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Consents and Acknowledgements Form

Child's Name: ______________________________ *DOB:* ______________

Child's Name: ______________________________ *DOB:* ______________

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Child's Name: ______________________________ *DOB:* ______________

PATIENT PORTAL CONSENT: **Version:** ____________ **Initials:** __________

Our patient portal offers secure viewing of medical information and communication with our staff as a service to our established patients. I acknowledge that I have received, read and fully understand Pediatrics & Newborn Care's Policies for Patient Portal Use and consent to its guidelines.

E-mail address to be used for access to the patient portal:

______________________ **@** ______________________

VOICE MESSAGING: **Initials:** __________

I authorize Pediatrics and Newborn Care, LLC to call and leave messages at the following phone number concerning appointments, test results, medical advice and account information. It is your responsibility to keep this information updated and you may rescind this authorization at any time by written notice.

Phone Number ________-________-________ Alternate Phone Number ________-________-________

NOTICE OF PRIVACY PRACTICES: **Version:** ____________ **Initials:** __________

I acknowledge receipt of Pediatrics & Newborn Care's Notice of Privacy Practices. I understand that Pediatrics & Newborn Care complies with all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Pediatrics & Newborn Care can use private health information for treatment of my child as defined in the Notice of Privacy Practices.

CHILDREN'S IQ NETWORK: **Version:** ____________ **Initials:** __________

I have received a copy of the Children's IQ Network (CIQN) Information Sheet. I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt out) health information with other providers within the CIQN.

X______________________________________ ________/________/________

Acknowledgement of receipt: Signature of Parent/Guardian **Today's Date**

DEMOGRAPHICS: Providing the following information is voluntary. It is being requested as part of the American Reinvestment & Recovery Act (ARRA) which was enacted on February 17, 2009 and includes the "Health Information Technology for Economic and Clinical Health (HITECH) Act".

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐White ☐Other ____________ ☐Do not want to report

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Do not want to report

Primary Language: ☐English ☐Spanish ☐Hindi ☐Other ____________ ☐Do not want to report