PATIENT NAME {LAST, FIRST, MIDDLE}	DATE OF BIRTH:	GENDER:
1)________________	__________	M / F
2)________________	__________	M / F
3)________________	__________	M / F
4)________________	__________	M / F
5)________________	__________	M / F

MOTHER'S NAME: ________________________________ DOB:____________

ADDRESS:____________________________________ APT:____________

CITY:________________________ STATE:______ ZIP CODE:____________

EMAIL:____

EMPLOYER:________________________OCCUPATION:________________

PHONE#:__________________________ETHNICITY:_________________

FATHER'S NAME: ________________________________ DOB:____________

ADDRESS:____________________________________ APT:____________

CITY:________________________ STATE:______ ZIP CODE:____________

EMAIL:____

EMPLOYER:________________________OCCUPATION:________________

PHONE #:__________________________ETHNICITY:_________________

_ _ _ _ _ _ _ _ _

INSURANCE CO:__________________ MEMBER ID#:______________________

SUBSCRIBER NAME & RELATION TO PATIENT:____________________________

PATIENT'S EMERGENCY CONTACT/PHONE #:_____________________________

HOW DID YOU FIND US?____

As a Parent or Legal Guardian, I give permission to Mar and Sea Pediatric to treat the patient(s) listed above. I agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I understand that I am responsible for any co-payments and/or non-covered insurance charges. I also authorize the release of medical information necessary for the processing of insurance claims. Please sign below signifying that you have read and understand the above statement and that thus the office has permission to submit insurance claims.

PRINT NAME OF PARENT OR GUARDIAN:__________________________________

SIGNATURE:______________________________ DATE:__________________

NEWBORN INSURANCE ENROLLMENT POLICY STATEMENT

Adding your newborn to your insurance policy is not automatic. **You, the insured, must call and initiate the addition of your new baby to your policy**, including the selection of Dr. Maria Arreaza as the child's pediatrician, also referred to as primary care physician, or PCP. Insurance companies require you to enroll your newborn in your health plan within 30 days of your baby's birth. If your baby is not enrolled, your insurance plan will deny claims for your baby's care and

you will be responsible for full payment.

• Contact the **EMPLOYER** that provides the insurance you will be using
• Fill out the necessary enrollment forms to notify the employer of the birth and add your child to the policy
• Submit these forms ASAP
• Call your **insurance company** member services department (the phone number is on the **back of the insurance card**) and:

1. Confirm receipt of your forms
2. Confirm enrollment of your newborn
3. Confirm your choice of a PCP with your insurance
   PCP: (MAR AND SEA PEDIATRIC OR DR. MARIA)
4. Request all of your policy information, including the details of your coverage, benefits and limitations.These may include co-payments, coinsurance, deductibles and/or out-of-pocket expenses
5. Familiarize yourself with policy coverage details and rules, exclusions, referral procedures that may result in patient financial responsibility.

ANY QUESTIONS FEEL FREE TO CALL US AT 561-270-5144 OR EMAIL: FAXMARANDSEA@GMAIL.COM

If your baby is not added to the insurance policy within 30 days of their date of birth you will be financially responsible for all charges. It is the patient/parent's responsibility to bring to the office his/her insurance card and information. We are making every effort to keep down the cost of your medical care. **Please understand that you ultimately have the final responsibility of your bill.** If you are applying for Medicaid or Self-Funded coverage through the Marketplace payment is due at time of service until coverage is active. The office will issue you a detailed statement at which time you can submit to the insurance once active for reimbursement.
If you have any questions or concerns, please contact your insurance company immediately. **I certify that I have read the above policy statement and understand that I am responsible for my child's medical cost.**

PATIENT NAME: ________________________________ **DATE OF BIRTH:**______________

SIGNATURE OF PARENT:___________________________ **DATE:**____________________

Vaccination Disclosure

Dear Parent or Guardian,

Vaccinations are a crucial aspect of pediatric care. We strongly recommend and support vaccinations as part of the recommended immunization schedule. However, we respect the diversity of our patients and understand that some families may have religious or personal reasons to opt out of vaccinations.
Here's a revised version.

Mar and Sea Pediatrics professional team will administrate vaccinations to their patients accordingly. The cost of the vaccinations and visit will be submitted to the patient insurance company ONLY if insurance is accepted at our facility. In case the patient's insurance company does not take charge or does not cover it fully. The balance will be the patient's parent or guardian responsibility to fulfill the payment or pay the difference of the vaccines provided. Parent/Guardian Initials: ______

In the case we do not take your insurance, you will also be offered the self pay prices.

For our SELF PAY patients, the cost of each vaccine is $24 + the visit cost.

Patient Name: ________________________________ DOB: ______________

Patient Name: ________________________________ DOB: ______________

Patient Name: ________________________________ DOB: ______________

Patient Name: ________________________________ DOB: ______________

Patient's Parent/Guardian Name: ____

Patient's Parent/Guardian Signature: ______________________ Date: ___________

** I DO NOT VACCINATE MY CHILD Parent/Guardian Initials: _______

For families who choose not to vaccinate their children, we encourage independent research on the benefits of vaccination through credible sources. Dr. Maria Arreaza is not obligated to discuss or challenge parents' decisions during your child's appointment. We will continue to offer the best care and support while maintaining a safe healthcare environment. Parent/Guardian Initials: ______

GENERAL CONSENT FORM

Patient Name:_______________________________________ DOB:___________

Patient Name:_______________________________________ DOB:___________

Patient Name:_______________________________________ DOB:___________

Patient Name:_______________________________________ DOB:___________

I acknowledge by signing this, it's a written consent allowing Mar and Sea Pediatric to treat and conduct any medical treatment, medications, immunizations, and any tests needed to effectively access and maintain my/our child's health and to access, diagnose, and treat my/our child's illness or injury.
I understand that giving this consent to treatment, as a legal parent/guardian we have the right to refuse any treatment, any particular exam, any medication or immunizations that may be recommended or deemed medically necessary by the treating health care provider.

Financial Policies and Responsibility, Insurance, Authorization, & Assignment of Benefits.
I acknowledge receipt of the "Financial Policies for Medical Services." I authorize Mar and Sea Pediatric to release to my carrier or their agents any information necessary to determine benefits payable related services. I also authorize the payment of medical benefits directly to Mar and Sea Pediatric. I understand I am financially responsible for all charges, whether or not paid by insurance.
Parent/Guardian Initials:_______

By signing below I acknowledge that I have read, understand and agree to abide by the statements contained in this document for the above listed patient.

___________________________	___________________________
Parent/Guardian Signature	Relationship to Patient
___________________________	___________________________
Parent/Guardian Printed Name	Date

OFFICE POLICIES

OFFICE HOURS

MONDAY to FRIDAY: 9:00 am - 5:00 pm

SATURDAY (on Mid July, August, and September) 9:30 am - 1:00 pm

IF THIS IS A MEDICAL EMERGENCY, PLEASE CALL 911

Please, write the brant and address of your **Pharmacy of preference:**

Name / Brand: ____

Address: ____

The doctors and team make every effort to return calls on the same day, even after hours. If you have an urgent matter, please schedule a same-day appointment. For appointments, record requests, referrals, refills, etc., please speak with our office staff.

- **Referrals and authorizations** typically take between 5-7 days to process. Urgent requests will be addressed immediately. Each insurance varies in processing time; some require less or more time. We will do our utmost to accommodate and expedite your requests.
- For any **Letters, school forms, or specific requests,** please allow at least one to three days. Again, we will do our best to accommodate and expedite your requests.
- **Patients with appointments are given priority.** To enhance the convenience for our patients, we now request that you schedule your appointments. This will reduce the wait time to see our doctor and team.
- **All co-payments or payments** for office visits are due at the time services are rendered. Co-payments are typically collected after seeing the doctor. We accept cash, personal checks, Visa, Mastercard, American Express, and Discover.

TO "WRITE OFF" A CO-PAY, OR TO ALLOW A PATIENT IN TO SEE THE DOCTOR WITHOUT COLLECTING THE CO-PAYMENT, IS AGAINST THE LAW.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO IT - PLEASE REVIEW CAREFULLY. MAR AND SEA PEDIATRIC PROVIDES MANY TYPES OF HEALTH RELATED SERVICES. WE REQUIRED TO PROTECT THE INFORMATION WE COLLECT. THIS INFORMATION IS CALLED "PROTECTED HEALTH INFORMATION" OR PHI.

THIS NOTICE OF PRIVACY PRACTICES WILL TELL YOU HOW MAR AND SEA PEDIATRIC MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION. MAR AND SEA PEDIATRIC MAY USE AND DISCLOSE INFORMATION WITHOUT YOUR AUTHORIZATION FOR: TREATMENT WITH HEALTHCARE PROVIDERS WHO ARE INVOLVED WITH YOUR CARE. YOUR HEALTH WITH FAMILY MEMBERS OR ASSIGNED DESIGNEE'S WHO ARE INVOLVED WITH YOUR CARE. PAYMENT: TO RECEIVE PAYMENT OR TO PAY FOR THE HEALTH CARE SERVICES YOU RECEIVE. HEALTH CARE OPERATIONS IN ORDER TO MANAGE ITS PROGRAMS AND ACTIVITIES AND REVIEW THE SERVICES YOU RECEIVE, APPOINTMENTS AND OTHER HEALTH INFORMATION: TO SEND YOU REMINDERS FOR MEDICAL CARE OR CHECKUPS. FOR PUBLIC HEALTH ACTIVITIES: TO PUBLIC HEALTH AGENCY THAT KEEPS VITAL RECORDS AND TRACKS SOME DISEASES, AS REQUIRED; BY LAW. FOR HEALTH OVERSIGHT ACTIVITIES: TO DISCLOSE INFORMATION TO INSPECT OR INVESTIGATE HEALTH PROVIDERS. AS REQUIRED BY LAW: TO DISCLOSE INFORMATION WHEN REQUIRED BY FEDERAL/STATE LAW OR COURT ORDER: FOR GOVERNMENT PROGRAMS: TO DISCLOSE INFORMATION FOR PUBLIC/ GOVERNMENT BENEFITS. TO AVOID HARM: TO DISCLOSE TO LAW ENFORCEMENT IN ORDER TO AVOID A SERIOUS THREAT TO HEALTH/SAFETY. FOR OTHE SITUATIONS, MAR AND SEA PEDIATRIC WILL ASK YOU FOR YOUR WRITTEN AUTHORIZATION BEFORE USING OR DISCLOSING INFORMATION

YOU MAY CANCEL THIS AUTHORIZATION IN WRITING. MAR AND SEA PEDIATRIC CAN TAKE BACK AND USES OR DISCLOSURES ALREADY MADE WITH YOUR AUTHORIZATION. OTHER LAWS PROTECT PHI. YOUR PHI PRIVACY RIGHTS: RIGHT TO SEE AND GET COPIES OF YOUR RECORDS, RIGHT TO REQUEST TO CORRECT OR UPDATE YOUR RECORDS, RIGHT TO GET A LIST OF DISCLOSURES, RIGHT TO REQUEST LIMITS ON USES OR DISCLOSURES OF PHI, RIGHT TO REVOKE PERMISSION, RIGHT TO CHOOSE HOW WE COMMUNICATE WITH YOU, RIGHT TO FILE A COMPLAINT, RIGHT TO GET A PAPER COPY OF THIS NOTICE. PLEASE CONTACT MARIA ARREAZA, M.D.

PRINT NAME (PARENT OR GUARDIAN):____

SIGNATURE:______________________________________ **DATE:**______________________

WHAT TO BRING TO YOUR BABY'S FIRST APPOINTMENT

Dear Parent or Guardian,

If Dr. Maria Arreaza haven't been visited you during your hospital stay after delivery, please ensure to bring the following information:

- ○ Hospital Newborn Discharge Documents or Midwife Newborn Discharge record
- ○ Insurance Card where Newborn will be added.

Parent/Guardian Initials: ______