as evidence in court. E-mail may also be used to introduce viruses into a computer system.

CONDITIONS FOR THE USE OF E-MAIL: We will use reasonable means to protect the security and confidentiality of e-mail communications. However, we cannot guarantee the security and confidentiality of e-mail communication, nor will we be held liable for improper disclosure of confidential information. Therefore, patients must consent to the use of e-mail for the purposes of communicating with us, subject to the following conditions: (a) all e-mails to or from the patient concerning diagnosis or treatment will be added to the patient's own medical record (b) we may forward e-mails internally to our staff responsible for handling the subject matter or content of your email. However, we will not forward your e-mails to other third parties without your prior written consent except as authorized or required by the law (c) you are responsible for protecting your own password or other means of access to your e-mail.

PATIENT RESPONSIBILITIES AND INSTRUCTIONS: You agree to limit or avoid using your employer's computer. Please inform us of any changes to your e-mail address. Please confirm receipt of e-mail from our office. You agree to take precautions to preserve the confidentiality of e-mail, including, but not limited to, protecting your passwords and/or devices utilized for accessing your e-mail. You may withdraw your consent at any time by e-mail or written notice to our office.

TERMINATION OF THE E-MAIL RELATIONSHIP: We reserve the right to immediately terminate the e-mail relationship with you if at our own discretion, we determine that you have violated the above terms and conditions or otherwise breached this agreement.

By your signature below, you hereby indicate that you have read, fully understand, and that all of your questions regarding this consent have been answered. You consent to the use of internet communication with our office as outlined above. You further agree to indemnify and hold harmless Marimón Pediatrics and its trustees, officers, directors, employees, agents, information providers and suppliers from and against all losses, expenses, damages, and costs relating to or arising from any information loss due to your use of the internet to communicate with our office.

SIGNATURE OF PARENT OR GUARDIAN

_____ DATE _____