Pediatric Patient Registration

Patient Information

Name: _____ Date of Birth: _____

Home Address: _____ City, State Zip: _____

Names & Ages of Immediate Family Members (e.g., Jack, 9): _____

_____

Parent/Guardian Information

Primary Family Email: _____ Primary Family Phone: (_____) _____

Parent/Guardian 1 Name: _____ Date of Birth: _____

Relationship to Patient: _____ Primary Phone: (_____) _____

Home Address (if different from child): _____

Employer: _____ Email address: _____

Parent/Guardian 2 Name: _____ Date of Birth: _____

Relationship to Patient: _____ Primary Phone: (_____) _____

Home Address (if different from child): _____

Employer: _____ Email address: _____

Home Pharmacy Information

Pharmacy Name: _____ Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Insurance Information *Please bring insurance cards to each visit.*

Primary Insurance Plan: _____ Member ID: _____

Guarantor/Primary Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Effective Date: _____

Email Address: _____ Primary Phone: (_____) _____

I understand that payment of all medical care is due at the time of service. I am responsible for all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs. I hereby grant permission to Growing Health Together to release any pertinent information to my insurance company upon request. By signing below, I authorize Growing Healthy Together to provide me with medical services and to seek reimbursement for those services. A photocopy of this authorization shall be considered as effective and valid as the original.

Guarantor/Primary Subscriber Signature: _____ Date: _____

Secondary Insurance Plan: _____ Member ID: _____

Guarantor/Secondary Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Effective Date: _____

Email Address: _____ Primary Phone: (_____) _____

I understand that payment of all medical care is due at the time of service. I am responsible for all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs. I hereby grant permission to Growing Health Together to release any pertinent information to my insurance company upon request. By signing below, I authorize Growing Healthy Together to provide me with medical services and to seek reimbursement for those services. A photocopy of this authorization shall be considered as effective and valid as the original.

Guarantor/Primary Subscriber Signature: _____ Date: _____

Pediatric Patient History

Name: _____ Pronouns used: _____

Date of Birth: _____ Sex assigned at birth: ☐ Female ☐ Male ☐ Other: _____

Current gender identity (*Choose all that apply*):

☐	Male
☐	Female
☐	Transgender male/transgender man/female-to-male (FTM)
☐	Transgender female/transgender woman/male-to-female (MTF)
☐	Genderqueer (neither exclusively male nor female)
☐	Other: _____
☐	Choose not to disclose

Prenatal History

Any infectious illness during pregnancy (e.g., German measles (rubella), flu, bladder, or kidney infection)? ☐ Yes ☐ No

Type of infection: _____ Month of pregnancy: _____

Medication given: _____

Check all items used during pregnancy. If checked, please describe.

Vitamins	☐	
Laxatives	☐	
Iron	☐	
Antibiotics	☐	
Aspirin/Tylenol	☐	
Prescriptions	☐	
Cigarettes	☐	
Alcoholic beverages	☐	
Birth control pills	☐	
Other OTCs	☐	
Marijuana or other drugs	☐	
X-rays	☐	

Describe any complications during pregnancy (e.g., diabetes, thyroid disease, toxemia, excessive bleeding): _____

_____

Describe any complications of the labor and delivery (e.g., prolonged labor, prematurity, fetal distress, c-section, forceps, difficulty in getting baby to breathe): _____

_____

Birth weight: _____ Length: _____ Did the infant stay longer than the birth parent? ☐ Yes ☐ No

If so, why? _____

Birth location: ☐ Home ☐ Hospital ☐ Birth Center ☐ Other: _____

Birth location name: _____ Address: _____

Birth provider name: _____ Address: _____

Pediatric Health

Has your child been hospitalized? ☐ Yes ☐ No Has your child had any major medical problems? ☐ Yes ☐ No

Any "childhood" illness (e.g., chickenpox, measles)? ☐ Yes ☐ No Fractures or other injuries? ☐ Yes ☐ No

Any signs of breast development, adult body odor, voice change, adult hair patterns, menstruation? ☐ Yes ☐ No

If yes to any of the above, please describe: _____

Child's medication name, dose, & frequency, if any: _____

Child's allergies: _____

Brief description of child's diet: _____

Family Medical Conditions

Please list any medical problems with immediate family members (i.e., biological mother, age 34, hearing problems, brother, 10, asthma): _____

_____

Please list medical conditions of biological aunts, uncles, cousins, or grandparents.

Skin (e.g., eczema, psoriasis, ichthyosis): _____

Eyes (e.g., blindness, cataracts, lazy eye): _____

Ears (e.g., deafness, ear infection, deformities): _____

Nose/throat (e.g., sinus problems, lack of sense of smell, tonsillitis): _____

_____

Mouth (e.g., cleft palate, cleft lip): _____

Glands (e.g., thyroid, diabetes): _____

Lungs (e.g., asthma, cystic fibrosis): _____

Heart (e.g., murmurs, heart attacks, congenital abnormalities, high blood pressure): _____

_____

Stomach/bowel (e.g., ulcers, colitis, lactose intolerance): _____

Kidney/bladder (e.g., congenital abnormalities, infections, kidney stones): _____

_____

Bone/joint disease (e.g., osteoarthritis, rheumatoid arthritis osteogenesis imperfecta): _____

_____

Neurological problems (e.g., seizures, paralysis, strokes): _____

Cancer: _____

Developmental problems: _____

Psychiatric conditions (e.g., manic depressive (bipolar) disorder, schizophrenia): _____

_____

Other: _____

Childhood Development

Please estimate the age at which your child could do the following things:

Sat alone: _____ Walked alone: _____ Spoke first word: _____ Several words: _____

School Performance

Please list everyone who lives at home: _____

_____

Who provides care for the child during the day? _____

Does parent/guardian work? ☐ Yes ☐ No Does child go to school/daycare? ☐ Yes ☐ No

If yes, what is the name of the school or daycare: _____

Immunizations

	Date of last vaccine		Date of last vaccine
Tetanus (Td or Tdap)		Influenza	
MMR (measles, mumps, rubella)		Varicella	
Pneumococcal		Zoster (shingles)	
Meningococcal		Hib	
Hepatitis A		Polio	
Hepatitis B		HPV	
COVID-19		Other:	

Review of Systems

Has your child experienced any of the problems listed on the family history? ☐Yes ☐No

If yes, which? _____

Has your child had any frequent problems with the following? Check all that apply.

Headaches	☐	**Frequent sore throat**	☐	**Shortness of breath**	☐
Dizziness	☐	**Trouble with swallowing**	☐	**Heart murmur**	☐
Head injury	☐	**Neck stiffness**	☐	**Rheumatic fever**	☐
Vision problems	☐	**Neck swelling**	☐	**Vomiting**	☐
Eye infection	☐	**Swollen glands**	☐	**Abdominal pain**	☐
Hearing problems	☐	**Chest deformity**	☐	**Diarrhea**	☐
Ear infection	☐	**Pneumonia**	☐	**Constipation**	☐
Nose that bleeds easily	☐	**Cough**	☐	**Pain on voiding urine**	☐
Frequent stuffy nose	☐	**Asthma**	☐	**Urinating frequently**	☐
Tooth decay	☐	**Chest pain**	☐	**Bed wetting**	☐
Poor bite	☐	**Blue color**	☐	**Skin rash**	☐
Abnormal walking	☐	**Weight gain/loss**	☐	**Skin infection**	☐
Joint pain/swelling	☐	**Intolerance to heat/cold**	☐	**Developmental problems**	☐
Abnormal bleeding	☐	**Excessive thirst**	☐	**Seizures**	☐
Anemia	☐	**Hair changes (thinning/falling out)**	☐	**Meningitis**	☐

Other: _____

If yes to any of the above, please explain: _____

_____

_____

What are your child's chief symptoms or medical problems at this time, if any? _____

_____

_____

_____

Permission to Treat

I (We) _____authorize Growing Healthy Together and its personnel
print name(s)
to deliver medical services to myself **OR** my children, listed below.

Name(s) of Child(ren) (if applicable)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Emergency Contact

I (we) authorize the following people to contact in case of emergency.

For parents/guardians: I (we) authorize the following person(s) to bring my child(ren) in for treatment and/or to contact in case of emergency.

Name: _____ Phone: (_____) _____ Relationship: _____

Name: _____ Phone: (_____) _____ Relationship: _____

Name: _____ Phone: (_____) _____ Relationship: _____

Name: _____ Phone: (_____) _____ Relationship: _____

Please check one of the following:

☐ **I am an adult patient, signing on behalf of myself.**

☐ **I am a parent/guardian, signing on behalf of my child(ren), listed above.**

_____ _____
Signature(s) Date

(_____)_____ _____
Primary Phone Relationship to Patient (if applicable)

Financial Policy

Insurance Coverage: Your insurance plan is a contract between you and your insurance company. It is your responsibility to understand the benefits and coverages your medical plan provides. Please verify that Growing Healthy Together and our practitioners are registered as an "in-network" provider, and we are assigned as your primary care provider (managed care/HMO policyholders). Bring your insurance card(s) with you to each visit. Providing your insurance card and information does not guarantee payment from your insurance company. If we do not have your current, active insurance policy on file, you may be asked to pay at the time of service.

Cash Patients: Payment in full is required at the time of service. Exam fees do not cover add-on services like additional tests,screenings, vaccines, or procedures. Exceptions to this policy must be arranged with management before your visit.

New Patient Appointment Deposit: A $50 non-refundable deposit is required for new patients to confirm and hold their appointment at the time of scheduling. If you keep your appointment, the deposit is applied to the cost of the visit or applied to a future visit. If you cancel your appointment at least 24 hours before, the deposit will be applied to a future appointment. If you miss the appointment, you will lose your deposit.

Consults, Preventative Care, & Sick Visits: Claims are billed based on your provider's clinical evaluation and diagnosis during exams. A preventative care appointment can become an office consult or sick visit, resulting in fees (e.g., co-pays, co-insurance) that are the patient's responsibility to pay. If you require the assessment, evaluation, or provider intervention during a vaccine-only appointment, it will become a consult or sick visit.

Telemedicine/Virtual Appointments: Telemedicine, Spruce messages, and phone calls are subject to insurance or self-pay billing, determined by your provider's medical evaluation and clinical judgment at the time of the exam. Co-pays, co-insurance, and deductibles may apply.

Coordination of Benefit Holds (COB): A claim may be placed on a COB hold if the insurance company needs to verify whether the patient had dual coverage at the time of service or if the insurance company requires additional information before they can process the claim. If a claim is unpaid due to a COB hold, the member's responsibility is to clear the hold within 30days of notification. Uncleared claim amounts due to COB holds are the patient's responsibility to pay without a guarantee of reimbursement or reprocessing by the insurance company.

Co-Pays, Deductibles, and Co-Insurance: Co-payments are due at check-in before being seen by your provider. Co-insurance and deductible amounts are determined by the contract you have with your insurance company. After your insurance company has processed a claim, any balances they determine are the patient's responsibility will be billed to you to be paid within 30 days of receipt.

Late/Missed Appointments: All appointments must be confirmed before the date of service. If you are unable to make your appointment, we require a 24-hour cancellation notice. If you are running late, please notify the office. We may need to rescheduleyour appointment so that our providers can spend an adequate amount of time with your child and other patients. A $50 late/no-show fee is charged for patients who do not notify us of late arrival and appointment cancellations within 24-hours of the visit.

Non-Covered Services: "Services" describe any interaction or service provided by an employee of GHT, including but not limited towellness, office, sick, vaccine-only, nurse-only, and consultation visits.

Returned Check Fee: If your payment is made by e-check or paper check and the check is returned from the bank asdishonored, a $25.00 return check fee will apply.

Transaction Fee: If a credit card payment is returned, declined, or incorrectly disputed, a $25.00 processing fee will apply.

Form Fee: Patients often request various forms (school, disability, etc.) to be completed by GHT. Forms require a review and completion of a detailed medical history by our providers. Our documentation fee is $25.00 and must be paid in full at thetime forms are submitted. As a courtesy, we waive this fee if the patient provides forms during their scheduled visit.

Unpaid/Outstanding Balances: Full payment of all outstanding balances must be made before your next appointment unless prior arrangements have been made through our billing department. You may also set up payment arrangements through our billingdepartment, if necessary. Overdue balances may be considered for further collection activity.

We offer convenient ways to pay your bill: You can submit payments through online bill pay after creating your patient portal account. You can also mail us your payments or call our office at (562) 473-4441 for assistance.

I understand if I have an unpaid balance to Growing Healthy Together and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for Growing Healthy Together or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Growing Healthy Together and the designated external collection agency are authorized to:

- *(i) Contact me by telephone at the telephone number (s) I am providing, including wireless telephone numbers, which could result in charges to me,*
- *(ii) Contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and*
- *(iii) Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.*

Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification.

By signing, I acknowledge that I have read and understood the policies of Growing Healthy Together described above. I agree to be personally responsible for all applicable fees.

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (if applicable): _____

Primary phone: _____ Primary email: _____

Signature: _____ Date: _____

Notice of Privacy Policies

As required by the privacy regulations created due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you, or your child (as a patient of our practice) may be used and disclosed, and how you can get access to your or your child's individually identifiable health information.

Our Commitment to Your Privacy

Growing Healthy Together is dedicated to maintaining the privacy of you or your child's individually identifiable health information (IIHI). In conducting our business, we create records regarding you or your child and the treatment and services we provide. We are required by law to maintain the confidentiality of health information that identifies you or your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning you or your child's IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

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

- How we may use and disclose you or your child's IIHI
- You or your child's privacy rights in their IIHI
- Our obligations concerning the use and disclosure of you or your child's IIHI

The terms of this notice apply to all records containing you or your child's IIHI created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all your records that our practice has created or maintained in the past and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Site Manager, Growing Healthy Together at 562-473-4441.

We May Use and Disclose You or Your Child's Individually Identifiable Health Information (IIHI)

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment: Our practice may use you or your child's IIHI for treatment. For example, we may disclose your IIHI as follows:

- To order laboratory tests (e.g., blood or urine tests), we may use the results to help us reach a diagnosis.
- To write a prescription, we might disclose your IIHI to a pharmacy when ordering a prescription.
- To treat or to assist others in the treatment of you or your child.
- To inform you of potential treatment options or alternatives or programs, such as our Asthma Program.
- To others who you have permitted to bring your child to the office for treatment. For example, if you ask your babysitter to bring your child in to treat a cold, they may have access to your child's medical information, if applicable.
- To other health care providers for purposes related to their treatment.
- If applicable, to a parent, guardian, or other responsible people if the patient is a minor.

Payment: Our practice may use and disclose your IIHI to bill and collect payment for the services and items provided by us for you or your child. For example, we may disclose your IIHI as follows:

- To contact your health insurer to certify that your child is eligible for benefits, and we may provide your insurer with treatment details to determine if the insurer will cover, or pay for, you or your child's treatment.
- To obtain payment from other third parties that may be responsible for such costs.
- To bill you directly for services and items.
- To other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations: Our practice may use and disclose your IIHI to operate our business. As examples of how we may use and disclose you or your child's information for our operations include, but are not limited to the following:

- To evaluate the quality of care you received or conduct cost-management and business planning activities for our practice.
- To other health care providers and entities to assist in their health care operations under certain circumstances.
- To contact you and remind you of your appointment.
- To inform you of health-related benefits or services that may be of interest to you.
- When we are required to do so by federal, state, or local law.

Use and Disclosure of You or Your Child's IIHI in Certain Special Circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information to the extent such use or disclosure is required by law:

Public Health Risks: Our practice may disclose you or your child's IIHI to public health authorities that are authorized by law to collect information for:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect

- preventing or controlling disease, injury, or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

Health Oversight Activities: Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings: Our practice may use and disclose your IIHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose you or your child's IIHI in response to a discovery request, subpoena, or other lawful processes by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement: We may release IIHI if required by law to do so. For example:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena, or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person

Deceased Patients: Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information for funeral directors to perform their jobs.

Research: Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your child's IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your consent satisfies the following: (i) the use or disclosure involves no more than a minimal risk to you or your child's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the Protected Health Information (PHI) will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

Serious Threats to Health or Safety: Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to you or your child's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization to help prevent the threat.

Workers' Compensation: Our practice may release you or your child's IIHI for workers' compensation and similar programs.

Compliance: We are required to disclose you or your child's IIHI to the Secretary of the Department of Health & Human Services or their designee upon request to investigate our compliance with HIPAA or to you upon request.

Your Rights Regarding You or Your Child's IIHI

You have the following rights regarding the IIHI that we maintain about you:

Confidential Communications: You have the right to request that our practice communicates with you about your health and related issues in a particular manner or at a specific location. For instance, you may ask us not to contact your work. To request a type of confidential communication, you must make a written request to the Site Manager, specifying the requested method or the location you wish us to contact. We will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions: You have the right to request that we limit the use and disclosure of your IIHI for treatment, payment, and health care operations. Additionally, you have the right to request that we restrict our disclosure of you or your child's IIHI to only specific individuals involved in you or your child's care, such as family members or friends. You must make your request in writing to the Site Manager. Under federal law, we must agree to your request and comply with your requested restrictions if:

- Except as otherwise required by law, the disclosure is to a health plan for payment for health care operations (and not treatment); and,
- The medical information pertains solely to a health care item or service for which provided health care has been paid out of pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is required by law or necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time if we notify you of the cancelation and continue to apply the restriction to information collected before the cancelation.

Inspection and Copies: You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you or your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Site Manager to inspect and obtain a copy of your child's IIHI. Our practice may charge a fee for the costs of

copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for 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 the Site Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures: All our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of you or your child's IIHI for non-treatment, non-payment, or non-operation purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your child's information to file your insurance claim. We also will not provide an accounting of disclosures made to you about your child or incident to a use or disclosure we are permitted to make as described above or according to an authorization. To obtain an accounting of disclosures, you must submit your request in writing to the Site Manager. All requests for an "accounting of disclosures" must state a period, which may not be longer than six (6) years from the date of disclosure. The first list you request within 12 months is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy at any time. To obtain a paper copy of this notice, contact the Site Manager or visit our website at www.ghtkids.com.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or the Department of Health and Human Services Secretary. To file a complaint with us, contact us at Growing Healthy Together, 3835 E 7th. St, Long Beach, CA 90804, Attn: Site Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you or your child's IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. We are required to retain records of your care.

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, explaining how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Self or Parent/Legal Guardian _____ Date _____

Print Name of Self or Parent/Legal Guardian _____ Legal relation to the child(ren), if applicable _____

List each child that is seen at our practice, if applicable (please print):

Child's First Name	Child's Last Name	Date of Birth