

OBSTETRIX MEDICAL GROUP OF COLORADO, P.C.  
PATIENT REGISTRATION

HOW WELL DO YOU SPEAK ENGLISH? \_\_\_VERY WELL\_\_\_WELL\_\_\_NOT WELL\_\_\_NOT AT ALL

RACE \_\_\_\_\_ETHNICITY \_\_\_\_\_LANGUAGE \_\_\_\_\_RELIGION \_\_\_\_\_

\_\_\_\_\_I DO NOT WISH TO PROVIDE SOME OR ALL OF THE ABOVE INFORMATION

PATIENT NAME: \_\_\_\_\_MOTHER'S MAIDEN NAME \_\_\_\_\_

HOME PH.NO. \_\_\_\_\_CELL \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYER PH.NO. \_\_\_\_\_

OCCUPATION \_\_\_\_\_

SPOUSE'S/PARTNER'SNAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYER PH.NO. \_\_\_\_\_

OCCUPATION \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PHONE NO. \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

PATIENT'S PRIMARY INSURANCE NAME \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

IS THIS POLICY? HMO \_\_\_PPO\_\_\_ EPO \_\_\_POS\_\_\_ OTHER \_\_\_\_\_

PRIMARY CARD HOLDER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PRIMARY CARD HOLDER SSN \_\_\_\_\_ DOB \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_

PATIENT'S SECONDARY INSURANCE \_\_\_\_\_

SECONDARY INSURANCE ADDRESS \_\_\_\_\_

SECONDARY INSURANCE PHONE NO. \_\_\_\_\_

IS THIS POLICY? HMO \_\_\_PPO\_\_\_ EPO \_\_\_POS\_\_\_ OTHER \_\_\_\_\_

SECONDARY CARD HOLDER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SECONDARY CARD HOLDER SSN \_\_\_\_\_ DOB \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_

\*\*\*\*\*WHOSE INSURANCE WILL THE BABY HAVE? (IF APPLICABLE) \_\_\_\_\_

I authorize the release of any medical or other information necessary to process claims on my behalf. I hereby request payment of authorized benefits and/or any insurance benefits to be paid directly to Obstetrix Medical Group of Colorado, P.C. for any services furnished to the patient by Obstetrix Medical Group of Colorado, P.C. I agree to be fully responsible for all lawful debts incurred by myself for services rendered whether or not covered by insurance.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

rev. 10/03/2012



**Name** \_\_\_\_\_  
Last
First
Middle

**SSN** \_\_\_\_\_ **DOB** \_\_\_\_\_ **AGE** \_\_\_\_\_

**Are you currently pregnant?**     **Yes**     **No**    **Due Date** \_\_\_\_\_

**Last Menstrual Period**     **Definite** \_\_\_\_\_    **Referring Doctor** \_\_\_\_\_  
 **Unknown**

**Are there any problems with your current pregnancy**  **Yes**     **No**    **If "Yes" please explain**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Obstetric History**

Please list past pregnancies starting with the first one:

Date	Weeks	Length of Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Hospital/Doctor
<i>Example: 2/2/2000</i>	<i>37 wks</i>	<i>6 hours</i>	<i>6lb 3oz</i>	<i>male</i>	<i>vacuum</i>	<i>Epidural</i>	<i>Las Vegas/Smith</i>

Total Pregnancies	Full Term	Premature	Abortions Induced	Miscarriages	Ectopics	Multiple Births	Living Children

**Comments** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Reviewed by** \_\_\_\_\_

**Review of Systems/Medical History**

**Please list medications you have taken in the last year or are currently taking:**

Medication Taken	Dose	Date Taken

**Please list any known allergies:**


Have you used any street drugs since becoming pregnant?  Yes  No  
If "Yes" what type \_\_\_\_\_

Have you consumed any alcohol since becoming pregnant?  Yes  No  
If "Yes" what type \_\_\_\_\_

Do you smoke?  Yes  No

**Do you have or have you had any of the following conditions?**

Unexplained fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Vision Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Ear Infections (other than childhood)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Sinus Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Repeated Nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Long Term Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Close contact with person with TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis Vaccine (BCG)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Positive TB Skin Test	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Unexplained Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Unexplained Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Other Lung Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Other Heart Valve Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Unexplained Chest Pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Unexplained Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Other Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
High Blood Pressure in Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
High Blood Pressure, Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Raynaud's Disease, Raynaud's Phenomenon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Poor Blood Circulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Severe Nausea and Vomiting in Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Severe Nausea and Vomiting before Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Intestinal Problems (Irritable Colon, Crohn's Disease, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Dietary Restrictions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Unexplained Recurring Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Constipation Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Heartburn, Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Hepatitis, Yellow Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Liver Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Bladder or Kidney Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Problem with Urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Menstrual Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Infertility, Difficulty Getting Pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Herpes or A Partner With Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Sexually Transmitted Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Pelvic Inflammatory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Chlamydia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Syphilis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Genital Warts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
HIV Infection, AIDS or a Partner with HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Abnormal Pap Smear	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Diabetes (High Blood Sugars)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Other Hormone Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Epilepsy, Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Unexplained Drowsiness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Migraine/Cluster Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Other Recurring Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Panic Attack Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Psychiatric/Mental/Emotional Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Skin Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Unexplained Hair Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Arthritis/Joint Pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Blood Transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Bleeding Tendency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Blood Clots, Thrombophlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Rh Sensitized	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Do You Currently Smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Any Past Surgeries (If yes please list below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Any Known Drug Allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Year	Type of Operation	Type of Anesthesia	Hospital/City	Surgeon
<b>Example:</b>				
1999	<i>Appendectomy</i>	<i>General</i>	<i>Good Sam/San Jose, CA</i>	<i>Smith</i>

Reviewed By \_\_\_\_\_

**Genetic/Family History**

**Please describe your ancestry: Please check all that apply**

- White     Guamanian     Hawaiian     Filipino     Taiwanese  
 African     French Canadian     Samoan     Japanese     Korean  
 Hispanic     Native American     Chinese     Laos     Asian-East Indian  
 Ashkenazi     Greek     Cambodian     Vietnamese     Middle Eastern  
 Cajun     Italian     Other Southeast Asian     Unknown Race     Other \_\_\_\_\_

Are you and the father of this baby blood relatives (example: cousins)?     Yes     No

What is your occupation? \_\_\_\_\_

What is the Name of the Baby's Father \_\_\_\_\_    What is the age of the father of the baby? \_\_\_\_\_

What is the occupation of the father of the baby? \_\_\_\_\_

**How would you describe the ancestry of the father of this baby? Please check all that apply**

- White     Guamanian     Hawaiian     Filipino     Taiwanese  
 African     French Canadian     Samoan     Japanese     Korean  
 Hispanic     Native American     Chinese     Laos     Asian-East Indian  
 Ashkenazi     Greek     Cambodian     Vietnamese     Middle Eastern  
 Cajun     Italian     Other Southeast Asian     Unknown Race     Other \_\_\_\_\_

Is the father of this baby your partner?     Yes     No

**Do you, the father of this baby, or any close relatives have:**

- |  |                              |                             |   |                              |                             |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Thalassemia (Greek, Mediterranean, or Asian Background)            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other inherited Genetic Disorder                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neural Tube Defect (Meningomyelocele Spina Bifida, of Anencephaly) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Maternal Metabolic Disorder (ex: Insulin-Dependent Diabetes, thyroid) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital Heart Defect  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Birth Defects   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Down Syndrome  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recurrent Pregnancy loss, Stillbirth                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tay-Sachs (ex: Jewish, Cajun, French Canadian)                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blindness or Deafness   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone or Skeletal Disorder (Dwarfism)                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hemophilia or Bleeding Problems                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breast, Ovarian, Colon Cancer   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscular Dystrophy   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disorder   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cystic Fibrosis or Canavan Disease                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mental Retardation/Autism  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood Clots/Stroke  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Yes: Tested for Fragile X                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____   |                              |                             |
| Huntington Chorea  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |   |                              |                             |

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION**

### **What is Ultrasound?**

Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta and baby, making echoes which a computer converts into detailed images. In essence, an ultrasound exam is a series of pictures of the baby and organs in the mother's pelvis.

### **Is Ultrasound safe?**

There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either the mother or the baby when ordinary power and frequency is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

### **Does a normal Ultrasound prove that my baby will have no abnormalities?**

Ultrasound examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the baby and the baby's organs but does not give complete information about the function of the baby's organs or tell us that the baby is completely "healthy." Abnormalities of brain function such as mental retardation cannot be detected by ultrasound. Additionally, there are many conditions that evolve over time, appearing normal at the time of the ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities or those abnormalities that can appear later in the pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal.

### **Can Ultrasound determine if there are chromosomal abnormalities?**

Findings on an ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently, the only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cells by amniocentesis, chorionic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities, either because of the mother's age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby's chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasound, please do not hesitate to ask the ultrasound technologist, perinatologist or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

**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



**AUTHORIZATION TO RELEASE RECORDS**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

**I give permission for information pertaining to my ultrasound appointment(s) and lab results to be called to the following telephone numbers, addresses and individuals:**

**PLEASE CIRCLE EITHER YES OR NO AND FILL IN BLANKS FOR ALL QUESTIONS**

1. I authorize leaving a message of normal results on the answering machine: YES NO

2. I authorize sending a text message to my cell phone: YES NO

3. I authorize sending a detailed message to my e-mail address: YES NO

Email address: \_\_\_\_\_

4. I authorize leaving a message at my work number \_\_\_\_\_: YES NO

5. I authorize leaving any message with my spouse/partner: YES NO

Spouse/Partner's name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

6. I authorize leaving any message at my spouse/partner's work number: YES NO

Spouse/Partner's name: \_\_\_\_\_ Work Number: \_\_\_\_\_

7. I authorize leaving a message of normal results with my children: YES NO

Child name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

8. I authorize leaving any message with my parent(s): YES NO

Parent name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

9. I authorize Obstetrix Medical Group to release to me and/or my partner YES NO  
photographic images of my unborn child(ren)

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

This is an **out-patient** facility

You will receive two bills for your services with Obstetrix Medical Group.

- One from Obstetrix Medical Group for the Physician's professional interpretation.
- One from the Hospital for the facility and equipment usage.

This may impact the way your insurance processes the claim. It is your responsibility to check with your insurance carrier if you have questions regarding the benefit level for out-patient services verses office services.

---

Signature

---

Date



I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW OUR PATIENTS OR THEIR LEGAL REPRESENTATIVE(S) CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. [The use of the words “you” and “your” in the remainder of this document refer to you and/or your child(ren) under the care of any of our physicians, and your legal representatives.]

## II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information “protected health information,” or “PHI” for short, and it includes information that can be used to identify you, that we have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy practices at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in our offices. You can also request a copy of this notice from the contact person listed in Section VI below at any time and can view a copy of the notice on our Web Site located at: [www.mednax.com/noticeofprivacypractices](http://www.mednax.com/noticeofprivacypractices). When required, we will redistribute the notice.

## III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization, and for others, we do not. The following categories describe different ways that we may use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use and disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose PHI will fall into one of the categories.

### A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

We may use and disclose your PHI for the following reasons:

1. For treatment. We may disclose your PHI to provide you with medical treatment or services. Therefore, we may disclose PHI about you to physicians, nurses, technicians, medical students, and other health care personnel who provide you with health care services or who are involved in your care, such as pharmacists, dieticians, genetic counselors, etc.

2. For payment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and to your health plan to get paid for the health care services we provide to you. We may tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims. However, we may not provide your PHI to your health plan or our billing companies if you self-pay and request a restriction in writing.

3. For health care operations. We may disclose your PHI for our health care operations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care service to you. In order to decide whether or not new treatments are effective, we may combine health information about many patients. We may disclose your PHI to medical students and other health care providers for review and teaching purposes. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

### B. Uses and Disclosures for Patient Directories and to Persons Assisting in Your Care.

Generally, we will obtain your verbal agreement before using or disclosing PHI in the following ways. However, in certain circumstances, such as an emergency, we may use and disclose your PHI for these purposes without your agreement.

1. Patient directories. We may include your name, location, general condition, and religious affiliation in a patient directory for use by clergy and visitors who ask for you by name.

2. Disclosures to family, friends or others. We may provide your PHI, including your condition and status, to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that a family member or other person responsible for your care can be notified about your condition, status and location.

### C. Certain Other Uses and Disclosures that Do Not Require Your Authorization.

We may use and disclose your PHI without your consent or authorization for the following reasons:

1. Appointment Reminders. We may use and disclose PHI to contact you as a reminder that you have an appointment for tests or treatment.

2. Treatment Alternatives. We may use and disclose PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

3. Health-Related Benefits and Services. We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

4. Research. Under certain circumstances, we may use and disclose your PHI for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. In some cases, research will be conducted through a limited database of PHI that we maintain for research and quality improvement purposes that excludes patient names and other identifying information. All other research projects involving the use of PHI are subject to a special approval process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with the patients’ need for privacy of their PHI. Before we use or disclose PHI for research without your consent, the project will have been approved through this research approval process. We may, however, disclose your PHI to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave our control.

5. As Required By Law. We will disclose your PHI when required to do so by federal, state or local law.

6. To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any such disclosure, however, would be to someone able to help prevent the threat.

7. Organ and Tissue Donation. If you are an organ donor, we may release PHI about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

8. Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

9. Workers’ Compensation. We may release your PHI for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

10. Public Health Risks. We may disclose PHI about you for public health activities. These activities generally include the following:

- a. Preventing or controlling disease, injury or disability;
- b. Reporting births and deaths;
- c. Reporting child abuse or neglect;
- d. Reporting reactions to medications or problems with products;
- e. Notifying people of recalls of products they may be using;
- f. Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

11. Victims of Abuse, Neglect or Domestic Violence. We may notify the appropriate government authorities if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make such disclosures if you agree or when required or authorized by law.

12. Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.



13. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

14. Law Enforcement. We may release your PHI if asked to do so by a law-enforcement official:

- a. In response to a court order, subpoena, warrant, summons or similar process;
- b. To identify or locate a suspect, fugitive, material witness, or missing person;
- c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- d. About a death we believe may be the result of criminal conduct;
- e. About criminal conduct at the hospital or in our offices; or f. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

15. Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

16. National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

17. Protective Services for the President and Others. We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

18. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release may be necessary for a number of reasons, such as:

- a. For the institution to provide you with health care;
- b. To protect your health and safety or the health and safety of others; or

- c. For the safety and security of the correctional institution.
- D. All Other Uses and Disclosures Require Your Prior Written Authorization.

In any situation not described in sections III.A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (but only to the extent that we haven't already taken any action relying on the authorization).

#### IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Receive a Copy of this Notice. You have a right to obtain a copy of this Notice in paper form, even if you have received a copy electronically.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or permitted to make without your authorization (which are generally described in sections III.C(4) through (18) above. However, unless the purpose of the disclosure relates to your treatment, when you pay out-of-pocket in full for a treatment and request a restriction in writing, we must comply with your request that we not disclose your PHI to a health plan. To request restrictions, you must make your request in writing to the person listed in Section VI below.

C. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (e.g., your work address rather than your home address) or by alternate means, such as electronic mail ("email") instead of regular mail. Your request must be in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

D. The Right to Review and Get A Copy of Your PHI. In most cases, you have the right to review and get a copy (or electronic version if available) of your PHI that we have, but you must make the request in writing. If we don't have your PHI, but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request, unless we need additional time (up to 30 days more)



to respond. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

E. The Right to Get a List of the Disclosures We Have Made.  
1. You have the right to get from us or our business associates a list of certain instances in which we or our business associates have disclosed your PHI. If the services were provided by our business associates, we may identify the business associate and the business associate will provide the disclosures for you. The list will not include uses or disclosures to carry out treatment, payment, or health care operations or disclosures directly to or authorized by you. The list also won't include uses and disclosures that are incidental to a permitted use or disclosure, that are part of the limited data set we maintain for research and quality improvement purposes, that are made for national security purposes, to corrections or law enforcement personnel, or that were made before April 14, 2003.

2. We or our business associates will respond within 60 days of receiving your written request, unless we need additional time (up to 30 days more) to respond. The list we give you will include disclosures made during the time period you specify, provided, however, that the time period may not be longer than six (6) years and may not include dates before April 14, 2003. The list will indicate the date of the disclosure, to who PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same twelve (12) month period, we may charge you for the costs of providing the additional list(s). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

F. The Right to Correct or Update Your PHI.

1. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing.

2. We will respond to you within 60 days of receiving your request, unless we need additional time (up to 30 days more) to respond. We may deny your request in writing if the PHI:

- a. Is accurate and complete;
- b. Was not created by us;
- c. Is information that we are not required to provide access to; or



d. Is not part of our records.

3. Any written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

G. The Right to Receive Notice of a Breach of Unsecured PHI.

1. In certain circumstances you have a right to receive notice of a breach of unsecured PHI.

2. In the case of a breach of unsecured PHI, as defined under HIPAA, we shall notify you in no later than 60 days of our discovering the breach (or of being notified of the breach by our business associate). The determination that such notifications are required, and the manner in which they are made, shall be in accordance with HIPAA and under the direction of our Privacy Officer.

#### V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

#### VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, you may contact our Privacy Officer: by e-mail at [privacy\\_officer@mednax.com](mailto:privacy_officer@mednax.com); or by phone at (954) 384-0175; or by writing to: Privacy Officer, MEDNAX Services, Inc., 1301 Concord Terrace, Sunrise, FL 33323.

#### VII. EFFECTIVE DATE OF THIS NOTICE

The effective date of this notice is February 17, 2010.