Pediatric Kidney Center of South Florida

7800 SW 57th Ave,
Suite 305
Miami, FL 33143

9960 N. Central Blvd,
Suite 300
Boca Ratón, FL 33428

Tel: 305-856-7005
Fax: 786-577-2117

Dr. Fanny González, *Pediatric Nephrologist*
Pediatric Kidney Center of South Florida, LLC

PATIENT INFORMATION:

Patient Name:_____ Social Security#: ____/____/____
Date of Birth: _____/____/_____ Sex ☐ Male ☐ Female Race:_____
Address:_____City_____State_____Zip Code_____
Telephone (Home):_____(Mobile):_____(Work):_____
E-mail Address:_____
Preferred Language: (Spanish) or (English)
Pharmacy Name:_____ Pharmacy Address/Telephone:_____
Referring Physician/Pediatrician:_____Phone:_____
****How did you hear about our practice?**_____

PARENT / LEGAL GUARDIAN INFORMATION:

Mother:_____Date of Birth:_____
Social Security Number:_____/_____/_____Employer/Occupation:_____
Mobile Phone:_____Work Phone:_____
Father:_____Date of Birth:_____
Social Security Number:_____/_____/_____Employer/Occupation:_____
Mobile Phone:_____Work Phone:_____

INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Company Name:_____	Company Name:_____
Policy ID Number:_____	Policy ID Number:_____
Group Number:_____	Group Number:_____
Policy Holder:_____	Policy Holder:_____
Policy Holder SS#:_____	Policy Holder SS#:_____
Policy Holder Date of Birth:_____	Policy Holder Date of Birth:_____
Relationship to Patient:_____	Relationship to Patient:_____

*****If your insurance requires a referral for you to see Dr. Fanny González, 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 Kidney Center of South Florida in full for any charges incurred during your visit.**

Patient/ Guardian Signature: _____ Date: _____

Insurance Release Information

I hereby authorize the office Pediatric Kidney Center of South Florida, 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 Kidney Center of South Florida. I understand I am financially responsible for any balance not covered by my insurance carrier.

Patient/Guardian Signature: _____ Date: _____

Pediatric Kidney Center of South Florida

7800 SW 57th Ave, Suite 305
Miami, FL 33143

9960 N. Central Blvd, Suite 300
Boca Ratón, FL 33428

Tel: 305-856-7005
Fax: 786-577-2117

Dr. Fanny González, *Pediatric Nephrologist*
Pediatric Kidney Center of South Florida, LLC

Office Policies And Procedures

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

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 your 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 future 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 to enusre that our doctor actively participates with your insurance carrier. 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 pay in full at the time of the visit. All insurance co-payments and deductibles must be paid at the time of service. We accept cash, personal checks, Visa, MasterCard, and Discover.

Cancellation/No Show/Late Arrival Policy
We understand that there are times when you must miss an appointment due to emergencies or obligations at work or with family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly full appointment book. Therefore, if an appointment is not cancelled and/or rescheduled at least 24 hours prior to the appointment time you will be subject to a fifty-dollar ($50) fee which will be automatically billed to your credit card on file. If we do not have a credit card on file this fee must be paid prior to any other appointment. This fee will not be covered by your insurance company.

In an effort to keep our very busy schedule on time, patients who arrive 15 minutes or more past their scheduled appointment time will be subject to a fifty-dollar ($50) fee and risk losing their scheduled appointment.
We use a text messaging service to verify your appointments. Whoever receives this message MUST reply to the message. If you do not receive a message, you must notify our office so that we can investigate. Failure to respond to appoint verification text will be subject to a cancellation fee of $50 and you will lose your appointment.

Forms There is a $20 fee for school forms and copy of all medical records.

Test Results Test results require a follow-up visit to review and discuss any diagnostic testing.

Credit Card on File

We have a requirement to maintain a valid and non-expired card on file with our office. This card will be used to take payment for copay/balance/etc. at the time of service. We will let you know at check-in or check-out the amount we will be charging. You may also choose to pay with a different method at time of service if desired, just let the front desk know. IF you are using an HSA/FSA card. We will require a backup card also be kept on file. We will always attempt to use HSA/FSA first, but in case it does not have enough funds we will use the backup. HSA/FSA accounts allow you to reimburse yourself for payments made for medical expenses. We will provide all necessary receipts and details. **For balances older than 30 days we will attempt to contact you. If we do not hear back your balance will be automatically charged to the card on file. We will send a notification the day before we run the transaction. We will charge a maximum of $200 every 2 weeks until balance is fully paid.**

Name on Card: _____
Credit Card#_____
Exp. Date: _____
CVC: _____
Billing Address: _____

Deductibles / Copays / Payments / Past Due Accounts

Our insurance contracts require us to collect deductible amounts and copays at the time of service. For your convenience, we accept cash, check (in-state only), and Credit Card. All checks retuned by the bank will be subject to a $30 charge as well as any bank fees associated with the returned check. Payment for past-due balances for previous services rendered is also expected when your child is seen in this office. All accounts that are over 90 days past due will be subject to a finance charge that will be applied every 30 days. This charge will be the greater of $25 or 25% of the current balance. It is the policy of this office to turn accounts with balances overdue for 120 days or more to a collection agency. We would prefer not to take this course of action as it may adversely affect your ability to obtain credit in the future. We understand that many of our patients and parents have HSA or FSA accounts for their medical expenses. However, when the available balance on those accounts cannot fully cover your expected payment, we expect you to pay the difference in another way. HSA/FSA accounts allow you to reimburse yourself for payments made for medical expenses on another card/cash/check. We will provide all necessary receipts and details.
While we understand that there are occasionally complicated financial agreements between estranged/separated/divorced parents, we cannot and will not be directly involved in these situations. Payments and balances are expected to be paid at the time of service by WHOEVER brings the child into our office. To help with this, we have also instituted a credit card on file program. Proper receipts and documentation are always available for you to settle the matter between yourselves, as adults.

Telemedicine

We offer telemedicine visit only for Test Results if insurance covers for it. Be aware that some insurance have different payment regarding telemedicine depending the insurance plan. We won't give out any test results if payment is not paid first. For any other questions, it will have to be in person office visit such as, pre-op, follow up appointments, surgery clearance etc. The website we use for our telemedicine visit is DOXY.ME/DRFG.

Prescriptions

The parent has the responsibility of obtaining a photocopy of the prescriptions that are given out in the office, as copies are not maintained by us. Prescriptions are not faxed to the hospital. Prescriptions that are misplaced will have a cost of $25 to resend.

Minors

A parent/legal guardian must accompany a patient under the age of 18 years on every visit to our office.
I hereby authorize Pediatric Kidney Center of South Florida, LLC to release information required by my insurance company for payment of my child's medical bills or to review activities related to my healthcare provider's participation in my health plan. I assign Pediatric Kidney Center of South Florida, LLC any and all benefits to which the patient or insured party is entitled for medical services rendered. I have read these Office Policies and agree to abide by it.

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 (EOB), payments, denials, or requests for your further information. Please review all insurance correspondence.

Please sing and return to the front desk after reading. If you have nay questions, feel free to speak to one of our office personnel.

I have read and understand the above information.

Parent Name: _____

Signature: _____ Date: _____

Pediatric Kidney Center of South Florida

7800 SW 57th Ave,
Suite 305
Miami, FL 33143

9960 N. Central Blvd,
Suite 300
Boca Ratón, FL 33428

Tel: 305-856-7005
Fax: 786-577-2117

Dr. Fanny González, *Pediatric Nephrologist*
Pediatric Kidney Center of South Florida, LLC

COMMUNICATION AUTHORIZATION

Pediatric Kidney Center of South Florida would like to communicate with you in the ways you prefer. By signing below, you allow us to disclose your Protected Health Information (PH) as described on this form. PHI includes all information about your treatment or payment for your care. We may disclose your PHI in other ways if it is permitted by law and we determine such disclosure to be necessary under the circumstances.

Patient Name: _____

Date of Birth: _____ **Today's Date:** _____

			Initials
1	**Telephone messages:** We may leave messages on answering machines or with individuals answering the phone at numbers written in this section, including referral information, prescription refill reminders, appointment reminders, test results, and other information the Practice determines to be appropriate to leave on voicemail.	Phone numbers:	
2	**Email Communications:** We may send email messages to your listed email address including referral information, test results, and other information.	Email:	

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

_____ Yes, my child may be treated when accompanied by:

Name	Relationship

_____
Name of Parent/Legal Guardian (print)

_____ _____
Signature of Parent/Legal Guardian Date

Pediatric Kidney Center of South Florida

7800 SW 57th Ave,
Suite 305
Miami, FL 33143

9960 N. Central Blvd,
Suite 300
Boca Ratón, FL 33428

Tel: 305-856-7005
Fax: 786-577-2117

Dr. Fanny González, *Pediatric Nephrologist*
Pediatric Kidney Center of South Florida, LLC

Notice of Privacy Acknowledgement

Pediatric Kidney Center of South Florida

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 (print) Patient Date of Birth

_____
Name of Parent/Legal Guardian (print)

_____ _____
Signature of Parent/Legal Guardian Date

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: _____

Pediatric Kidney Center of South Florida

7800 SW 57th Ave,
Suite 305
Miami, FL 33143

9960 N. Central Blvd,
Suite 300
Boca Ratón, FL 33428

Tel: 305-856-7005
Fax: 786-577-2117

Dr. Fanny González, *Pediatric Nephrologist*
Pediatric Kidney Center of South Florida, LLC

MEDICAL RECORD RELEASE FORM

Telephone: 305-856-7005
Fax: 786-577-2117
Only fill out what's highlighted

_____ _____
Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to Pediatric Kidney Center of South Florida:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records from _____ to _____
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Films (X-ray, Ultrasound, CT, MRI, etc.)

_____ _____
Signature of Patient or Parent/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 disclosedmay, 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 of the consent.

Pediatric Kidney Center of South Florida

7800 SW 57th Ave,
Suite 305
Miami, FL 33143

9960 N. Central Blvd,
Suite 300
Boca Ratón, FL 33428

Tel: 305-856-7005
Fax: 786-577-2117

Dr. Fanny González, *Pediatric Nephrologist*
Pediatric Kidney Center of South Florida, LLC

Patient Name: _____

DOB: _____

Acknowledgements/Authorizations/Consent to Treatment

I hereby consent to any and all diagnostic procedures, tests, and medical treatments required in the diagnosis of my illness and course of treatment by the physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any other services rendered.

I hereby authorize the physician designated to release all necessary information (via Fax Transmittal, e-mail or hard copy) acquired in the course of my examination and treatment to secure payment. I hereby assign payment directly to the designated physician for any medical/surgical procedures performed. I hereby authorize my consent for medication release.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein. I agree that this authorization shall be valid until rescinded in writing or replaced by of a later date.

_____ _____

Signature of Patient, Parent or Guardian Date

Pediatric Kidney Center of South Florida

7800 SW 57th Ave, Suite 305
Miami, FL 33143

9960 N. Central Blvd, Suite 300
Boca Ratón, FL 33428

Tel: 305-856-7005
Fax: 786-577-2117

Dr. Fanny González, *Pediatric Nephrologist*
Pediatric Kidney Center of South Florida, LLC

NEW PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Nickname: _____

Sex: _____ Age: _____ Date of Birth: _____

What problem brings you today? _____

How long has this problem been going on for? _____

SOCIAL HISTORY:

	Name	Age	Medical Problem	Medications
Mother:	_____	_____	_____	_____
Father:	_____	_____	_____	_____
Siblings:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

If mother and father don't live together, or child doesn't live at home, what is the child's custody status? _____

Is patient in daycare/school? ☐ Yes ☐ No; If yes: Name of school and grade? _____

BIRTH HISTORY:

Birth Weight: _____ Full term? ☐ Yes ☐ No; If early/late, how many weeks gestation? _____

Any problems with the pregnancy (high blood pressure, blood or protein in urine, etc)? ☐ Yes ☐ No _____

Was the delivery ☐ vaginal OR ☐ C-section ; If ceasarian, why? _____

Did the patient have any problems at birth? ☐ Yes ☐ No _____

Was the patient on a ventilator? ☐ Yes ☐ No; If yes, how long? _____

MEDICAL HISTORY:

Does the patient have any serious illnesses or medical conditions? ☐ Yes ☐ No EXPLAIN: _____

Has the patient had any surgeries (When/Type)? ☐ Yes ☐ No EXPLAIN: _____

Has the patient ever been hospitalized? ☐ Yes ☐ No EXPLAIN: _____

Is the patient allergic to any medicines or drugs? ☐ Yes ☐ No EXPLAIN: _____

What medications (including over the counter) is the patient currently taking? _____

_____

Immunizations up to date? ☐ Yes ☐ No

FAMILY HISTORY:

Has any family member had any of the following?

Kidney disease	☐ Yes ☐ No	Who: _____	Comments: _____
Kidney stones	☐ Yes ☐ No	Who: _____	Comments: _____
Kidney failure	☐ Yes ☐ No	Who: _____	Comments: _____
Dialysis (kidney treatments)	☐ Yes ☐ No	Who: _____	Comments: _____
Kidney transplant	☐ Yes ☐ No	Who: _____	Comments: _____
High blood pressure	☐ Yes ☐ No	Who: _____	Comments: _____
Deafness	☐ Yes ☐ No	Who: _____	Comments: _____
Vesicoureteral reflux	☐ Yes ☐ No	Who: _____	Comments: _____

Additional Family History: _____

PAST MEDICAL HISTORY:

Does the patient have/ever had any of the following:

Fever	☐ Yes ☐ No	Explain: _____
Fatigue	☐ Yes ☐ No	Explain: _____
Headaches	☐ Yes ☐ No	Explain: _____
Dizziness	☐ Yes ☐ No	Explain: _____
Vision problems	☐ Yes ☐ No	Explain: _____
Nose bleeds	☐ Yes ☐ No	Explain: _____
Sore throats/throat infections	☐ Yes ☐ No	Explain: _____
Heart problems (murmur)	☐ Yes ☐ No	Explain: _____
High blood pressure	☐ Yes ☐ No	Explain: _____
Asthma, Bronchiolitis, Pneumonia	☐ Yes ☐ No	Explain: _____
Blood transfusions	☐ Yes ☐ No	Explain: _____
Vomiting	☐ Yes ☐ No	Explain: _____
Diarrhea	☐ Yes ☐ No	Explain: _____
Blood in urine	☐ Yes ☐ No	Explain: _____
Protein in urine	☐ Yes ☐ No	Explain: _____
Urine, bladder, and/or kidney infection	☐ Yes ☐ No	Explain: _____
Pain when urinates	☐ Yes ☐ No	Explain: _____
Urinating more often	☐ Yes ☐ No	Explain: _____
Urinating less often	☐ Yes ☐ No	Explain: _____
Accidents or bedwetting	☐ Yes ☐ No	Explain:_____
Joint pain or swelling	☐ Yes ☐ No	Explain: _____
Muscle problems	☐ Yes ☐ No	Explain: _____
Rashes	☐ Yes ☐ No	Explain: _____
Neurologic problems (Seizures)	☐ Yes ☐ No	Explain: _____