Patient Name: ______________________________ **Date:** ____________________

Date of birth: ______________

■ **Medical Information**

Please state the reason(s) for your visit today: ____

____

Due Date: ___________

Primary Ob/Gyn: ______________________________________ Phone ________________________

Hospital where you will deliver? ______________________

Preferred Pharmacy Name ____________ Pharmacy Telephone Number _____________

Pregnancy History:

Total # of pregnancies: ____

# of term deliveries (>/= 37 weeks): ___ # of abortions: ___

# of preterm deliveries (< 37 weeks): ___ # of ectopics: ___

# of miscarriages: ____ # of living children: ___

Pregnancy details: (please list all pregnancies)

	Delivery Date	Gest Age (weeks)	Birthweight	Sex(M/F)	Type of Delivery	Comments/complications
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Do you have a history of any of the following:

	Yes	No
Anemia (low blood count)	☐	☐
Asthma	☐	☐
Blood Disorder	☐	☐
Cancer/Chemotherapy	☐	☐
Congenital Heart Defects	☐	☐
Diabetes	☐	☐
Deep Vein Thrombosis	☐	☐
Epilepsy/Seizure Disorder	☐	☐
Headaches	☐	☐
Heart Murmur	☐	☐
Hepatitis – Type ____	☐	☐
High Blood Pressure	☐	☐
HIV / AIDS	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Multiple Sclerosis	☐	☐
Pacemaker	☐	☐
Psychiatric Care	☐	☐
Respiratory Disease	☐	☐
STDs	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Any Other Condition	☐	☐

Please Describe: ____________

____

Medical History

	Yes	No
1. Any additional Past Medical History?	☐	☐
Please describe: ________________________		
2. Have you ever had any surgeries?	☐	☐
Please describe: ________________________		
3. Are you taking any medications?	☐	☐
Please list: ____________________________		
4. Do you have any Allergies to medications?	☐	☐
Please list: ____________________________		
5. Do you smoke tobacco?	☐	☐
6. Have you ever used drugs or alcohol during this pregnancy?	☐	☐
Have you had a problem with drugs or alcohol in the past?	☐	☐
Does your partner have a problem with drugs or alcohol?	☐	☐
Did one of your parents have a problem with drugs or alcohol?	☐	☐
Do your friends have a problem with drugs or alcohol?	☐	☐

High Risk Pregnancy Center

PLEASE PRINT VERY CLEARLY

■ Patient Information

Name (Last, First, Middle) ____________________

Birthdate ____________ Soc. Sec. # ____________ Home Phone ____________

Address ____________________ Cell Phone ____________

City ____________ State ________ Zip________ Work Phone ____________

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Email address ____________________ Employer ____________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language Spoken: ☐ English ☐ Spanish ☐ Other ____________

Race: ☐ White ☐ Hispanic ☐ African American ☐ Indian ☐ Asian ☐ Pacific Islander ☐ Other ____________

Referring Physician ____________________ Phone ____________

■ Spouse / Legal Guardian

Name (Last, First, Middle) ____________________ Home Phone ____________

Birthdate ____________ Soc. Sec. # ____________ Cell Phone ____________

Address ____________________ Employer ____________

City ____________ State ______ Zip ________ Sex: ☐ M ☐ F

■ Emergency Contact

Name (Last, First) ____________________ Phone Number ____________ Relationship ____________

■ Primary Insurance

Insurance Company ____________________

Insurance ID # ____________________ Group # ____________

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) ____________________

Relationship to Patient____________ Soc. Sec. # ____________ Birthdate ____________

Address ____________________ Home Phone ____________

Employer ____________________ Work Phone ____________

■ Secondary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company ____________________

Insurance ID # ____________________ Group # ____________

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) ____________________

Relationship to Patient____________ Soc. Sec. # ____________ Birthdate ____________

Address ____________________ Home Phone ____________

Employer ____________________ Work Phone ____________

■ Assignment and Release

I hereby authorize payment directly to High Risk Pregnancy Center of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: ____________________ **Date:** ____________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): ____________________ **Relationship to Patient:** ____________

■ Financial Responsibility

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE. I / we do hereby acknowledge it is my/our responsibility to pay the deductible, co-insurance and any other balance not paid by my/our insurance. I / we agree to pay all collection fees, attorney's fees, service fees, court costs, and filing fees, including charges of commissions that may be assessed to me by any collection agency retained to pursue nonpayment, which may be as much as 50% of the principle owing. I further agree to pay interest at the rate of 2% per month or $5.00 per month, whichever is greater on all Invoices past due by thirty (30) days. I / We certify & I / we have read and understand all the information provided. I / we certify the information provided is true and correct to the best of my/our knowledge.

Printed Name Signature Date

Printed Name Parent I Guardian Signature Date

■ Authorization for Release of Medical Records and Information

I do hereby agree to the request for release of all of my medical records including physician office notes, hospital documentation & reports, all laboratory and radiology reports to High Risk Pregnancy Center. I absolve all physicians and staff of any liability resulting from the release of such said records. I do hereby also agree to the release of my medical records by High Risk Pregnancy Center to any office or facility I am referred to. I do hereby also agree to allow HRPC to follow/access the data and records for my fetus/baby/child for quality, safety and research purposes. I absolve all physicians and staff of any liability resulting from the release of such said records.

Printed Name Signature Date

Printed Name Parent I Guardian Signature Date

■ Appointment Cancellation Policy

I do hereby agree to notify The High Risk Pregnancy Center within 24 hours prior to any scheduled appointments if I am unable to make my appointment. I understand that if I fail to contact the office and do not show for my scheduled appointment I agree to a $**50.00** fee that will be not be covered by my insurance company and will be my sole responsibility.

Printed Name Signature Date

Printed Name Parent I Guardian Signature Date

BILLING and COLLECTION POLICIES

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration, we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment and notify the office at your first appointment after if changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged **$50** for each no-show occurrence. Should this occur more than twice within a 12 month period, you may be dismissed from the practice. By signing below, you accept this policy.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans every week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Authorizations: You are responsible to obtain all necessary referrals, or other required documentation prior to your appointment. If our team office determines that your plan requires a referral, and you do not provide such referral, you may be required to sign a waiver in order to receive services. Additionally, even should our team fail to request such a waiver, you will nonetheless be responsible for all charges that are not paid by your insurance carrier due to lack of authorization. By signing below, you accept these policies.

Copayments: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. By signing below, you accept these policies.

Telemedicine and/or Telephonic Visits: Evaluation and follow-up by our provider may be done via telemedicine and/ or telephonic systems. By signing below, you consent for this evaluation and acknowledge responsibility, as detailed by the terms of your health insurance coverage, to pay any copays, coinsurance, or deductibles for this care.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account will be sent to collections (and subject to an additional collection fee) and/or legal action will be pursued. You may be dismissed as a patient by our practice for failure to meet your financial obligations. By signing below, you accept these policies.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. By signing below, you accept these policies.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to High Risk Pregnancy Center for any services furnished to me or my dependents.

Signature of Patient: ____ Date: ____________________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

ULTRASOUND
CONSENT FORM

An ultrasound has been ordered on you and your unborn child by your physician. There are many reasons that this diagnostic test may have been ordered. Some of these include evaluation of your baby for birth defects, growth patterns, amniotic fluid level, Doppler flow indices, abnormal blood test results, or as adjuncts to diagnostic therapeutic testing or procedures. The quality of ultrasound examinations are extremely dependent on the equipment utilized, the sonographer doing the ultrasound, the position of your baby within your womb, your body size, previous abdominal surgery and the physician who interprets your exam.

Ultrasound examinations have never been shown to damage you or your baby. This is not an x-ray. Ultrasound uses sound waves. The ultrasound produces a small burst of high frequency sound and then listens for the "echo" of the sound in your body. A computer then integrates this information to make the picture that you see on the screen. Many things can be seen about your baby, such as birth defects and growth abnormalities. Ultrasound is also used to see where the baby is in relation to the needle when certain invasive procedures are done, such as amniocentesis.

Failure to have this ultrasound done may make it difficult, if not impossible, to care for you and your pregnancy in the best way possible. There may be abnormalities of your reproductive system that may benefit from diagnosis and treatment. You may not be able to take advantage of many options afforded to you bylaw. The birth of your baby may be compromised by not being able to have the appropriate specialists present during your pregnancy and at the time of your delivery that your baby may need. Without ultrasound, therapeutic measures would also not be possible, and this may result in a damaged baby or even the loss of the life of your baby.

The utmost care and concern is given to you and your unborn child. Even so, ultrasound is not a perfect science and things may not be seen. Factors that may limit the accuracy of the ultrasound include the gestational age of your baby, your body composition, previous abdominal surgery and the position of your baby within the womb. There are some abnormalities that are never seen with ultrasound.

I understand that ultrasound cannot see all things in my unborn child or me but that it may be a very helpful tool to help manage my pregnancy and plan the delivery.

I have read this consent, fully understand the above information, have had all my questions answered to my satisfaction.

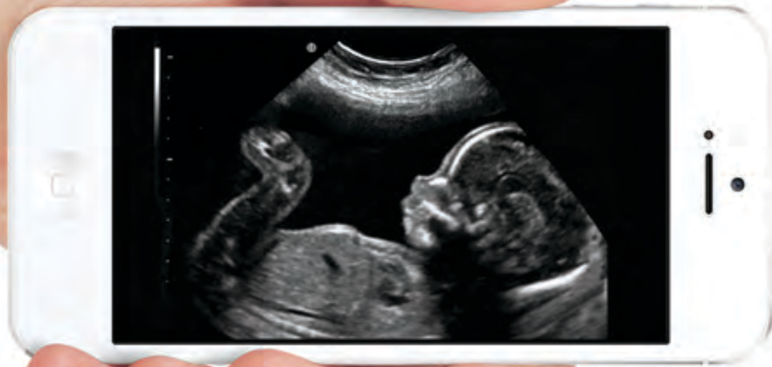
☐ I want an ultrasound performed on me.

☐ I decline to have an ultrasound performed on me.

Signed:____ Date: ____________

Witness:____ Date: _____________

Tricefy™ your ultrasound at



☐ I want my ultrasound images delivered digitally as an email or text.

Email Address: ______________________________

Mobile Phone Number: ______________________________

☐ I authorize the sending of images during my pregnancy.

☐ I have read, understand, and agree to this disclaimer.

☐ I will have access to my images for 90 days from my exam date.

It is highly recommended that you download and store your images on your computer or other device since they will be removed from the server at the end of 90 days.

Name: ______________________________

Signature: ______________________________ Date: ____________

Patient Disclaimer and Authorization

Tricefy™ is a communication service licensed to High Risk Pregnancy Center (hereafter called: "HRPC"). This Disclaimer and Authorization Agreement sets forth the terms and conditions under which you, the undersigned patient authorize HRPC to transmit your ultrasound examination through Trice Imaging, Inc. to a mobile phone number and email address of your choice. This Agreement will become effective on the date of your signature and will terminate after all images throughout your current pregnancy are sent to you.

After you complete and sign this Agreement, a mobile telephone number or email address you designate will be entered into our ultrasound system and re-verified with you. When your ultrasound screening is complete, in accordance with the HRPC policies and procedures, the sonographer will trigger the ultrasound machine to send an encrypted copy of your examination to the Tricefy™ server. The server will reformat and encrypt the file and provide access to the examination through your mobile phone number and a text or email. The Physician will have the discretion to determine whether your ultrasound screening is complete and whether to transmit your images to Tricefy™. The Physician has the right to refuse to transmit or to delay the transmission of your images. Both the text and email message will contain secure links and instructions on how to access the images. Images and videos can be accessed and downloaded to your mobile phone and computer.

You agree to pay all costs for the services if applicable. Transmission of the images through Trice Imaging, Inc. is not a medical service. The transmitted images are not considered diagnostic medical images and are not a part of your medical record; they are not to be used for your health care, diagnosis or treatment. If you want to see your medical records, you need to contact HRPC, who is responsible for maintaining your medical records. Neither HRPC nor Trice Imaging, Inc. is responsible for the security of the transmitted images once the text and email recipients you have designated download the images. By directing HRPC to transmit the images to an email address and telephone number that you specify, you authorize HRPC and Trice Imaging, Inc. to provide the images to the person who owns or uses the email address and telephone number and any persons who may have access to the telephone number and email address. Once the images have been accessed and each link to them is broken, the services are complete. We would recommend immediate download of any images, as the link to the images will only be active for a maximum of 90 days. Any transmission of additional images will be considered new services, the cost for which the patient is obligated to pay, if applicable. Trice Imaging, Inc. will not store the images on its server for you.

As a licensee of Tricefy™ through Trice Imaging, Inc., HRPC is permitted to offer the services under the terms and conditions of the license. This is the sole agreement between Trice Imaging, Inc. and HRPC.

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* (“PHI”), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: ______________

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: ______________

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: ______________

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my PHI may be shared with my spouse. ______________________________________

♦ I agree that my PHI may be shared with the following other people:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to High Risk Pregnancy Center.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time (“HIPAA”)*

Patient Name (print):____

Signature: ____ Date: _______________________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): __________________ Relationship to Patient: ____________________

Brian K. Iriye, MD
Stephen M. Wold, MD
Wilson H. Huang, MD
Laura A. Gorski, DO
Lauren Giacobbe, MD
David Jackson, MD
Manijeh Kamyar, MD
Garrett Lam, MD
Roxanna Twedt, MD

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

This is your Health Information Privacy Notice from the High Risk Pregnancy Center. The goal of our physicians and office is to provide the utmost in quality care for our patients in doing so we strongly believe in protecting the confidentiality and security of information we collect about you.
This notice describes how we protect the personal Health Information of our patients and your rights as a patient with respect to your Personal Health Information (PHI) and how you may exercise those rights.
The Health Insurance Portability *& Accountability* Act of 1996 (HIPAA) requires our office to maintain the privacy of protected health information and to provide you notice of our legal duties to abide by those privacy practices with respect to IHI.
We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information that it maintains. You may access a revised notice upon request or by contacting one of our HIPAA point persons or by referring to the most updated notice posted in our waiting areas.
For any additional information regarding our HIPAA Medical Information Privacy Policy please ask for or write to one of our HIPAA point persons (HHP's) Privacy officers listed below, request for any restrictions or to revoke any restrictions must be done in person with either person feed below or in written form signed, dated and received via pre-paid certified return receipt mail to.
Angelina Cruz 2845 Siena Heights Dr. Ste 350 Henderson, NV 89052 – Nubia Sandhu 2011 Pinto Ln. Ste 200 Las Vegas, NV 89106 – Yolanda Castaneda 9090 W Post Rd, Ste 100 Las Vegas, NV 89148-- Cindy Diaz 9780 S, McCarran Blvd Ste 1 Reno, NV 89523 Phone: (702)382-3200 Fax (702)382-3575
Under applicable laws our office may use or disclose your PHI for the purpose of carrying out treatment, payment or health care operations. This may be done orally, electronically or by means of paper form.
Treatment - Means use and disclosure will take place in providing, coordinating, or managing healthcare and its related services by one or more of your health care providers, such as when our physician consult with your primary care physician regarding your condition.
Payment - Means activities such as obtaining or provide benefits, authorization or reimbursement for providing healthcare, Collection activities, and utilization review. Example: obtaining authorization required by your insurance to provide services.
Health Care Operations - Include the business aspects of running our practice, such as quality assessment and improvement, providing review and training, auditing functions, cost-management analysis, management and administration purposes and providing quality customer care. An example of this would be to assist in an audit of the quality of care provided by our staff.
We may use and disclose your PHI, without your consent or authorization as required and permitted under Nevada State Law. These laws relate to public health activities and safety issues. An example of this would be someone coming into contact with a communicable disease that could possible become a public health risk. We may also create and distribute de identified health information by references to individually identifiable information.
We may contact you to provide appointment reminders or information alternatives or other health-related benefits and services that may be of removing all about treatment interest to you.
You have the right to request the following with respect to your PHI, which you can exercise by presenting a written request to the HHP or Privacy Officer at the above listed address. The right to request restrictions on certain uses and disclosures of PHI to carry out treatment, payment or healthcare operations, However our office is not required to agree to your requested restriction.
The right to receive and our office is required to accommodate reasonable request to receive confidential communication of your PHI.
The right to inspect and copy your PHI
The right to amend your PHI
The right to receive a copy of the disclosures of your PHI
The tight to obtain a copy of this notice from our office upon request
Unless you object, we may disclose to family members, relatives, friends, or other persons identified by you, PHI that is directly relevant to the persons involvement with your care. In addition, unless you object, we may use or disclose the PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for your cam, or certain disaster relief agencies of your location, general condition, or death. Objection to this may be communicated to one of the above listed HPP.
If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to object to this notice, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick-up medical supplies, x-rays or similar forms of Protected Health Information.
Any other uses and disclosures will be made only with your written consent and authorization. You have the right to revoke your consent at any time, except to the extent that the Center for Maternal-Fetal Medicine has taken action in reliance of a prior consent or authorization.

"Notice to Patients Regarding the Destruction of Health Records"

NRS 629 -

a.) Pursuant to the provisions of subsection 7 of the NSR 629.051:

1. The health care records of a person who is less than 23 years of age may not be destroyed; and
2. The health care records of a person who has attained the age of 23 years may be destroyed for those records which have *been* retained for at least 5 years or for any longer period provided by federal law: and

b.) Except as otherwise provided in subsection 7 of NRS 629.051 and unless a longer period is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

If you believe that your privacy rights have been violated, you may complain to one of our Privacy Officers at the Address and Numbers fisted above or by contacting the Secretary Department of Health and Human Services, Hubert H. Humphrey Building 200 Independence Ave. SW, Washington DC 20201. You will not be retaliated against for filing a complaint
Revised: January 18, 2010

INFORMED CONSENT AND AUTHORIZATION TO PERMIT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Introduction and Purpose

All pregnancies have some level of risk. But not all risks are equal. A high-risk pregnancy is one where a pre-existing condition or problem diagnosed during pregnancy puts the mother or fetus (or both) at an increased risk for complications during or after pregnancy and birth. The High Risk Pregnancy Center specializes in maternal-fetal medicine and provides fast, responsive care and the compassion and attention expectant mothers need during their exciting but stressful time of pregnancy.

The High Risk Pregnancy Center is dedicated to providing the best care possible to its patients. In order to do so, the High Risk Pregnancy Center is engaged in an ongoing review of the treatment of each one of its patients, including care during the stages of pregnancy through the birth of each child, for the purpose of **optimizing the quality of care provided to those patients and future patients alike**.

The purpose of the High Risk Pregnancy Center's research is driven by its dedication to continuously improve the quality of care it provides to its patients. By participating in this research, the High Risk Pregnancy Center will review your treatment and the treatment of your newborn, to determine the effectiveness of certain treatment methods, including medicinal treatments, tests, evaluations and counseling, on expectant mothers and their unborn children at the various stages of pregnancy and through the birth and infancy of each child.

What information will be collected?

In order to determine the effectiveness of certain treatment plans and care provided, the High Risk Pregnancy Center will review the medical records, including office notes, results of physical examinations, medical history, hospital documentation and reports, and all laboratory and radiology reports, that it created and maintained through the course of your treatment at the High Risk Pregnancy Center. To follow up on your health and the health of your baby, the High Risk Pregnancy Center will obtain the same types of medical records, including notes, results of physical examinations, medical history, documentation and reports, and laboratory and radiology reports, from any hospitals or other healthcare providers that cared for you during or directly after your pregnancy, or for your child at birth and into his or her infancy.

This Informed Consent and Authorization to Permit the Use and Disclosure of Protected Health Information ("Consent and Authorization") expressly authorizes the High Risk Pregnancy Center to: use your medical records and personal information, as well as that same information from your child to conduct the research discussed above, and to request and/or obtain the same medical records and personal information about you and your newborn child from any other healthcare provider, including any medical office, hospital, urgent care center and/or medical treatment facility which treats you or your child after your child is born.

The medical records that may be disclosed and used, as discussed in this section, will only be provided to the High Risk Pregnancy Center after those records have been created, independent of the High Risk Pregnancy Center's research.

Who will use my information?

Your information will be used by the High Risk Pregnancy Center, its employees, agents and/or other researchers or data processors it contracts with or employs to conduct the research discussed above.

What does informed consent mean?

By consenting to participate in this research and authorizing the use and disclosure of your protected health information, you are expressly allowing the High Risk Pregnancy Center to use and obtain your health information as discussed in this Consent and Authorization form.

The High Risk Pregnancy Center will take great care to preserve the confidentiality of your, and your child's, protected health information. Because the information the High Risk Pregnancy Center will obtain and use for its research is created in the ordinary course of your medical treatment, this research will not affect the medical treatment or care you receive from any healthcare provider.

By signing this Consent and Authorization form, you acknowledge that you understand its contents and you consent to participate in the research described above. If you do not understand something about this Consent and Authorization form, please ask a High Risk Pregnancy Center employee to explain it to you.

HIGH RISK Pregnancy CENTER

When does this Consent and Authorization expire?

There is no expiration date for the High Risk Pregnancy Center's ability to use your information for this research, or for the High Risk Pregnancy Center to obtain and use your information from other health care providers who have treated you. However, you may revoke your authorization to participate in this research at any time, by following the requirements set forth below.

Revocation of Consent and Authorization

You may change your mind and revoke this signed Consent and Authorization form at any time by sending or delivering a written request to revoke your Consent and Authorization to:

The High Risk Pregnancy Center
Attn: Brian Iriye
2011 Pinto Lane, Suite 200
Las Vegas, Nevada 89106

If you revoke your Consent and Authorization, the High Risk Pregnancy Center will not be able to obtain or use any of your protected health information for the purposes listed above, after it receives your written revocation. But it may still keep and use any information about you and/or your baby which it received while your Consent and Authorization was effective.

Do I need to sign this Consent and Authorization?

No. By law, the High Risk Pregnancy Center may not refuse to treat you, or treat you any differently if you do not sign this Consent and Authorization form. The High Risk Pregnancy Center also may not condition any payment, eligibility or enrollment obligation you may have related to your healthcare upon your signing of this Consent and Authorization.

The High Risk Pregnancy Center is required by law to protect your health information. By signing this Consent and Authorization, you agree to participate in the research discussed above and to allow the High Risk Pregnancy Center to use your protected health information for the purposes listed above. You also agree to authorize the High Risk Pregnancy Center to request and/or obtain your, and your baby's protected health information from other healthcare providers to use for the same purposes. The persons who receive your health information may not be required by Federal privacy laws to protect it and may share your information with others without your permission, if permitted by the relevant laws.

CONSENT AND AUTHORIZATION

I hereby acknowledge that I have read and understand this Consent and Authorization, and by signing below, I voluntarily consent and authorize the High Risk Pregnancy Center to obtain and use my protected health information in accordance with the terms above. I understand that I will be given a copy of this signed Consent and Authorization form for my personal records.

I give permission for the High Risk Pregnancy Center to present this signed Consent and Authorization form to other healthcare providers (as discussed above) who have provided me and/or my newborn with medical care, and for the same healthcare providers to disclose my medical records (as discussed above) to the High Risk Pregnancy Center for its use in accordance with this Consent and Authorization form.

______________________________	____________________________	___________________
Name	Signature	Date

I hereby represent that I have the authority to act as a personal representative of my newborn child, and that I have the authority to authorize the use and disclosure of his or her protected health information. By signing below, I voluntarily consent to and authorize, on behalf of my newborn child, the use and disclosure of my newborn child's protected health information in accordance with the terms of this Consent and Authorization.

______________________________	____________________________	___________________
Name	Signature	Date