IN UTERO PATIENT REGISTRATION FORM

Patient Name: Last _____ First _____ MI _____ D.O.B _____

Social Security # _____ Sex: (M) (F) Marital Status: □ Married □ Single □ Divorced □ Widowed □ Separated

Language: English, Spanish or other: _____ How well do you speak English? □Very Well □Well □Not Well □Not at All

Ethnicity: Hispanic or Non-Hispanic Race: African American, Asian, Caucasian or Other: _____

Address: _____City/State/Zip: _____

Cellular Phone: _____ Work Phone: _____

Employer: _____ Email: _____

Spouse/Partner: Last Name:_____ First: _____ D.O.B _____

Address: _____City/State/Zip: _____

Cellular Phone: _____ Work Phone: _____

Employer: _____ Email: _____

Primary Insurance: _____ Provider Phone: _____

Address for Claims: _____City/State/Zip: _____

Policy Holder: _____ SS#: _____ DOB: _____

Address (if different from above): _____

Relationship to Patient: _____ ID#: _____ Group#: _____

Secondary Insurance: _____ Provider Phone: _____

Address for Claims: _____City/State/Zip: _____

Policy Holder: _____ SS#: _____ DOB: _____

Address (if different from above): _____

Relationship to Patient: _____ ID#: _____ Group#: _____

Emergency Contact _____Phone: _____

Obstetrician: _____ Phone: _____

Perinatologist: _____Phone: _____

ASSIGNMENT OF BENEFITS

I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

Patient/Guardian signature _____ Relationship _____ Date _____

****** PLEASE FILL OUT THIS PORTION COMPLETELY ******

Fetal Diagnosis: _____

Projected Due Date: _____ Date of Last Menstrual Period: _____

Check if you now have or have had the following illness or problems:

__ Trauma (broken bones, loss of consciousness, etc)
__ Diabetes
__ Seizures
__ Emotional/behavioral problems
__ Anemia or blood disorder
__ Growth problems
__ Heart problems
__ Neurological problems
__ Stomach of intestinal problems
__ Asthma
__ Cancer
__ Past surgeries

Please explain:

_____

_____

ALLERGIES (list or indicate none if applicable):

_____

BIRTH HISTORY FOR PREVIOUS PREGNANCIES: (please list separately)

Sibling's Name: _____ Sex: (M) (F) Birth weight: _____
Type of delivery: ___ Vaginal ___ C-Section Baby was: ___ Full Term ___ Premature
Other complications: _____

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Type of delivery: ___ Vaginal ___ C-Section Baby was: ___ Full Term ___ Premature
Other complications: _____

FAMILY HISTORY

___ Bleeding ___ Problems with anesthesia ___ Cancer or blood disorder ___ Heart disease or liver disease

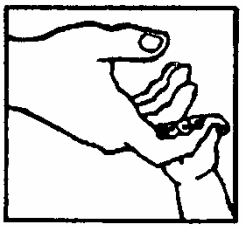
Please explain:

_____

_____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician (s) is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand by law that I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Patient/Guardian signature _____ Relationship _____ Date _____



PEDIATRIC SURGICAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

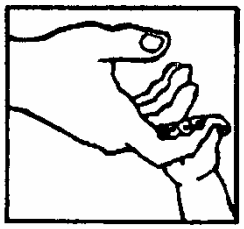
If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **privacy_officer@pediatrix.com** or a letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Print Name of Patient/Authorized Representative



PEDIATRIC SURGICAL ASSOCIATES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1._____

2. _____

3. _____

4. _____

___ Yes ___No The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staff have my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)

__ Home Voice Mail or Answering Machine Home Phone number: _____

__ Cell phone Cell phone number: _____

__ Work Voice Mail Work phone number: _____

__ **NO INFORMATION:** I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____

Print Name of Patient *Print Name of Authorized Representative

_____ _____

Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

- o Parent/legal guardian o Power of Attorney

*Evidence of authority must be provided and on file with the practic