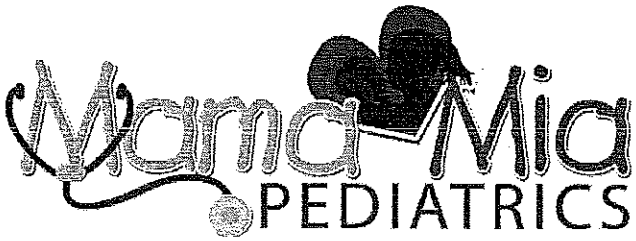


2315 E. CHEYENNE AVE. SUITE 100
N.LAS VEGAS, NV 89030
TEL: 702-633-4000 FAX: 702-633-4346

This complete form authorizes a third party to disclose a patient's protected health information to MAMA MIA PEDIATRICS.

Patient's Name: _____ **Date Of Birth:** _____

Patient's Address: _____ **City, State, Zip:** _____

Check the reports to be disclosed:

[ ] History and Physical Exam	[ ] Growth Charts
[ ] Consultation Reports	[ ] Operative Reports
[ ] Progress Notes	[ ] Billing Claims Forms
[ ] Radiology Reports	[ ] Itemized Statement Of Charges
[ ] Laboratory Reports	[ ] Pathology Reports
[ ] Immunization Record	[ ] All Information

If Other, Please Specify: _____

➢ **RECORDS RELEASED FROM:** _____

Mailing Address: _____ City, State, Zip: _____

Tel: _____ Fax: _____

➢ **RECORDS RELEASED TO:** MAMA MIA PEDIATRICS

Mailing Address: 2315 E. CHEYENNE AVE. SUITE #100 City, State, Zip: NORTH LAS VEGAS, NV 89030

Tel: (702) 633 – 4000 Fax: (702) 633 -- 4346

For Purpose of: _____

- EXPIRATION: This authorization for release of protected health information for a maximum of one year from the date signed below.
- Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- I authorize the third party named above to discuss the protected health information about myself (or the Patient) as described above I understand:
- I may revoke this authorization at any time by notifying Mama Mia Pediatrics in writing.
- If I revoke the authorization, I understand it will have no effect on action on Mama Mia Pediatrics took in good faith before receiving the revocation.
- The information released may contain information related to AIDS OR HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes. Mama Mia Pediatrics may not contain treatment or payment on my completion of this form Mama Mia Pediatrics reserves the right to verify my identity or guardianship.

_____ _____ _____

Print Patient, Parent, or Guardian Name **Signature** **Date**

_____

Relationship To Patient

PATIENT INFORMATION

PATIENT'S NAME: _____

SEX: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONE: HOUSE: _____ **CELL:** _____

EMAIL: _____

RACE: WHITE: _____ HISPANIC: _____ AFRICAN-AMERICAN: _____ OTHER: _____

MARITAL STATUS: CHILD: _____ SINGLE: _____ MARRIED: _____ SEPARATED: _____ WIDOW: _____

IF PATIENT IS A MINOR

MOTHER'S NAME: _____ DATE OF BIRTH: _____

FATHER'S NAME: _____ DATE OF BIRTH: _____

POLICY HOLDER OF INSURANCE

NAME: _____ DATE OF BIRTH: _____

S.S. #: _____ TEL #: _____

ADDRESS: _____

MARITAL STATUS: CHILD: _____ SINGLE: _____ MARRIED: _____ SEPARATED: _____ WIDOW: _____

INSURANCE: _____ POLICY: _____

PLACE OF EMPLOYMENT: _____ TEL #: _____

RELATIONSHIP TO PATIENT: _____

IN CASE OF EMERGENCY

NAME OF A FRIEND OR RELATIVE (NOT LIVING AT THE SAME ADDRESS): _____

RELATIONSHIP TO PATIENT: _____ TEL #: _____

The above information is true to best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mama Mia Pediatrics or insurance company to release any information required to process my claims.

PATIENT, PARENT, OR GUARDIAN SIGNATURE: _____ DATE: _____

IN CASE OF ANY EMERGENCY, I'M NOT ABLE TO BRING MY CHILD

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I, _____
(PARENT OR GUARDIAN NAME)

GIVE MY AUTHORIZATION TO TAKE ANY MEDICAL DECISION TO:

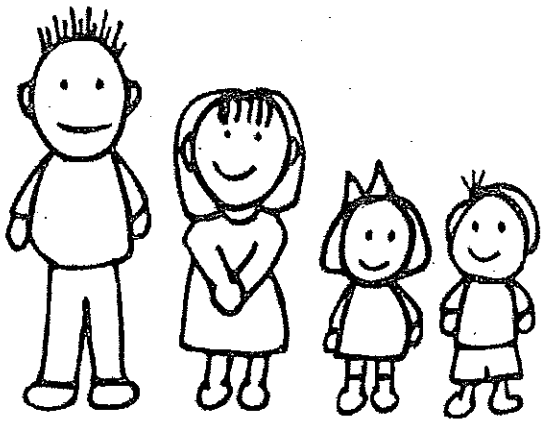
NAME: _____
RELATIONSHIP TO PATIENT: _____

NAME: _____
RELATIONSHIP TO PATIENT: _____

NAME: _____
RELATIONSHIP TO PATIENT: _____

NAME: _____
RELATIONSHIP TO PATIENT: _____

PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____



NOTICE OF PRIVACY PRACTICES

To our patients: This notice describe how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. Please review it carefully. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realized that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuit and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For workers compensations and similar programs.

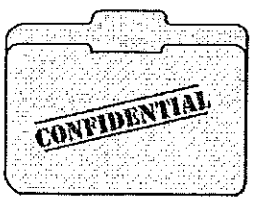
Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to medical records department (Mama Mia Pediatrics).
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to medical records department (Mama Mia Pediatrics). You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint without practice or with the secretary of the department of health and human services. To file a complaint with our practice, contact privacy officer, (Mama Mia Pediatrics). All complaints must be submitted in writing. You will not be penalized for filling a complaint.
7. Right to provide an authorization for other uses and disclosures. Our patient will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies please contact (Mama Mia Pediatrics, 702-633-4000, 2315 E. Cheyenne Ave. #100, N. Las Vegas, NV 89030).

If you would like a copy of this document please ask front desk receptionist.

PATIENT, PARENT, OR GUARDIAN SIGNATURE: _____ DATE: _____



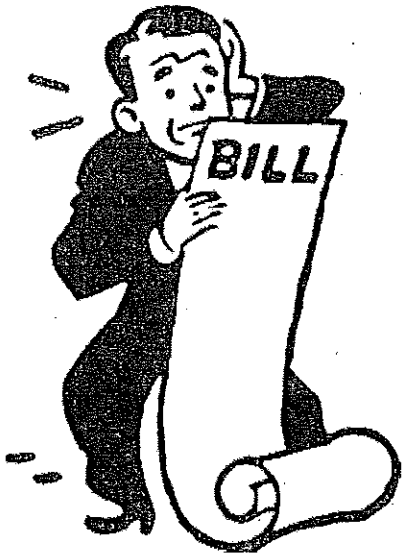
INSURANCE / PATIENT AGREEMENT

I understand that I am financially responsible for any and all charge for professional services, whether or not paid by an insurance carrier or health plan. I understand that it is my responsibility to pay, in a timely manner, any deductible, co-payment, and "non-covered" services and items which may not be covered by a particular insurance plans. Requests for completion of disability forms, reports, or other paperwork may require a fee, paid in advance, related to the amount of the preparation involved. Please allow 5 business days for completion of any disability forms.

COST OF COLLECTION

If these accounts become delinquent, I may be responsible for additional billing costs and if this account is assigned to a collection agency or attorney for collection, this may result in additional 25% of the original balance.

PATIENT, PARENT, OR GUARDIAN SIGNATURE:_____ DATE: _____



PATIENT MEDICAL HISTORY

All questions in this questionnaire are strictly confidential and will become part of your medical record.

PATIENT'S NAME: _____ DATE OF BIRTH: _____

MARITAL STATUS: CHILD: _____ SINGLE: _____ MARRIED: _____ SEPARATED: _____ DIVORCED: _____ WIDOW: _____

CHILDHOOD ILLNESS (CIRCLE ALL THAT APPLY)

MEASLES MUMPS RUBELLA CHICKENPOX RHEUMATIC FEVER POLIO

VACCINATIONS:

_____ COMPLETE: _____ INCOMPLETE: _____ _____

LIST ANY MEDICAL PROBLEMS

SURGERIES / HOSPITALIZATIONS	YEAR	REASON

HAS THE PATIENT HAD A BLOOD TRANSFUSION? YES [ ] NO [ ]

ANY MEDICATION OR FOOD ALLERGIES? YES [ ] NO [ ]
IF YES, PLEASE LIST:

_____

_____

_____

OTHER PROBLEMS (CIRCLE ALL THAT APPLY):

SKIN	CHEST	HEART
HEAD	NECK	BACK
WEIGHT	EARS	INTESTINAL
ENERGY LEVEL	NOSE	BLADDER
ABILITY TO SLEEP	THROAT	BOWEL
LUNGS	CIRCULATION	DISCONFORT / PAIN

LIST YOUR PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS (SUCH AS VITAMINS AND INHALERS):

NAME OF MEDICATION	STRENGTHS / DOSES	FRECUENCY TAKEN

MENTAL HEALTH

1. Is stress a major problema for you?	YES	NO
2. Do you feel depressed?	YES	NO
3. Do you panic when stressed?	YES	NO
4. Do you have problems with your appetite?	YES	NO
5. Do you cry frequently?	YES	NO
6. Have you ever attempted suicide?	YES	NO
7. Have you ever thought about hurting yourself?	YES	NO
8. Do you have trouble sleeping?	YES	NO
9. Have you ever been to a counselor?	YES	NO

FAMILY MEDICAL HISTORY

(CIRCLE ALL THAT APPLY)

ASTHMA	HYPERTENSION	ANEMIA	EARLY DEATH
DIABETES	HEART DISEASE	KIDNEY DISEASE	BLOOD DISEASE
TUBERCULOSIS	SEIZURES	DEVELOPMENTAL DELAYS	PSYCHIATRIC PROBLEMS

ANY OTHER MEDICAL PROBLEMS DOCTOR SHOULD KNOW ABOUT?

PATIENT, PARENT, OR GUARDIAN SIGNATURE: _____ DATE: _____