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:_____

DR. MARIA MARGARITA ARREAZA, M.D.
14000 S. MILITARY TRAIL SUITE #106
DELRAY BEACH FL, 33484
P: 561-270-5144 F: 561-450-7599 E: Faxmarandsea@gmail.com

RELEASE OF MEDICAL RECORDS TO MAR AND SEA PEDIATRIC

I, _____ do hereby authorize the release of medical records for my child_____ whose date of birth is _____ to the office of Maria Arreaza M.D. **Mar and Sea Pediatric**.

If more than one patients:

Patient Name: _____ Date of Birth:_____
Patient Name: _____ Date of Birth:_____
Patient Name: _____ Date of Birth:_____
Patient Name: _____ Date of Birth:_____

Please email or fax records to:

ATTN: Medical Records
FAX#: 561-450-7599
FAXMARANDSEA@GMAIL.COM

This signature below serves as authorization to transfer the records.

Signature: _____ Relationship to Patient:_____

Date:_____

Release:
( ) All records
( ) Scans (X-ray, blood work, or lab results)
( ) Other:
_____

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.

Mar and Sea Pediatrics professional team will administrate vaccinations to their patients accordingly. we require all of our patients to be vaccinated on time. If your child is behind on vaccines at their time of transfer to our practice, we will begin a catch-up schedule. If parent chooses to separate vaccines during the catch-up phase, they are to be scheduled a minimum of 2 weeks apart until the child is up to date. This vaccination update will be perform by nurses and medical assistant staff if patient's vitals are same as previous vaccination visit.

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 + the visit cost. For our SELF PAY patients prices, please contact our office or visit www.marandseapediatric.com

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

** 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: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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 (Biweekly on Mid July, Aug, and Sept) 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 three to five 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.
- **No-Show to Appointment.** We strive to have available appointments to meet the needs of all of our patients. In order for us to provide complete care for your child, it is very important that every appointment is kept. Missed appointments negatively impact our ability to care for your child and others. A $50 no-show fee will be charged to your account for any missed appointment. If you have 3 no-show appointments, you will be dismissed from the practice.
- **Arrived Late to Appointment.** We recommend all patients arrive 15 minutes early for their appointment. Arriving late to an appointment causes delays for subsequent appointments. In our office, we have a policy that all patients receive the same time and care respect as your child. Arriving late to your appointment can affect the healthcare of others.
- **Calls** During Office Hours. We encourage you to call the office with your questions. You can reach us from 8:30 am to 4:30 pm, Monday through Friday. You will speak with our nurse for recommendations first. The nurse may consult the doctor if needed. During office hours, we will do our best to respond to your message as quickly as possible. For After-Hours calls, please contact our answering service at (561) 270-5144, and a doctor or staff member will get back to you as soon as possible. **IMPORTANT:** Beginning July 1st, 2024, we will be charging your insurance for doctor calls exceeding 10 minutes or nurse-only calls exceeding 15 minutes. Brief calls under these thresholds will remain complimentary. Whether you have a cost share is determined by your insurance plan and policy.
- 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:**_____