MARION PEDIATRICS, PA REGISTRATION FORM
YVES-LANDE PIERRE, MD
3105 SW 13TH STREET
OCALA FL 34474

CHILDS INFORMATION:

Last Name First Middle DOB Sex SS# Race Ethnicity

ADDRESS INFORMATION: list information for Custodial Parent

Street Address of Parent/Custodian____

Street Address **City/State/**zip

Mailing Address of Parent/Custodian____

Street Address **City/State/**zip

Home Phone ( ) ____________________ Cell Phone ( ) ____________________

MOTHER'S INFORMATION:

Last Name **First Name** **Middle** **Date of Birth**

Mother's Social Security Number **Occupation**

Mother's Employer **Employers Phone #**

FATHER'S INFORMATION:

Last Name **First Name** **Middle** **Date of Birth**

Father's Social Security Number **Occupation**

Father's Employer **Employers Phone #**

Custodian's Name:____
If child not living with parents Last Name First Middle DOB

EMERGENCY CONTACT:

Name of Contact Other Than Parent **Relationship** **Phone Number**

INSURANCE INFORMATION:

Name of Insurance____________________ Who is the Primary Holder: ____________________

Insurance ID# Group # Effective Date

I hereby authorize payment of insurance benefits to Marion Pediatrics. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf for my dependents. I authorize the above named provider of services to release any information to secure the payment of benefits. I authorize the use of the signature on all the insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred.

Parent/Guardian:______________________________ Date: ____________________

PHARMACY INFORMATION:

Pharmacy Name Address Phone Number

AUTHORIZATION FOR MEDICAL TREATMENT FOR MINORS:

I, _______________________________________, the parent(s) or legal guardian of (child's name) ____
Do, hereby authorize the following individuals (must be over the age of 18) to schedule and/or accompany my child to medical appointments. Please list anyone other than the child's biological mother or biological father who maybe accompanying the child to appointments. This may include siblings over the age of 18, baby-sitters, step –parents, grand-parents, neighbors, friends, family, etc. I understand that only my child's biological mother and father *and* those listed below will have the authority to authorize treatment. Authorized individuals included (please print name and relationship)

____ ____

____ ____

____ ____

*****Please inform the above listed individuals to bring photo ID to appointments *****

PRIVACY STATEMENT ACKNOWLEGEMENT:

I acknowledge Marion Pediatrics, PA has provided its Notice of Privacy Practices, either Posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my child's protected health information. If I desire a copy of the Notice of Privacy Practices is available for me to keep. If revisions are made, I understand it is my responsibility to request a revised copy (see date on posted copies) _____ (initials)

____ ____
Signature of Parent/Guardian/Personal Representative **Printed Name** of Parent/Guardian/Personal Representative

____
Date

AUTHORIZATION TO LEASVE MESSAGE ON VOICE MAIL / MACHINE:

I acknowledge that it is my right to refuse to authorize reminder calls and other type of detailed messages be left on my voice mail and/or message machine. This authorization can only be revoked in writing. ________ (initials)

YES, please leave me a message: _____________________________________ Date: _________________________________

No, do not leave any specific message: ________________________________ Date: _________________________________

ACKNOWLEGEMENT OF "ABUSE FREE ZONE":

At Marion Pediatrics we appreciate and respect our staff. It is our belief our staff should have a work environment free from verbal and physical abuse. We expect each of you to treat each one of our staff members, as you would like to be treated. Outbursts against our staff, physicians, and covering physician's will not be tolerated and will result in your immediate discharge from the practice. ________ (initials)

____ ____
Signature of Parent/Guardian/Personal Representative **Printed Name** of Parent/Guardian/Personal Representative

____
Date

FOR FAMILES NEW TO OUR PRACTICE:

How did you find out about our office / doctor? ____

Friend / Relative _____________________________________ Referred by: ___________________________________

Phone book (indicate source) ___________________________ Health Dept ____________________________________

Hospital ___________________________ other (indicate source) ____

FINANCIAL POLICY ACKNOWLEGMENT: All payments are due at the time of service, no exceptions. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at time of service. IT IS YOUR RESPONSBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines". If we are not provided with the accurate information at the time of service, you may be responsible for payment in full for all services rendered. ______ (initials)

Marion Pediatrics, PA, has preferred contracts with several major insurance companies. Please contact your insurance company to determine if our practice has a contract with your insurance company. Any financial portion that is "member responsibility", such as co-pay, deductible, co-insurance or a non-covered percentage or procedure will be collected **at time of service** _____ (initial). If, for any reason, it is not collected at the time of service, a billing statement will be mailed to you, payment is due within 15 days of billing cycle _____ (initial). Remember, your insurance coverage is a contract between you and your insurance. Marion Pediatrics, PA is not responsible for services denied by your insurance company _____ (initials)

PPO INSURANCE PLANS: We have agreed to accept discounted rate for plans we participate in, however, all co-insurances and/or deductibles are your responsibility. We will estimate co-payments to the best of our ability. Since the co-payments are only estimates, we will bill and/or credit your for your balance. It is your responsibility to know your insurance benefits and coverage. _____ (initials)

HMO INSURANCE PLANS: Co-pays must be paid at each and every visit. If a service provided is not a covered benefit of your plan, you will be responsible for payment in full at time of service. It is your responsibility to know your insurance benefits and coverage. _____ (initials)

NON-CONTRACTED INSURANCE: If we are not contracted with your insurance you will be asked to pay in full at the time of service. We can supply you with a billing copy to attach to a claim form (should be supplied by your insurance broker or Human Resources Dept) to send to your insurance company to request that payment be sent to you. ______ (initials)

INDEMNITY INSURANCE PLANS: We estimate co-pays to the best of our ability. Since co-pays are estimates only, we will bill and/or credit you for your balance. ______ (initials)

MEDICAID: We accept Medicaid for newborn hospital exams only. If you do not have the baby's Medicaid information available at the time of the exam we will hold the charge for 15 days to allow for the Medicaid number to be assigned. If you do not provide us with the Medicaid billing information within the 15 days, the account will be changed to "Self Pay – No Insurance", at that point you will be required to make all payments. ____ (initials) Newborns must show active Medicaid within 15 days _________ (initials)

MEDICAID/ MEDIPASS: We have a very limited Medcaid/Medipass panel. If your child is currently a patient please be advised that your child must be assigned to our provider and assigned to our Medipass panel within 30 days. It is your responsibility to know your child's Medipass eligibility. _____ (initials)

SECONDARY INSURANCE: We DO NOT file for secondary coverage. A billing copy will be presented to you upon request as you check out of the office that can be used for that purpose. _______ (initial)

DIVORCE DECREE: We are not party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult. ______ (initial)

PAYMENTS: We accept cash, debit cards, Visa, MasterCard, Discover and personal checks (with photo ID only) we do not accept business checks or starter checks. Any outstanding balances are due within 30 days of statements. If you are experiencing circumstances beyond your control, please call our office and we will be happy to make payment arrangements with you. All balances reaching 90 days past due with no action on the accounts are subject to being sent to collections. ______ (initial)

COLLECTION AGENCY: In the event your account becomes delinquent and is turned over to a collection agency, you will be financially responsible for all associated collection fees and legal fees that Marion Pediatrics, PA incurs through the process utilized to collect the delinquent balance. Please be aware if your account is turned over to a collection agency your child is subject to discharge from Marion Pediatrics, PA. _____ (initials)

RETURENED CHECKS: Checks returned to Marion Pediatrics, PA, by the bank will be assessed a $25 returned check fee, in addition to the original amount of the check. You have ten (10) days to clear up the outstanding check. If you do not pay the check plus the returned check fee in the specified time, the check will be sent to a collection agency. Should the check be sent to a collection agency your child is subject to discharge from Marion Pediatrics, PA ______ (initials) In addition, we will only accept cash or credit cards for any future visits. ______ (initials)

MISSED APPOINTMENTS: We understand that there will be times when a **scheduled** appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If you do not cancel your will child "physical" appointment by the deadline a $25 no show fee will be added to your account, this fee is not payable by your insurance provider and will be your responsibility to pay before your next appointment ______ (initials) Reminder calls are not a guarantee it is your responsibility to keep up with your children's appointments. **SAME DAY MISSED APPOINTMENT** Any appointment scheduled and missed on the same day will be charged a $10 fee. This fee is your responsibility and must be paid at your child's next appointment._____ (initials) **Three missed physical/well baby appointments or three same day appointments and you are subject to discharge. _____(initials)**

I authorize medical care and accept financial responsibility for my children, step-children, and/or the child(ren) that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time. I authorize the release of any medical or other information necessary to process any and all claims. I have read and fully understand the financial policies of Marion Pediatrics, PA, and agree to the terms and conditions. I also understand that the terms of these financial policies may be amended by the practice at any time with prior notification.

Parent/Guardian/Personal Representative: ____________________________________ Date: ____________________________________