Molinares Medical and Holistic Centre, Inc
2311 Cypress Cove, Suite 101, Wesley Chapel, FL 33544
Phone 813-994-5039 Fax 813-994-5098

Patient Registration Form

PCP: Alexandra M. Molinares Sosa

Last Name: _____ First Name: _____ Middle Name: _____

Social Security: _____ Sex: _____ DOB: _____ Marital Status: _____

Address: _____ Phone: _____

_____ Other Phone: _____

_____

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Name: _____	Insurance Name: _____
Insurance ID: _____	Insurance ID: _____
Group #: _____	Group #: _____
Primary Person Insured: _____	Primary Person Insured: _____
Primary Person DOB: _____	Primary Person DOB: _____
Social Security: _____	Social Security: _____

What Pharmacy are you using

Pharmacy Name: _____

Phone: _____

Patient Portal Access

Please provide an email address so we can send you the registration link to gain access to the Patient Portal account.
Your email address will only be used for direct communications from the office.
No marketing or soliciting will be sent from the office.

Email: _____

Emergency Contact

Please list the name and phone number from a family member or friend that we can contact in case of emergency

Name: _____ Phone: _____

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

Patient printed Name: _____

Patient Signature: _____ Date: _____

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FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS FORM

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Molinares Medical & Holistic Centre, Inc. medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Molinares Medical & Holistic Centre, Inc. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Molinares Medical & Holistic Centre, Inc. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

RELEASE OF MEDICAL AND BILLING INFORMATION

I ☐ **authorize** ☐ **do not authorize** Molinares Medical & Holistic Centre, Inc. and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:

Name _____ Relationship_____

I understand that the designated person(s) above will be able to speak to any member of Molinares Medical & Holistic Centre, Inc. staff. Furthermore, I understand that the physician's office cannot be held liable for any information the above stated person(s) may obtain regarding my medical care or my account and/or appointment.

Molinares Medical & Holistic Centre, Inc. ☐ **may** ☐ **or may not** leave test notifications, instructions regarding medications or appointments at the phone number(s) that I provided, including an automated answering machine or voice mail.

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FINANCIAL POLICY

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. **MOLINARES MEDICAL & HOLISTIC CENTRE, INC.** accepts cash, Care Credit, VISA, MasterCard, and AMEX. There is $30 fee for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered 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.

4. **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.

5. **Claims submission.** We will submit your insurance claims **as a courtesy** and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will be accepted, however that will not constitute a payment arrangement unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you will be responsible for all costs of collection and/or attorney's fees. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

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8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We will charge you a no call/no show fee of $60 or whichever amount is higher posted at the office. Once you reach 3 no call/no show fee, you will be dismissed from the office.

CONSENT TO TREAT

I hereby give my consent to the physician and healthcare providers at Molinares Medical & Holistic Centre, Inc. to provide medical treatment as deemed necessary.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize Molinares Medical & Holistic Centre, Inc. to view my external prescription history via the RxHub service. I understand that prescription history from multiple other medical providers, insurance companies and pharmacies may be viewable by the office staff of Molinares Medical & Holistic Centre, Inc., and may include historical prescription for several years.

NOTICE OF PRIVACY POLICIES ACKNOWLEDGEMENT

By law, we are required to make available to you a copy of our Notice of Privacy Policy. By signing below, you acknowledge that you received or been offered and declined a copy of our Privacy Policy. A current copy of the Privacy Policy is available to you upon request. If the Privacy policy is revised, you may review and obtain the new version at any time.

I have received, or declined a copy of our Notice of Privacy Policy.

SIGNATURE SECTION

The undersigned has read and agrees to the information stated above for the:

- Assignment of Benefits
- Release of Medical and Billing Information
- Financial Policy, including prompt payment and no show fees
- Consent to Treat
- Consent to obtain external prescription history
- Notice of Privacy Policy

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

_____ _____
Patient Name (print) Date

_____
Patient Signature

_____ _____
Witness Name (printed) Date

_____
Witness Signature

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name: _____ Date of Birth: _____

Social Security_____/_____/_____

Authorization for Use/Disclose of Information: I voluntary authorize and direct:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

To release my health information during the term of this authorization to the recipient that I have identified below:

Molinares Medical & Holistic Centre, Inc.
2311 Cypress Cove Suite 101
Wesley Chapel, FL 33544
Phone (813) 994-5039 Fax (813) 994-5098

Purpose: I understand that the specific purpose of this Authorization is:

_____ Medical Care (entire medical record) _____ Insurance Purposes _____ Patient Request

I understand that I may revoke this Authorization in writing at any time, except to the extent information was released or other action taken in reliance on it. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to the Privacy Official, Molinares Medical & Holistic Centre, Inc., 2311 Cypress Cove Lane Suite 101, Wesley Chapel, FL 33544.
I understand the potential for further disclosure by recipients of the information to persons who may not be subject to privacy or confidentiality protections.
I understand that the above identified health information may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and/or information.
I understand that I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.
I understand that I may refuse to sign this Authorization, and that no treatment, payment or benefits are conditioned upon my providing this Authorization. If I refuse to sign this Authorization, I understand that the disclosure described above cannot be made unless it is authorized or required by law.

_____
Signature of Patient or Legal Representative Patient Date

_____
Printed Patient Name or Legal Representative

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Payment Authorization Form

Unfortunately, we have experienced a significant amount of cancellations and NO-SHOWS from new and previously established patients without providing a 24 hours' notice. This represents a cost for us since Dr. Molinares is reserving that time to see you and not seeing other patients that are sick and need to come in. The office staff will give you a courtesy call to remind you of your appointment, we would really appreciate if you call to let us know that you will not come in. We kindly request you to call 24 hours before your appointment if you already know that you will not make it.

We understand that emergencies do happen, and we are fine with that, however, calling in to cancel your appointment because you are sick does not constitute a valid reason to cancel an appointment. If you are sick, that is enough reason for you NOT to cancel your appointment and to be seen by Dr. Molinares.

The purpose of this form is to obtain authorization from you to process a $60 charge for cancelling or no showing to your appointment ***ONLY*** if you fail to notify the office staff within a 24 hours' notice. If you leave a voicemail, please clearly say your full name, date of birth, appointment date and time, and a brief explanation of the cancellation request.

If we notice 3 (three) recurring cancellations or No-Shows, we will reserve the right to schedule future appointments and/or we may dismiss you from the office.

By signing this form, I authorize Molinares Medical & Holistic Centre, Inc. to charge the account indicated in this authorization form according to the terms outlined above. This payment authorization is for the described purpose above, for the amount indicated above ***ONLY***. I certify that I am an authorized user of this account and that I will not dispute the payment with my bank. We will use this form for future cancellations and no shows.

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover ☐ Care Credit

Accountholder Name _____

Account Number _____

Expiration Date _____ CCV _____

_____ _____

Patient Name Date

_____

Patient Signature