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Pediatrics
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Acknowledgment of Receipt of Notice of Privacy Practices:

_____
Initial I have received this office's Notice of Privacy Practices, which explains how my child(ren)'s medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Privacy Questionnaire:

I. Please list the family members or other persons, if any, whom we may inform about your child/children's general medical condition and diagnosis (including treatment, payment, and health care operations.)

_____
_____
_____

II. Please print the address of where you would like your **billing statements** and/or **correspondence** from our office to be sent if other than your home:

_____
_____

III. Please print the telephone number where you want to receive calls about your child/children's appointments, lab and x-ray results, or other health care information if other than your home phone number: _____

Initial _____ ***I am fully aware that a cell phone is not a secure and private line***

IV. Can confidential messages (e.g., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐No

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Print Name of Parent or Legal Guardian Legal relation to child(ren)

List name (s) of child(ren) covered by this form:

_____ _____
_____ _____
_____ _____