pediatric center
OF EXCELLENCE

4425 Ponce de Leon Blvd., Suite 115
Coral Gables, FL 33146
Tel: 305-667-3152
Fax: 305-667-6702
Email:info@pediatricexcellence.com
pediatricexcellence.com

Dr. Mercedes Gonzalez, *Pediatric Dermatologist*
Miami Pediatric Dermatology, LLC

Patient Information:

Patient Name: _____ Social Security Number: ____/____/____ Date of Birth: _____/_____/_____ Sex: M / F (**Circle one**) Married/Single/Divorced/Widow

Address: _____Zip Code: _____

Home Phone: (_____) _____-_____ E-mail Address: _____ Cell Phone: (_____)_____-_____

Preferred Language: (Spanish) or (English)

Pharmacy Name: _____ Phone: _____

Referring Physician/Primary Care Physician: _____ Phone: _____

****How did you hear about our Practice?** _____

Who to call for an emergency:

Name: _____ Relationship: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Primary Insurance	Secondary Insurance
Company Name: _____	Company Name: _____
*I.D. Number: _____	*I.D. Number: _____
Group Number: _____	Group Number: _____
*Policy Holder: _____	*Policy Holder: _____
Policy Holder's Social Security Number: _____ - _____ -_____	Policy Holder's Social Security Number: _____ - _____ -_____
Policy Holder's Date of Birth:_____/_____/_____	Policy Holder's Date of Birth:_____/_____/_____
Sex: M / F	Sex: M / F
Relationship to patient:_____	Relationship to patient:_____

****If your insurance requires a referral for you to see Dr. Mercedes Gonzalez, it is your responsibility to provide our office with the referral. If your insurance company denies payment (due to no referral) you, the patient, agree to pay Pediatric Dermatology of Miami in full for any charges incurred during your visit.**

Patient/ Guardian Signature: _____ Date: _____

Insurance Release Information

I hereby authorize the office Pediatric Dermatology of Miami, to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to Pediatric Dermatology of Miami. I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient/Guardian Signature: _____ Date: _____

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Notice to All Patients

Your health plan has specify regulations you must follow in order for you to avoid liability from full payment on service rendered by our physicians.

Referrals: We participate with many health plans. It is your responsibility as a patient to provide us with an updated referral on the day of you scheduled appointment. Our office cannot be held responsible for obtaining referrals. If we do not have a referral on file on the date of your scheduled appointment, we will reschedule you for a later date. To avoid this problem, we suggest you contact your primary care physician in advance.

Payment Policy: Please be prepared to present your insurance card and Identification Card at every visit. Ensure that our Doctor actively participate with your insurance carrier. Be aware of your insurance policy benefits and limitations. Make sure your insurance is current and active before your arrival. If we cannot verify coverage or there are services rendered that are not covered by your policy, it is your responsibility to paying full at the time of the visit. All insurance co-payments and deductibles must be paid at the time of service.

Patients may receive and are responsible for bills for services sent to another facility such as a laboratory or diagnostic center which may not be covered by the insurance. Patients will be responsible for any bills of unpaid services including services that may have been denied or non-covered by your insurance carrier. Patients will be responsible for paying claims where either the practice or the insurance plan failed to receive accurate patient information. Statements will be mailed for unpaid services. Balances must be paid in 30 days. If a balance is due over 90 days and we have not been contacted to arrange payments, the account may be turned over to a collection agency. Please notify us if you are experiencing financial difficulty and we will work with you on developing a payment plan. We accept cash, Visa, MasterCard, Discover, and personal checks.

Non-Cancellation Policy: Please be courteous and call us if you cannot make your scheduled appointment 24 hours in advance. This allows us to see other patients who may be in need is our services.

Forms: There is a $20 to complete the non-insurance related disability, jury duty or school forms.

Test Results: Pediatric Dermatology of Miami may require a follow-up visit to review and discuss any diagnostic testing or pathology results

Finally, this is your information plan. Please familiarize yourself with every rule of the health plan you are enrolled in. your insurance company will mail a summary of charges, payments, denials, or requests for your further information. Please review all insurance correspondence.

Please sign and return to the front desk after reading it. If you have any questions, feel free to speak to one our office personnel.

I have read and understand the above information.

Patient Name: _____

Signature of patient or guardian: _____ Date: _____

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Medical History Form

Patient Name: _____ Age: _____

Why are you seeing the doctor today? _____

_____

How long: _____

Past Treatments: _____

Current treatment: _____

Past Medical History:

Birth history: Circle: C-section or vaginal Birth weight: _____

Medical Problems: _____

List current medications: _____

Allergies? _____

List prior surgeries or hospitalizations and dates: _____

_____

Family history

	Yes	No	Family member?
Skin cancer: melanoma/ basal cell/ squamous cell			
Abnormal moles			
Eczema			
Asthma			
Diabetes			
High cholesterol			

I acknowledge the above information is true to the best of my knowledge.

Patient Name (print): _____ Date: _____

Signature: _____ Med. Asst: _____

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PARENTAL AUTHORIZATION TO TREAT MINOR CHILDREN WHEN ACCOMPANIED OR NOT ACCOMPANIED BY PARENT OR GUARDIAN

_____ Yes, my child may be treated with Parent or Guardian _____
Yes, my child may be treated when accompanied by:

Name	Relationship	Name	Relationship

_____ Yes _____ No My child over 16 years old may present and be treated unaccompanied by an adult.

Signature of Parent or Legal Guardian:_____ Date:_____

_____

Patient Consent for Medical Photography

Patient name:_____ Date:_____

☐ Check here is minor or unable to provide consent

I consent for medical photographs to be made of me or my child, or person for whom I am legal guardian. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journal as I have designated below. By consenting to these medical photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

_____

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

1. I consent for these photographs to be used in medical publications, including medical journal, textbooks, and electronic publications. I understand that the image may be seen by member of the general public, in addition to scientist and medical researchers that regularly use these publications in their professional education. Although this photographs will be used with our identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.
   Signature:_____ Date:_____

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2. I agree for my image to be shown for teaching purposes and to be used for my medical record but **NOT FOR** medical publication
   Signature:_____ **Date:** _____
3. I agree to use of my image for my medical records **ONLY**
   Signature:_____ **Date:**_____

Notice of Privacy Acknowledgement

Pediatric Dermatology of Miami, LLC

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

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only:

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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MEDICAL RECORD RELEASE FORM

Telephone: 305-667-3152

Fax: 305-667-6702

_____ _____

Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to **Miami Pediatric Dermatology**:

Name: _____ Telephone#: _____

Address: _____ Fax#: _____

_____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records from _____ to _____
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}

_____ _____ Signature

of Patient or Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.11111

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OF EXCELLENCE
TopLine MD Alliance

Pediatric Center of Excellence, LLC
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Office: 305-667-3152

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

- ❑ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

- ❑ Disclose my complete health record except for the following information:
  - ❑ Mental health records
  - ❑ Communicable diseases including, but not limited to, HIV and AIDS
  - ❑ Disclose Alcohol/drug abuse treatment records
  - ❑ Genetic information
  - ❑ Other: _____

    _____

    _____

Form of Disclosure:

- ❑ Electronic copy or access via a web-based portal
- ❑ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

_____

This document will be retained by the providing organization for seven years.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s)listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

- ❑ From _____ to _____

Or

- ❑ All past, present, and future periods

Or

- ❑ The date of the signature in section VI until the following event: _____

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

This document will be retained by the providing organization for seven years.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section VI – Signature

_____ _____
Print Patient Name Date

_____
Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

_____

This document will be retained by the providing organization for seven years.