Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

PEDIATRIX-OBSTETRIX MEDICAL GROUP AND AFFILIATES
PATIENT ACKNOWLEDGEMENT 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 ("PHI") about our patients.

Federal regulation requires that we give our patients or their authorized representatives ("You") the opportunity to review our Notice before signing this acknowledgement. An on-page summary of our Notice is displayed in our offices and in the hospitals we serve. A copy of our Notice will be made available to you and you may also view our Notice by visiting our internet web site, www.pediatrix.com/HIPAA Privacy/Notice of Privacy Practices.

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 letter to:

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

We will respond to you within five (5) business days.

By signing this form, you acknowledge only that we have provided you with immediate access to our Notice of Privacy Practices.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Printed Name of Patient or Authorized Representative

Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

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 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 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).

_____ _____

Signature of Patient or Authorized Representative **Date**

_____

Print Name of Patient or Authorized Representative

Authorized Representative's authorized 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 practice.**

Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX®

FINANCIAL POLICY

OUR FINANCIAL POLICY: Our physicians and staff are very concerned about the cost of your health care and want to address some issues related to the cost of medical services in our office. Considerable care has been taken in setting our fees. We want to assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

HMO and PPO MEMBERS: If you are a member of an HMO or PPO in which we participate, your deductible or co-payment is required at the time of service. Sonograms may have a different co-payment than routine visits. You are responsible to see that we have a current referral on file if your insurance carrier requires one. If we do not have this referral at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to see your Primary Care Physician prior to being treated to obtain a current referral.

If you are not sure that our physicians are providers for your PPO, call your insurance carrier for clarification.

NEW INSURANCE/CHANGE OF INSURANCE: Should your insurance change at anytime during your pregnancy it is your responsibility to notify us in writing within 10 working days of this change. We have to have this information in order to file your claim with the correct carrier before the insurance company's filing deadline.

FEE FOR SERVICE: Our policy requires payment of your deductible and/or co-insurance at the time of service.

Our agreement is with you not your insurance company. Although we will assist you in submitting your claim to your insurance carrier, you are ultimately responsible for the service you receive. Payment to our office is neither contingent nor dependent upon your insurance carrier.

We are pleased to accept MasterCard, Visa, Discover, American Express, checks, cash, money orders, or traveler's checks.

MEDICARE: We are participating providers for Medicare. Please present your Medicare card at your visit. Patients are responsible for 20% of the amount that Medicare allows. If you have a supplemental insurance, we will submit a claim for you.

MEDICAID: We are Medicaid Providers. Please present your Medicaid letter of eligibility at each of your visits.

AMNIOCENTESIS, CHORIONIC VILLUS SAMPLING, AND OTHER SPECIALIZED TESTING: Our office will charge you for the services we provide. You will receive a separate bill from the laboratory that processes the test. Our office will be happy to provide you with an approximation of the laboratory charges.

If you have any questions regarding our financial policy or your insurance reimbursement, please feel free to discuss them with our billing office of the practice manager.

I have read and understand my financial responsibilities under this policy of Melbourne Maternal-Fetal Medicine.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Printed name of Patient or Authorized Representative DOB