Next Generation Pediatrics
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1. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received and read a copy of this office's Notice of Privacy Practices.

Patient Name:_____

Parent or Guardian Name:_____

(relationship to patient)_____

Signature_____

Date_____

FOR OFFICE USE ONLY

We attempted to obtain the written acknowledgement of receipt of our Notice of Privacy Practices, but were unable to do so as documented herein:

Date:_____Initials:_____

Reason:_____

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2. AUTHORIZATION FOR ACCESS TO HEALTH INFORMATION

In the event that I am unable to accompany my child(ren)to the doctor's office, I_____
Parent or guardian of the above named patient, authorize the following individuals to have access to and be informed of the above named patient's medical information and medical care. (Individual must be a legal adult with one form of identification)

Signature:_____Date_____

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

3. CONSENT TO TREATMENT AND PAYMENT

I, the parent or guardian of the above named child, authorize this office to provide medical care for the said individual. I understand that confidentiality of medical information and patient rights will be maintained as detailed by HIPAA regulations. I authorize the submission of any medical claims related to my child's care using standard medical office billing procedures. I understand that my consent is valid until I terminate verbally or by written consent and will be renewed annually or upon returning for medical care.

Signature_____ Date_____