Juan Carlos Millon, MD, FAAP
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We apologize for the inconvenience. However, due to the medical Reform Act that was written into law by Congress on January 29, 2009, we are required to update our patient's information into our system yearly in order for our transition to the Electronic Medical Records (EMR).

PATIENT REGISTRATION/ADDRESS CHANGE/INSURANCE CHANGE

Please Print

PATIENT'S Last Name ________________________________First: _____________________________Middle Initial:____
(Apellido de paciente) (nombre) (Segundo nombre)

Address ______________________________ Apt/Unit#_________ City ________________ Sate ___________ Zip ______
(Dirección) (# de apartamento) (Ciudad) (Estado) (Código postal)

Home Phone __________________ Cell Phone (18y/o & up) ________________Email Address ______________________
(# teléfono-casa) (# teléfono- móvil) (correo electrónico)

Age ___ Birth Date ____________ Gender: Female ____ Male ____ Birthday Place (Hospital) ______________________
(Edad) (Fecha de Nacimiento) (Género) (Nombre de hospital donde nació)

Race: (Circle) *White Asian Black/African American Hawaiian Pacific Islander Other*

Ethnicity: *(Circle) Hispanic/Latino Not Hispanic/Latino*

Primary Language Spoken: _____________________Referred by____
(Primer idioma) (Fuente de referencia)

PARENT'S marital status: (Circle) *Single Married Divorced Widowed*
(Estado civil de padres) (soltera) (Casada) (Divorciada) (viuda)

Mother's name ____________________________ _______________ D.O.B. ___________ Cell Ph # ____________________
(Nombre de madre) (Fecha de nacimiento) (# móvil)

e-mail _______________________Occupation _______________ Employer _______________Business Ph# ____________ Ext. #__
(correo electronico) (Ocupación) (Empleado) (# telefónico de trabajo)

Father's Name _____________________________ _________________ D.O.B. ___________ Cell Ph # ____________________
(Nombre de padre) (Fecha de nacimiento) (# móvil)

e-mail _______________________Occupation _______________ Employer _______________Business Ph# ____________ Ext. #__
(correo electronico) (Ocupación) (Empleado) (# telefónico de trabajo)

RESPONSIBLE PARTY

Name of Insurance ___________________________HMO or PPO/POS/Other ________________or Medicaid__________
(Nombre de Seguro medico)

Contract, ID or Policy # ______________________ Group # _____________ Group Name ______________
(número de póliza) (# de grupo) (Nombre de compañía)

Name of Insured ________________________________ Relationship to Patient ________________________
(nombre del asegurado) (relación con el paciente)

**Do you have Secondary Insurance you would like us to bill after primary: ☐ Yes (if so, provide information below) ☐ No
(tiene un seguro secundario que le gustaría que facturemos después de la primaria)

Name of Insurance ________________________ Contract, ID or Policy # ______________________ Group # ___________
(Nombre de Seguro medico) (número de póliza) (# de grupo)

SECONDARY INSURANCE WILL ONLY GET BILLED IF INFORMATION PROVIDED IS ON THIS FORM

Pharmacy Name ______________________ Address ____________________________ Phone _________________________
(nombre de Farmacia) (Dirección) (# de teléfono)

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Name of Person Bringing in Child in your Absence _______________________________
(Nombre de la persona que ira a traer a su hijo en su ausencia)

How Related ____________________________ Phone:__________________________
(relación) (# movil)

Emergency Contact: Please provide us with a reliable contact person in the event that you are not reachable by the phone numbers you gave us.
(contacto de emergencia)

Name: ________________________ Phone: _____________________ How Related: _____________________
(nombre) (# movil) (relación)

AUTHORIZATION

I, the undersigned, authorize my insurance to pay directly to Worldwide Pediatrics Group, LLC. and all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits from my Insurance Company or Plan. I authorize the use of this signature on all my insurance submissions. I also authorize release of all medical records to other physicians to whom I am referred for care.

I acknowledge that I am personally responsible and liable to Worldwide Pediatrics Group, LLC. for any and all fees billed. Should Worldwide Pediatrics Group, LLC. accept payment by direct assignment from Medicaid or any Insurance company, I understand that I am responsible and liable for any and all deductible expenses and “co-insurance” not covered by Medicaid or my primary Insurance company, I understand that any overpayment on my part will be refunded to me.

I acknowledge that I am personally responsible for full payment of all “non-covered” services, and I am responsible for all returned checks and I agree to pay a $25.00 per check per incident fee for each returned check. If I am placed into collections or if my account goes to litigation, I agree to be responsible for all collection and attorney’s fees.

Lifetime Signature: ________________________________ Date: ___________________

PLEASE NOTE: You must produce your Insurance card to Front Desk at Every visit

FINANCIAL POLICY

Thank you for choosing **Worldwide Pediatrics Group, LLC** 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
WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from us, your primary care physician, if your insurance carrier requires it for your visits. Referrals as well as authorizations can take anywhere from 3 – 10 days to complete. Authorizations due to relying on Insurance to approve.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

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 Medicare or other insurers. You must pay for these services in full at the time of visit.

NO SHOW FEE: if you do not call to cancel and/or reschedule your appointment 24 hours prior to your appointment, you will be charge a $20.00 no show fee.

RETURNED CHECKS: Any checks returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $25.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor 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 bureau.

CONVENIENCE FEES: There is a $20.00 convenience fee charged for having blood drawn in the office. ***Forms:*** Any forms completed during an office visit will have no charge; however, if they are requested outside of the office visit, a charge of $5.00 each will be applied. These forms are: WIC, 680, 3040, Sports and Camp forms. Also any form having to be filled out and/or signed by the doctor or the medical assistant will have a charge of $5.00.
Letters or FMLA applications requested on behalf of the patients and/or parent for any purpose $10.00. ***Copies of medical records:*** According to the Florida Administrative Code Rule F.S. 45S.309 the cost of producing copies of medical records is $1.00 per page for the first 25 pages, $0.25 cents for each additional page.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name: ____ Date: __________________________

Patient/Responsible Party Signature: ____

POLIZA FINANCIERA

Gracias por escoger **Worldwide Pediatrics Group, LLC** como su proveedor de salud. Estamos comprometidos a construir una exitosa relación médico-paciente. La siguiente información es nuestra Póliza financiera. Nuestra oficina amablemente responderá cualquier pregunta o inquietud que pueda tener.

EL PAGO DEBE OCURRIR EN EL MOMENTO DE LA VISITA
TODOS LOS COPAGOS Y DEDUCIBLES DEBEN SER CANCELADOS ANTES DE SER ATENDIDO

Aceptamos todo tipo de pago: Efectivo, Cheques, Visa, Mastercard, Discover, American Express

PRUEBA DE SEGURO MEDICO: Todos los pacientes deben completar las formas acerca de la información del paciente antes de ser atendido por el Doctor. Debemos obtener una copia de su licencia de conducir y de la tarjeta vigente u otra información del seguro como prueba de su seguro de salud. Si usted no nos provee a tiempo con la información correcta del seguro médico es posible que usted sea responsable por el balance de la visita. Nuestros Doctores están afiliados a la mayoría de las aseguradoras más conocidas, sin embargo, el paciente es responsable de saber y entender los requerimientos de su plan de seguro. Como parte de su contrato con su compañía de seguro, todos los co-pagos, co-insurances y deducibles deben ser pagados en el momento de la visita. Es importante notar que el no cobrar a los pacientes estos co-pagos y deducibles se pueden considerar como Fraude.

HMO/REFERIDOS: Es responsabilidad del paciente pedir la forma para los referidos de la oficina del Doctor si su seguro lo requiere para las visitas. Tanto los referidos como las autorizaciones pueden tomar de 3 a 10 días para ser completadas. Las autorizaciones toman más tiempo dado que dependen de la aprobación del seguro.

PACIENTES MENORES: Los padres o guardianes que acompañan al menor son los responsables del pago de la visita.

SERVICIOS NO CUBIERTOS POR EL SEGURO: Por favor tenga presente que algunos- o quizás todos- los servicios que reciba puedan no ser cubiertos por el seguro o ser considerados como no razonables o necesarios por Medicare u otros seguros de salud. El paciente debe pagar por estos servicios en su totalidad en el momento de la visita.

NO ASISTIR A SU CITA: si usted no llama a cancelar o cambiar su cita con 24 horas de anticipación se le cobrara $20.00 por la falta.

CHEQUES DEVUELTOS: Cualquier cheque devuelto por fondos no suficientes estará sujeto a comisiones bancarias (la cantidad que el banco cobra de la práctica) junto con un cargo de $25.00 NSF de la oficina.

POLIZA DE COLECCIÓN: Si su cuenta se vence, el paciente / deudor asume todos los costos de recolección, incluyendo, pero no limitado a, los honorarios de la agencia de cobro, los costos judiciales, los intereses y los honorarios legales. Todas las cuentas no pagadas serán reportadas a la oficina de crédito.

HONORARIOS DE CONVENIENCIA: Si el paciente decide sacarse la sangre en la oficina, se le cobrara una tarifa de $20.00 por conveniencia. ***Formas:*** Cualquier forma que se complete durante la visita al Doctor no tendrá ningún cargo, sin embargo si las formas son solicitadas en cualquier otro momento tendrán un cobro de $5.00 cada una. Las formas que se proveen en esta oficina son las siguientes: WIC, 680, 3040, deportes y campos de verano. Igualmente, cualquier otra forma que necesite ser completada y/o firmada por el médico o enfermera tendrá un cargo de $5.00. ***Las cartas o aplicaciones de FMLA*** solicitadas a favor del paciente y/o de los padres para cualquier propósito tendrán un costo de 10.00. ***Las copias de expedientes médicos***: Según la regla administrativa del Código de la Florida F.S. 45S.309, el costo de cualquier copia de historiales médicos es de$1.00 por página por las primeras 25 paginas, y $0.25 centavos por cada página adicional.

HE LEÍDO Y ENTENDIDO COMPLETAMENTE la Póliza Financiera y todas mis preguntas con respecto a esta póliza han sido contestadas. Por la presente, acepto hacer el pago de acuerdo con los términos y condiciones establecidos.

Nombre del Paciente: ____ Fecha: _______________________

Firma del Paciente o Persona responsable por el paciente: _______________________________________

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Notice of Privacy Acknowledgement

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: ________________________________

1222 N. University Drive
Plantation, FL 33322
T: (954) 581-3100
F: (954) 581-7773

7950 NW 53rd Street, Suite 102
Doral, FL 33166
T: (786) 631-3222
F: (786) 245-4721

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Notice of Insurance Acknowledgement

Please advise that recent changes have been made to our insurance agreements.

If it is required by your insurance company that a primary care physician is to be added to the benefits card, it is required prior to any services rendered. One of our providers *must* be listed on the designated insurance cards.

Failure to do so *or* if lack of insurance coverage occurs, it is under my responsibility to pay the balance of such office visits and any other necessary fees pertaining to that visit, including vaccinations, labs, eye exams, etc.

Please contact our billing department should any further questions arise.

____

Patient Name (print) Date

____

Parent/Legal Guardian Name (print) Parent/Legal Guardian Signature

1222 N. University Drive
Plantation, FL 33322
T: (954) 581-3100
F: (954) 581-7773

7950 NW 53rd Street, Suite 102
Doral, FL 33166
T: (786) 631-3222
F: (786) 245-4721

3/7/19

WORLDWIDE PEDIATRICS

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to: Worldwide Pediatrics Group, LLC. for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my Insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Worldwide Pediatrics Group, LLC. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I demand that payment of authorized benefits be made on my behalf.

ASIGANCION DE BENEFICIOS DE SEGURO

Autorizo el pago directo de beneficios quirúrgicos/médicos a Worldwide Pediatrics Group, LLC. por los servicios recibidos por el/ella en persona o bajo su supervisión. Entiendo que soy financieramente responsable por cualquier balance no cubierto por mi seguro.

AUTORIZACION PARA LA LIBERACION DE INFORMACION

Autorizo a Worldwide Pediatrics Group, LLC. a proveer cualquier información medica o incidental que pudiera ser necesaria para propósitos de cuidado médico o de aplicación para beneficios financieros.

Certifico que toda la información que he dado es correcta y autorizo la liberación de los expedientes cuando sea requerido. Solicito que el pago de beneficios sea autorizado a mi favor.

Patient Name: ____

Parent/Guardian Name: _________________________________

Signature: ______________________________________

Date: _____________________

WORLDWIDE PEDIATRICS

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Dear Parent,

Every child needs regular vision screening and our doctors follow the American Academy of Ophthalmology (AAO) suggestion "that during childhood, babies up to age 2 should have vision screening during regular pediatric visits and screening every one to two years for ages 3 to 19."

To effectively address vision issues in your children, our practice uses an automated vision screening technology which is a rapid and highly reliable method that instantly detects the most common treatable sight threatening conditions in children such as: **refractive errors** (*nearsightedness, farsightedness, unequal power & astigmatism*), **amblyopia** (*lazy eye*), **strabismus** (*crossed eyes*) and **media opacities** (*cataracts*).

By offering the latest technology, our practice is taking a leadership role in the community to identify vision issues that can hamper your child's ability to learn. The prevalence of vision issues has a profound social impact:

- **80%** of what a child learns until age 12 is **visually acquired**
- **25%** of school age children **have a vision issue**
- Unlike other ailments, **pain is not associated with vision issues**
- Children with vision issues **do not have a reference point for good vision**

Automated screening does not replace a complete and comprehensive eye examination by an optometrist or ophthalmologist, nor can it detect all eye diseases or conditions. Screening determines if your child requires the immediate attention of a vision care specialist.

While automated technology is designed to determine if your child should be referred to an eye care specialist, some insurance companies do not cover all aspects of healthcare and often do not cover expenses associated with automated vision screening.

Unfortunately we cannot offer this service for free, thus by checking "yes" below, you are accepting responsibility for any uncovered expenses associated with this **$25.00** screening.

PLEASE CHOOSE **ONE** OPTION:

☐ **Option 1. YES**, I want to have automated screening performed on my child

☐ **Option 2. NO**, I will seek vision care from an eye care specialist independently

____________________	____________________	__________
Parent Signature/DOB	Patient Name	Date

AGREEMENT FOR SELF-PAY PAYMENT OF TELEHEALTH SERVICES

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care.

TERMS

Worldwide Pediatrics Group, LLC is committed to providing the best quality healthcare services. Depending on your insurance coverage, your plan may *not* pay for these telehealth services. In the event that your health plan does not cover the telehealth service, we will charge *you* for the service.

We will provide you with an itemized statement and receipt which you can use as documentation should *you* choose to seek reimbursement from your insurance plan, employer, or an employer-sponsored medical savings account.

ACCEPTANCE OF TERMS

By signing this form, you are electing to purchase services that *may or may not* be covered by your insurance if you obtained those services from a different provider or if you obtained them through an in-person consult.

You have selected services for purchase from Worldwide Pediatrics, LLC on a self-pay basis and have directed your Payer to treat your purchase of these services as if you are an uninsured patient. *A signed statement reflects that you agree to be financially responsible for full payment of services.*

Please note that there is no guarantee that your insurance company will make any payment on the cost of the telehealth services you have purchased.

Worldwide Pediatrics, LLC. has provided you with the charges, in advance, for the services you have requested. You have been given a choice of different services, along with their costs.

I have read the Agreement for Self-Payment of Telehealth Services. I understand and agree to this Agreement.

____
Print Patient Name

______________________________________ ______________________________________
Patient Signature **Date**

____
Print Guardian Name

______________________________________ ______________________________________
Guardian Signature **Date**

Please provide which phone number and email address you will use to create your account in HEALOW
PHONE: ________________________ EMAIL:____