ADD/ADHD Diagnostic & Treatment Center Confidentiality Questionnaire

1. List ***ALL*** persons,(family or friend), we may inform about patient's (**you OR your child's)** general medical condition & diagnosis (including calling to make appointments, bringing to appointments, financial information, & healthcare/consent for medical treatment). Please provide at least one contact.
   1. Name:_____ Relationship:_____ Phone:_____
   2. Name:_____ Relationship:_____ Phone:_____
   3. Name:_____ Relationship:_____ Phone:_____
   4. Name:_____ Relationship:_____ Phone:_____
   5. Name:_____ Relationship:_____ Phone:_____

2. List **ONE** person (family or friend) ***ONLY IN AN EMERGENCY*** we may contact or inform about patient's (**you or your child's**) medical condition and include their phone number:
   _____
   _____

3. Indicate if we may OR may not send you e-mails and texts using our automated system for any office-related communications: No_____ Yes_____

4. Is there anyone other than yourself that we may speak to about ***payment of your account?***

   Name: _____ Relationship to patient: _____

   Phone: _____-_____-_____ Ext: _____

_____ _____

Patient/Guardian Signature **Today's Date**

_____ _____

Print Patient Name **Patient Date of Birth**

Date: 10/06/16 Revised