CASTRO PEDIATRICS, LLC.

PATIENT DEMOGRAPHIC

PLEASE COMPLETE ALL INFORMATION – POR FAVOR COMPLETE TODA LA INFORMACIÓN

PATIENT'S INFORMATION

TODAY'S DATE/FECHA_____

CHILD'S LAST NAME_____ FIRST NAME_____ MI_____ D.O.B._____
Apellido del menor Nombre del menor Inicial Fecha de nacimiento

SEX: M \ F AGE_____ HOME PHONE (INCLUDING AREA CODE)_____
Sexo Edad Numero de Teléfono de la casa

HOME ADDRESS_____ APT._____
Dirección de domicilio primario

CITY_____ STATE _____ ZIP_____
Ciudad/ Estado Código postal

RACE/RAZA ___ AFRICAN ___ ASIAN_ __CAUCASIAN ___ NATIVE AMERICAN __ OTHER (MIXED)____DECLINE TO ANSWER

ETHNICITY/ETNICO ___HISPANIC/HISPANO ___ NON-HISPANIC/NO HISPANO_____DECLINE TO ANSWER

PREFERRED METHOD OF CONTACT ___ HOME PHONE __ CELL PHONE ___ WORK PHONE ___ MAIL ____ EMAIL
Método de contacto preferido Teléfono a casa Teléfono cellular Teléfono commercial Correo Correo electrónico

FATHER'S INFORMATION

FATHER'S FULL NAME
Nombre completo del padre_____ DOB
Fecha de nacimiento _____

Cell#_____ Email_____
Teléfono cellular Dirección de correo electrónico

EMPLOYER NAME_____ WORK#_____ HOME #_____
Teléfono commercial Nombre de empleador Teléfono de la casa

PREFERRED LANGUAGE:_____ STATE & DRIVER'S LIC #_____
Idioma preferido Numero de Lic de Conducir y Estado

MOTHER'S INFORMATION

MOTHER'S FULL NAME
Nombre completo de la madre_____ DOB
Fecha de nacimiento _____

Cell #_____ Email_____
Teléfono celular Dirección de correo electrónico

EMPLOYER NAME_____ WORK#_____ HOME #_____
Nombre de empleador Teléfono comercial Teléfono de la casa

PREFERRED LANGUAGE: _____ STATE & DRIVER'S LIC #_____
Idioma preferido Numero de Lic de Conducir y Estado

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS? ___ MOTHER ___FATHER ___ OTHER (NAME) _____
¿Quién es responsable de hacer las citas? Madre Padre Otro (NOMBRE)

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT (OTHER THAN PARENTS)?
EN CASO DE UNA EMERGENCIA, quién debemos comunicarle (aparte de los padres)?

Name _____ Relationship_____ Contact #_____
Nombre Relación Numero de contacto

CASTRO PEDIATRICS, LLC

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CHIEF COMPLAINT / *QUEJA PRINCIPAL*

Why are you seeing the doctor today? _____
¿Porqué vienen a ver al médico hoy?

Who is Accompanying this child today? Mother_____Father_____Other(fill out 3 questions below please)
¿Quien acompana a el nino/a hoy?

Name_____ **Relationship to child**_____
Nombre *Relación con el niño*

Are you the legal guardian of the child?_____
¿Es usted el guardian legal del niño?

Referred by_____

If this first visit is for a checkup, did you bring vaccine records? If not, how do we obtain them?
¿Si la visita de hoy es para un chequeo(control), tiene la tarjeta de las fechas de vacunaciones? Si no, como podemos obtenerlas?

_____

Is there a family history of this problem? _____
¿Hay historial de este problema en la familia?

Do you have any difficulty understanding medically related information or the medical system in this country? _____
Tiene alguna dificultad para comprender la informacion medica o el Sistema medico de este pais?

Have you seen any other doctor (including in an ER) for this? If yes whom, when, what treatment was given?
¿Ha visto a algún otro médico (incluso en la Sala de Emergencias) por este motivo? Si lo ha visto, ¿a quién, cuándo, qué tratamiento le dieron?

_____

_____

PATIENT'S MEDICAL HISTORY/ *HISTORIAL MÉDICO DEL PACIENTE*

Allergies:_____ **Reaction:** _____
Alergias: *Reacción:*

Current Medications, Vitamins, Supplements & Herbs: Include Dosage/Route/How long?/Side Effects
Medicamentos, vitaminas, suplementos y productos herbales actuales: Incluya la dosificación/Vía/¿Por cuánto tiempo?/ Efectos secundarios

_____

_____

Length of Mother's Pregnancy _____ **Type of Delivery**_____ **Birth Weight**_____

Fetal Distress: No , Yes_____ **Complications:** _____
Sufrimiento del feto: No Sí *Complicaciones:*

Duracion del embarazo de la madre Tipo de parto Peso al nacer

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME_____ PHONE#_____

Nombre del seguro principal Teléfono de la compañía de seguros

INSURANCE CO. ADDRESS_____
Dirección de la compañia de seguros

POLICY ID #_____ **GROUP #** _____
Núm. de poliza Numero de grupo

CASTRO PEDIATRICS, LLC.

PATIENT RESPONSIBILITY

PLEASE COMPLETE ALL INFORMATION – POR FAVOR COMPLETE TODA LA INFORMACIÓN

ACCOUNT INFORMATION

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT: FATHER_____MOTHER_____
Persona responsable por la cuenta

OTHER PERSON/Name_____**Relationship**_____
Otra Persona/Nombre Relación

Billing Address_____
Dirección de facturación

Home Phone # -_____**Cell Phone** _____
Teléfono casa Teléfono cellular

Employer_____ **Employer Phone #** _____
Empleador Teléfono empleador

Driver's License # _____
Licencia de conducir #

DESIRED METHOD OF PAYMENT - MÉTODO DE PAGO DESEADO

___ CASH Efectivo ____ CHECK Cheque ____ CREDIT CARD Tarjeta de credito

CREDIT CARD # _____ **EXP DATE**_____
Tarjeta de credito Fecha de expiración

NAME AS IT APPEARS ON CARD _____
Nombre como aparece en la tarjeta

Our office policy requires payment in full for all services at the time of visit. The person bringing the patient to this office is responsible for the charges unless other arrangements have been made with the office manager. If the account I not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
Nuestra política de la oficina requiere el pago total de todos los servicios en el momento de la visita. La persona que presenta la paciente para esta oficina es responsable de los cargos a menos que otros arreglos se han hecho con el gerente de la oficina. Si la cuenta no se paga dentro de los 90
días de la fecha del servicio, y arreglos financieros no se han hecho, usted será responsable de los gastos incurridos en coleccionar su cuenta.

No shows for appointments are costly and wasteful of time, please cancel with 24 hours advance notice. A fee will be charged for no shows otherwise.
Si no se presenta para su cita es costosos y una pérdida de tiempo, por favor cancele con 24 horas de anticipación. Un efectuará cargos por no presentación.

I hereby authorize payment of benefits directly to provider f benefits due me for services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims.
I understand the above information, guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my child's medical status.
Por la presente autorizo el pago de beneficios directamente a los proveedores f beneficios me debidas por servicios prestados. Además, autorizo el médico y / o el proveedor para divulgar cualquier información necesaria para procesar reclamaciones de seguros.
Entiendo la información anterior, garantiza esta forma se completó correctamente a lo mejor de mi conocimiento y entiendo que es mi responsabilidad informar a esta oficina de cualquier cambio en el estado médico de mi hijo.

Date_____ Signature of Responsible Party_____
Fecha *Firma de la persona responsable*

Adriana M. Castro, M.D.

Attention

The following is a statement of our OFFICE POLICY, which we required you to READ and SIGN

Dear Parents:

1) Please be advised that it is our policy for payment to be made (co-pay or otherwise) at the time your child will be seen. If someone other than the person responsible brings the child in, payment is still expected at time of visit. If we do not receive payment at time of the visit then we must use our billing department to send notices for payment due. **Doing this will incur a billing charge of $5.00 additional to the amount due.**

If you anticipate sending your child to the office, please give the person who brings him/her a co-pay amount or call our office on the day of the visit with your Credit Card information and we can easily put the payment on your Credit Card.

Those who continually ignore these office policies will have their appointments reschedule (if it is not an emergency/life threatening visit) for a time when the person financially responsible can make or sent the expected payment.

2) We occasionally have parents who are divorced and the court makes one party responsible for all or part of the payments due. **We will collect the entire amount due at time the child is seen and issue receipts so that one parent can obtain reimbursement from other parent.**

3) We have a 24 hours cancellation policy for appointment. This allow the office time to fill the empty appointment slot with someone else who needs to be seen. We will be calling the day before the schedule appointment for your child, to remind you. However it is the parent's ultimate responsibility to keep the appointment. **Missed appointment that are not cancelled the day before will incur a fee of $25.00 or your co-payment, whichever is higher. Please, note that calling the same day of the appointment to cancel will still incur the same fee.**

4) We get request from parents to fill out many forms. These include health insurance request forms for medical history, clearance forms for sport, blue and yellow forms to attend school or summer camp, forms that school request for therapies, allergies, exercise modifications, etc. **Please note is our policy to charge $10.00 per sheet that the physician or nurse completes.**

5) The office has a policy of charging $35.00 service fee for any returned check plus $25.00 late fee After the second episode of returned check we will only accept cash or credit card as a form of payment When the patient is seen.

Patient name_____

Parent/Guardia Signature_____Date_____

Adriana M Castro MD

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
Dated April 14, 2003

I, [name of patient] _____, acknowledge and agree that I have received a copy of Adriana M Castro MD's Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____

_____
Print Name of Legal Representative Relationship to patient

FOR CLINIC USE ONLY:

Adriana M Castro MD made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

to decide upon, and not to a judge or jury. **Timing:** The parties agree to try to resolve all issues within 9 months of any complaint. **Entire Agreement Clause:** This Agreement represents the entire agreement made between the MCP and the Patient. It supersedes any other agreements between the Patient and the MCP. Except as expressly set forth herein, there are no other representations, promises, understandings, or agreements of any kind between the parties. The Patient signing this Agreement acknowledges that he or she has not relied in any way upon any oral or written statements made to them besides what is contained within this Agreement. **Pronouns and Headings:** The singular shall be held to include the plural, the plural held to include the singular, and the use of any gender shall be held to include every gender. All headings, titles, subtitles, or captions are inserted for convenience only, and are to be ignored in any construction of the provisions hereof. **Governing Law and Payment and Selection of Arbitrators:** This Agreement, its substantive provisions, the scope of the Agreement, the authority granted to the arbitrators and the limitations contained in this Agreement, are to be governed by, and interpreted pursuant to the Federal Arbitration Act, any conflicting state law notwithstanding. To the extent not inconsistent with the FAA, it shall also be governed by the provisions of the Revised Uniform Arbitration Act as adopted in the principal state where the MCP practices. The parties agree that any dispute between them shall be determined by a panel of three arbitrators. Each party shall select one arbitrator from lists of qualified legal/medical experts provided by the MCP. All arbitrators will hold either medical or both medical and juris doctor degrees. The two arbitrators selected shall then select a third arbitrator from the same list. Each party may remove the other's chosen arbitrator only once. The three arbitrators shall resolve any and all disputes between the parties generally pursuant to the National Arbitration Forum Code of Procedure or such procedures as they may jointly decide. All arbitration hearings shall be conducted by videoconference; the MCP will provide equipment and pay all costs of videoconference bridging and of the arbitrators. The parties shall adopt rules of evidence such as the arbitrators may see fit. The MCP shall pay the full costs of the arbitration, but shall not be responsible for paying any fees or costs charged to the Patient by their attorney save the first $2,500 as indicated above. Reasonable discovery will be permitted by both sides. The parties agree that the arbitrators are to render a written decision with reasons stated for the decision. **Right of Counsel & Rescission:** The Patient understands that this Agreement is a legal document, and the Patient has the right to consult with an attorney before signing it if desired. Your MCP encourages you to consult an attorney prior to signing or during a 15-day rescission period. You may rescind this Agreement for 15 days after signing it; you agree that it will be in full force and effect until the date received at the MCP's office. To rescind it, return a copy to the MCP by certified mail-return receipt only with "CANCELED" written on the first page, and signed by you underneath that word. The Agreement will then be rescinded for all future care, but you agree it will be valid for any and all care provided by the MCP to the Patient for the entire period of all medical services up to rescission. **Authority to Sign:** The Patient represents that he or she does in fact have the authority to sign and execute this document on his/her own behalf (if signed by the Patient), or on behalf of the Patient (if signed by a person or persons other than the Patient.) **No Undue Influence:** The individual signing this Agreement hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed it of his or her own free will and accord and not under duress of any kind. The parties agree that they have been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement. **Frivolous Legal Actions:** The Patient agrees that under no circumstances will a frivolous action or claim be brought against the MCP, and the MCP agrees to not bring any frivolous action or claim against the Patient. If two or more Arbitrators rule that any action or claim brought against either party is frivolous in nature, the prevailing party shall be entitled to economic and non-economic damages, including loss of wages or other compensation, damage to reputation, full attorneys' fees and punitive damages. **Mediation:** At the MCP's sole expense, upon any complaint or alleged injury, the parties agree to promptly mediate in good faith with a qualified mediator prior to any Arbitration hearing. A qualified professional mediator with medico-legal background shall be mutually agreed upon.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

I hereby agree that all provisions of this Agreement are in full effect, and no word, sentence, paragraph or provision may be crossed out, excised or removed.

Name of patient(s), if signed by someone other than the patient(s): _____

If signed by other than patient, please indicate nature of relationship: *"I am the patient's* _____ "

_____ Date: _____

SIGNATURE of Patient, Parent, Guardian, or Authorized Representative of Patient.

MEDICAL CARE PROVIDER'S CONSENT TO ARBITRATION: In consideration of the execution of this Binding Arbitration Agreement, the undersigned, as the legal representative of the Medical Care Provider, hereby agrees to be bound by all the terms set forth above.

_____ Date: _____

SIGNATURE of MEDICAL CARE PROVIDER – Adriana M. Castro, M.D., individually and on behalf of Adriana M. Castro M.D., P.A.

Adriana M. Castro, M.D.
10300 SW 72nd Street.
Suite #282
Miami, Florida 33173

I have read, received and understand the following items of information regarding the office policies.

Initials

_____ H I P P A agreement.

_____ Office policy on missed check-up appointments.

_____ Office policy on co-payments at time of visit.

_____ Office policy on divorce agreements.

_____ Office policy on document requests.

_____ Office policy on non-sufficient fund checks.

PATIENT(S) NAME(S) and DOB

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Parents or guardian signature. Date.