CHILD'S LEGAL NAME

FIRST_____ MIDDLE _____ LAST _____

BIRTHDATE _____ CHILD'S SS# _____ SEX _____

Guardian 1 / Relationship_____ ***PLEASE INCLUDE APT # OR LOT # IF YOU HAVE ONE

Last _____ First_____ SS#_____ Birthdate_____

Address _____ City _____ State _____ Zip Code_____

Home Phone _____ Cell Phone_____ Work Phone _____

Employer _____ Address _____

Guardian 2 / Relationship_____

Last _____ First _____ SS#_____ Birthdate_____

Address _____ City _____ State _____ Zip Code_____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Address _____

EMERGENCY CONTACT: _____

Other than parents Name Phone # Relationship

We are in the process of switching over from paper to electronic medical records. The government now requires that we ask the following questions and make them a part of your electronic medical record with us. If you choose not to answer please circle "Not Specified". Thank you for your cooperation.

Preferred method of communication: (Circle) Home Phone Cell Phone Mail

Email Address: _____

Ethnicity Non-Hispanic Hispanic Not Specified Gender Identity:_____ Not Specified

Preferred Language: _____ Not Specified Sexual Orientation:_____Not Specified

Race: _____ Not Specified

Authorization: I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records, if any; social services, if any, including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any, and records of communicable disease, if any; to my insurance company(s) for the purpose of payment of bill and to my health care provider for continuity of care, I authorize and request my insurance company to pay directly to the provider the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by my insurance.

I understand that if any employee, physician, or agent of Devyani Khambete, M.D., P.C. sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I hereby certify that the contents of this form are understood by me. Paragraphs or lines that I choose not to pertain to me, if any were stricken before I signed: **Privacy Practices Reviewed:** _____

Date

_____ _____ _____

Signature Date (Valid for One Year) Witnessing Signature Only

Form #16

(Please Fill & Sign Consent Form on back)

OVER →

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I acknowledge that I have today reviewed a copy of this office's Notice of Privacy Practices and I consent to your disclosures of information which you deem are necessary in connection with the treatment for the patient listed below. I understand that such discloser may not be of the type as listed on page 1.

_____

Child's Name

_____

Please Print Name of Person Signing

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgment or receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ The following circumstances prohibited an individual from signing the acknowledgment

_____

_____