PEDIATRIX CARDIOLOGY
an affiliate of MEDNAX

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BOARD CERTIFIED CARDIOLOGISTS

Patient's complete name_____ **Male**____ **Female**____
Social Security #_____ **Date of Birth** _____ **Home Phone** _____
Address_____ **City**_____ **Zip**_____
Race_____ **Religion** _____ **Decline to specify**_____

Child's Primary Doctor_____ Address_____
Phone Number_____

Referring Doctor_____ Address_____
Phone Number_____

Mother's Name_____ **Date of Birth:** _____ **Social Security #:** _____
Address_____ City_____ Zip_____
Cell Phone Number_____ Email address_____
Employer _____ City,State, Zip_____

Father's Name_____ **Date of Birth:** _____ **Social Security #:** _____
Address_____ City_____ Zip_____
Cell Phone Number_____ Email address_____
Employer _____ City,State, Zip_____

Legal Guardian (foster child)_____ **Date of Birth:** _____
Social Security #: _____
Address_____ City_____ Zip_____
Cell Phone Number_____ Email address_____
Employer _____ City,State, Zip_____

HEALTH INSURANCE INFORMATION
Insurance Company _____ Policy # _____ Group#_____
Policy Holder's Name_____ Date of Birth _____

Secondary Insurance Company _____ Policy # _____
Group#_____
Policy Holder's Name_____ Date of Birth _____

Name of Relative not living with you: _____ Phone #_____

I Authorize Pediatrix Medical Group to obtain from any physician, hospital or medical facility any medical information that, they deem necessary, during the examination and treatment of_____. I am the parent / legal guardian of this child. I also acknowledge that I am primarily responsible for all the charges generated during such examination or treatment regardless of insurance coverage. I further authorize payments directly to Pediatrix Medical Group for the surgical and/or medical benefits otherwise payable to us under the terms of my insurance. I acknowledge any photocopy of the form to be as valid as the original.

_____ _____
Parent / Legal Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. WHO WE ARE

This Notice of Privacy Practices ("**Notice**") describes the privacy practices of MEDNAX Services, Inc., and its affiliated entities, its physicians, nurses and other personnel ("**we**" or "**us**"). It applies to services furnished to you at all of the offices where we provide services.

II. OUR PRIVACY OBLIGATIONS

We are required by law to maintain the privacy of your health information ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. We are also obligated to notify you following a breach of unsecured PHI. When we use or disclose your PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

In certain situations, which we describe in Section IV, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and/or disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI, but not your "Highly Confidential Information" (defined in Section IV.B), in order to treat you, obtain payment for services provided to you and conduct our "health care operations" as detailed:

- Treatment. We may use and disclose your PHI to provide treatment, for example, to diagnose and treat your injury or illness. We may also disclose PHI to other health care providers involved in your treatment.
- Payment. In most cases, we may use and disclose your PHI to obtain payment for services that we provide to you, for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("**Your Payor**") to verify that Your Payor will pay for health care.
- Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI internally in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Use or Disclosure for Facility Directories. If we maintain a facility, we may include your name, location in the facility, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, that religious affiliation will only be disclosed to members of the clergy.

C. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

D. Public Health Activities. We may use or disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

E. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

F. Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

G. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

H. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

I. Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law.

J. Organ and Tissue Procurement. We may use or disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

K. Research. We may use or disclose your PHI without your consent or authorization if an Institutional Review Board or Privacy Board approves a waiver of authorization for disclosure.

L. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

M. Specialized Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

N. Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

O. As Required By Law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

A. Use or Disclosure with Your Authorization. We must obtain your written authorization for most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes and disclosures that constitute the sale of PHI. Additionally, other uses and disclosures of PHI not described in this Notice will be made only when you give us your written permission on an authorization form ("**Your Authorization**"). For instance, you will need to complete and sign an authorization form before we can send your PHI to your life insurance company or to the attorney representing the other party in a lawsuit in which you are involved.

B. Uses and Disclosures of Your Highly Confidential Information. Federal and state law requires special privacy protections for certain highly confidential information about you ("**Highly Confidential Information**"). This Highly Confidential Information may include the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about sexually-transmitted disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult with a disability; or (9) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must have Your Authorization.

C. Revocation of Your Authorization. You may withdraw (revoke) Your Authorization, or any written authorization regarding your Highly Confidential Information (except to the extent that we have taken action in reliance upon it) by delivering a written statement to your physician. A form of Written Revocation is available upon request from the Privacy Officer.

V. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. For Further Information; Complaints. If you would like more information about your privacy rights, if you are concerned that we have violated your privacy rights, or if you disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. Also, you may make a complaint by calling our Privacy Officer at 954-384-0175. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, our Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You have the right to request a restriction on the uses and disclosures of your PHI (1) for treatment, payment and health care operations purposes; and (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved in your care or with payment related to your care. For example, you have the right to request that we not disclose your PHI to a health plan for payment or health care operations purposes, if that PHI pertains solely to a health care item or service for which we have been involved and which has been paid out of pocket in full. Unless otherwise required by law, we are required to comply with your request for this type of restriction. For all other requests for restrictions on use and disclosures of your PHI, we are not required to agree to your request. If you wish to request additional restrictions, please obtain a request form from your physician. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you would like to access your records, please obtain a record request form from your physician's office. If you request copies, we will charge you a cost-based fee, consistent with State law, that includes (1) labor for copying the PHI; (2) supplies for creating the paper copy or electronic media if you request an electronic copy on portable media; (3) our postage costs, if you request that we mail the copies to you; and (4) if you agree in advance, the cost of preparing an explanation or summary of the PHI.

E. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from your physician. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

F. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a twelve (12) month period, we may charge you for the cost of the additional accounting statement(s). We will inform you in advance of any fee and provide you with an opportunity to withdraw or modify the request.

G. Right to Receive A Copy of this Notice. Upon request, you may obtain a copy of this Notice, either by email or in paper format. Please submit your request to:

Privacy Officer
MEDNAX Services, Inc.
1301 Concord Terrace
Sunrise, FL 33323
Phone: 954-384-0175
Email: privacy_officer@mednax.com

VI. EFFECTIVE DATE AND DURATION OF THIS NOTICE

A. Effective Date. This Notice is effective on September 23, 2013.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around our offices and on our Internet site at **www.mednax.com/noticeofprivacypractices**. You also may obtain any new notice by contacting the Privacy Officer.

VII. PRIVACY OFFICER

You may contact the Privacy Officer at:

Privacy Officer
MEDNAX Services, Inc.
1301 Concord Terrace
Sunrise, FL 33323
Phone: 954-384-0175
Email: privacy_officer@mednax.com

MEDNAX®
HEALTH SOLUTIONS PARTNER

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@mednax.com** or a letter to:

Privacy Officer
MEDNAX Services, 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

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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 has 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:

☐ Parent/legal guardian ☐ Power of Attorney

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

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Welcome to Our Office

Date of visit: _____

Patient's Last Name **First Name** **Middle** **Date of Birth**

Who is your **Child's Primary Care doctor**: _____

MEDICAL HISTORY:
BIRTHPLACE (hospital or city/state): _____ BIRTHWEIGHT: _____
PROBLEMS AT BIRTH: _____
_____

DEVELOPMENTAL HISTORY: ____Normal ____Delayed
Problems: _____
_____

Chronic Medical Illnesses (like asthma, seizure, ADHD, etc):
_____
_____

HOSPITALIZATIONS: _____
_____

SURGERIES (what year) _____
_____

IMMUNIZATIONS: ____Yes ____No
ALLERGIES: _____

MEDICATIONS regularly taken: (dose/frequency)
_____ _____
_____ _____

SOCIAL HISTORY: Lives with :
__ Father /stepfather Number of sister (s): ___ Other Relatives: _____
__ Mother / stepmother Number of brother (s): ___

FAMILY MEDICAL HISTORY: (if yes, who - list relationship)
Yes No Congenital heart disease *("heart defect"* noted in childhood) _____
Yes No Acquired heart disease (like rheumatic heart disease) _____
Yes No Arrhythmia _____
Yes No Cardiomyopathy _____
Yes No Sudden cardiac death (dying before 40y/o from heart problems) _____
Yes No Heart attack (had surgery or stents) _____
Yes No High Blood pressures _____
Yes No Diabetes _____
Yes No Hyperlipidemia (high cholesterol/triglyceride) _____
Others:
_____
_____
What is your primary language: _____
How well do you speak English? (Circle one) Very well / Well / Not well/ Not at all

Signature of Person filling paper: _____ **(relation:** _____**)**

For Office Use Only

Reviewed By:_____