MARIMÓN PEDIATRICS

PATIENT REGISTRATION

PATIENT INFORMATION		
Last Name:	**First Name:**	**Middle Name:**
Sex:	**Date of Birth:**	**Email:**
Address:		**Apt/Unit#:**
City, State, Zip:		
Home Phone:	**Cell Phone:**	
Sibling:	**Sex:**	**Date of Birth:**
Sibling:	**Sex:**	**Date of Birth:**
Sibling:	**Sex:**	**Date of Birth:**

RESPONSIBLE PARTY		
Last Name:	**First Name:**	**Middle Name:**
Patient Relationship to Guarantor:	**Sex:**	**Date of Birth:**
Address:	**City, State, Zip:**	
Home Phone:	**Work Phone:**	**Cell Phone:**

PARENT(S)/GUARDIAN(S)		
Last Name:	**First Name:**	**Middle Name:**
Patient Relationship:	**Sex:**	**Date of Birth:**
Address:	**City, State, Zip:**	
Home Phone:	**Work Phone:**	**Cell Phone:**
Last Name:	**First Name:**	**Middle Name:**
Patient Relationship:	**Sex:**	**Date of Birth:**
Address:	**City, State, Zip:**	
Home Phone:	**Work Phone:**	**Cell Phone:**

INSURANCE INFORMATION	
Primary Insurance:	Policyholder:
Address:	Date of Birth:
City, State, Zip:	Relationship to Policyholder:
Plan Phone:	Group Number:
Effective Dates:	Policy ID number:

EMERGENCY CONTACT INFORMATION		
Emergency Contact:	Patient relationship to Contact:	
Contact Home Phone:	Contact Work Phone:	Contact Cell Phone:

PHARMACY	
Pharmacy:	Pharmacy Phone:
Pharmacy Address:	
Pharmacy City, State & Zip:	

1. PATIENT FINANCIAL RESPONSIBILITY:

Thank you for choosing **MariPeds, LLC D/B/A 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 5 business days for processing referrals.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered at the time it is 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 non-sufficient funds (NSF) fee of no less than $25 from our office.

COLLECTION POLICY: Should your account become past due, the patient/guarantor 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 and may affect your credit score negatively.

CONVENIENCE FEES: Please be aware there may be other fees not described above that can 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, late or no-show fees, or fees for walk-in appointments.

PATIENT REGISTRATION

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

X ____ DATE: ___________________________

2. 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

X ____ DATE: ___________________________

3. 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

X ____ DATE: ___________________________

4. 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

X ____ DATE: ___________________________

5. 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

X ____ DATE: ____________________________

6. CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO:

I hereby give consent and permission to Marimón Pediatrics to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means and/or take photographs of the appearance of your minor child.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture and/or likeness by Marimón Pediatrics and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or for any and all purposes including, but not limited to film, photograph, television, radio, digital, internet or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that Marimón Pediatrics is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, internet, intranet or in other media once released.

Marimón Pediatrics has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the minor child or for participation in said productions. I agree to hold Marimón Pediatrics, its employees and other parties harmless against claim, liability, loss or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

☐ **ACCEPT.** By checking the Box for this CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO I hereby state that I have read, understood, and agree to the terms of this document.

☐ **REVOKE** CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO **-** I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable trimeframe. I also understand that this file may have been copied without permission, and I agree not to hold Marimón Pediatrics responsible for instances of these violations.

SIGNATURE OF PARENT OR GUARDIAN

X ____ DATE: ___________________________

7. TELEHEALTH INFORMED CONSENT

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "**Telehealth Informed Consent**" informs the patient ("**patient,**" "**you,**" or "**your**") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided: Telehealth services offered by Marimón Pediatrics ("**Practice**"), and the Practice's engaged providers (our "**Providers**" or your "**Provider**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the **Services**"). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic Transmissions: The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to: Appointment scheduling; Completion of medical intake forms; Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communications; Two-way interactive audio in combination with store-and-forward communications between you and your Provider; Two-way interactive audio-video interaction between you and your Provider; Review and treatment recommendations by your Provider based upon output data from medical devices and sound and video files; Delivery of a consultation report; and/or Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits: Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available on an as needed basis when the office is closed for unforeseen reasons or scheduled by the provider. Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by calling the office at (786) 600-4733 or via email at frontdesk@marimonpediatrics.com.

Service Limitations: The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination. **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT MARIMÓN PEDIATRICS OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.** If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security Measures: The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

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Possible Risks: Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability. In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at (786) 600-4733. The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services. In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor. In very rare events, security protocols could fail, causing a breach of privacy of personal medical information. In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.

Patient Acknowledgments: By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following: 1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services. 2. I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials. 3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures. 4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason. 5. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, at the direction of our Providers. 6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured. 7. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year. 8. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time. 9. I understand I have the right to object to the videotaping of the telehealth consultation. 10. I understand there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate. 11. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all. 12. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state. 13. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery. 14. I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send copy of my medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery. 15. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. 16. I understand that I may not be covered under my current health insurance plan for telehealth services. Patient Informed Consent I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

☐ **ACCEPT.** By checking the Box for this "TELEHEALTH INFORMED CONSENT" I hereby state that I have read, understood, and agree to the terms of this document.

SIGNATURE OF PARENT OR GUARDIAN

X ____ DATE: ____________________________