MARIMÓN PEDIATRICS

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name/Family Name:

First Name:	Middle Name:	Sex:	Date of Birth:
1:			
2:			
3:			
4:			

Address:	**Apt/Unit#:**
City, State, Zip:	**Email:**
Home Phone:	**Cell Phone**:

PARENT(S)/GUARDIAN(S)

☐ Responsible party

Last Name:	**First Name:**	**Middle Name:**
Relationship to Patient:	**Sex:**	**Date of Birth:**
Address: ☐ Same as above		**Apt/Unit#:**
City, State, Zip:	**Email:**	
Home Phone:	**Cell Phone**:	

☐ Responsible party

Last Name:	**First Name:**	**Middle Name:**
Relationship to Patient:	**Sex:**	**Date of Birth:**
Address: ☐ Same as above		**Apt/Unit#:**
City, State, Zip:	**Email:**	
Home Phone:	**Cell Phone**:	

PHARMACY

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

INSURANCE INFORMATION

Insurance Company:		**Group Number:**
Address:		**Policy Number:**
City, State, Zip:		**Plan Phone:**
Policyholder:	**Date of Birth:**	**Relationship to Policyholder:**

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT)		
Emergency Contact:	**Relationship to Patient:**	
Contact Home Phone:	**Contact Work Phone:**	**Contact Cell Phone:**

1. AUTHORIZATION FOR TREATMENT:

By my signature below, I hereby authorize Marimón Pediatrics to render medical treatment, which may be deemed medically necessary by its physicians and/or advanced practice providers in their professional judgement, for the care of the child(ren) listed above in this registration form.

SIGNATURE OF PARENT OR GUARDIAN

X _____ DATE: _____

2. PATIENT FINANCIAL RESPONSIBILITY:

Thank you for choosing **MariPeds, LLC (DBA 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/OR 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 a copy of your current valid insurance card as to provide proof of insurance. Proof of insurance is not required if 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 contracts we hold with your insurance companies, all co-payments, co-insurances, and deductibles must be paid at the time of service. Failure on our part to collect such payments may 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 as determined by state and local law, an amount which will be no less than $25 from our office.

COLLECTION POLICY: Should your account become past due, the parent(s) and/or guarantor(s) 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 fees in addition to those described above that may be added to your account. These fees may include, but are not limited to, fees for completing forms, convenience fees for obtaining laboratory samples, late or no-show fees, or fees for walk-in patients.

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: _____

3. 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: _____

4. NOTICE OF PRIVACY ACKNOWLEDGEMENT:

You understand that under the Health Insurance Portability and Accountability Act (HIPAA), you have certain rights to privacy regarding your Protected Health Information (PHI). You understand that our practice has the right to change, update, or otherwise modify our Notice of Privacy Practices. You may contact the practice at any time to obtain the most 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: _____

5. 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: _____

6. 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 (sending to an incorrect e-mail address), copying/backing up, falsification, or discoverability as evidence in court. E-mail may also be used to introduce viruses and other malware 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: _____

7. 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 this box, I hereby state that I have read, understood, and agree to the terms of this document.

☐ **REJECT/REVOKE.** By checking this box, I hereby state that I reject or am revoking this consent. I understand that every reasonable effort will be made to remove relevant media items from the Marimon Pediatrics website and/or social media pages within a reasonable timeframe. I also understand that these files may have been copied without permission by third parties, and I further agree to not hold Marimón Pediatrics responsible for any instances of these violations.

SIGNATURE OF PARENT OR GUARDIAN

X _____ DATE: _____