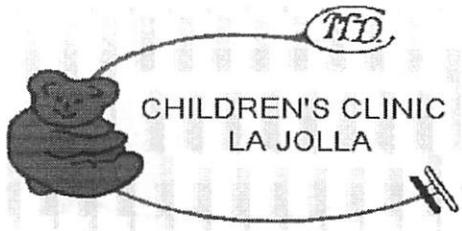


Policies and Procedures/New Patient Permission Form

Authorization to Release Information
I hereby authorize Children's Clinic La Jolla and/or its physicians to release, use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Children's Clinic La Jolla may refuse to treat me.

Authorization of Benefits
I hereby authorize payment of the surgical or medical benefits to Children's Clinic La Jolla and/or its physicians, unless benefits are otherwise payable to me for his/her services. I recognize and accept personal responsibility for any balance outstanding and the payment for such benefits.

Cancellation of Appointments
Scheduled appointments need to be cancelled 24 hours in advance of the appointment. Failure to do so may result in the patient and/or guardian being personally responsible for a missed appointment fee.

Insurance
We will bill your insurance company as a courtesy to you. Any claims not paid by the insurance company within 90 days of submission will become your responsibility for payment. You will also be responsible for any portion of the bill not covered under your insurance agreement, including co-payments, co-insurance and deductibles. Further, in the event of non-payment, you will bear the cost and legal fees for collections should this be required.

*Co-Payments/Cash Payments/Balances Due
Co-payments AND balances are due at check-in. Cash payments are due at the time of the appointment. We accept cash, personal checks, and most credit cards. If you pay with cash, please be sure to get a receipt prior to leaving the office.

Notice of Privacy Practice
I have received a copy of the Children's Clinic La Jolla Privacy Practice.

Responsible Parent/Guardian
Any patient under the age of 18 years must be accompanied to their office visit by their parent/guardian or an adult approved by the parent/guardian. Please list the names of any persons approved by the parent/guardian to accompany their child to an appointment (e.g., grandparents, aunts, neighbors). Anyone not on the list who accompanies the child to an appointment must have a note signed by the parent/guardian.

Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

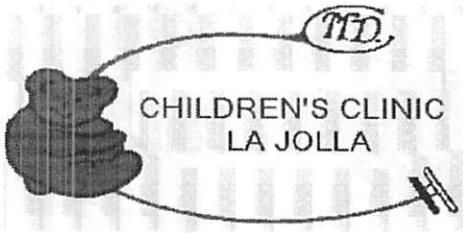
Photographs
Do the employees of Children's Clinic La Jolla have your permission to take photographs of the patient as part of their medical records? Photographs used as part of the medical to identify the patient as well as part of the diagnostic notations (e.g., location of rashes, hives, etc.). The photographs will be treated as confidential and are subject to the same privacy regulations as other diagnostics.
Yes_____No_____

Patient's Name (Printed):

_____

Patient's Signature (Age 18 and older) or Legal Guardian: Date:

_____ _____



Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health Information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up among the multiple
- Healthcare providers who may be involved in that treatment directly and Indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and Physician certification.

I have received, read and understand your *Notice of Privacy Practices*, contained within the Children's Clinic La Jolla's *Patient Information Booklet* (a summary is also available upon request) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy. In addition, my signature below indicates that I authorize Children's Clinic La Jolla and any employees within this organization to treat me for medical care.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name (Printed):

_____

Patient's Signature (Age 18 and older) or Legal Guardian: Date:

_____ _____

Printed Name of Above if Different Than Patient:

_____