

## Acknowledgment of Receipt of Notice of Privacy Practices:

\_\_\_\_\_ I have received this office's Notice of Privacy Practices, which explains how my  
Initial 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:)

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II. Please list the family members or other persons, if any, who have your permission to bring your child/children to Dr. Adams' office:

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III. 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:

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IV. 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.\***

V. 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

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Legal relation to child(ren)

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

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