YASMEEN GANGANI, M.D. PEDIATRICS
18550 DE PAUL DRIVE, SUITE 102
MORGAN HILL, CA 95037
(408) 778 - 2025

REGISTRATION FORM

Patient's Name _____ Date of Birth _____ M or F

Address _____ City, State, Zip Code _____

Pharmacy (include city and street name) _____

Mother's Name _____ Date of Birth _____

Address (If different than patient) _____ City, State, Zip Code _____

Phone Number _____ Email Address _____

Father's Name _____ Date of Birth _____

Address (If different than patient) _____ City, State, Zip Code _____

Phone Number _____ Email Address _____

Emergency Contact:

Name _____ Phone _____ Relation to Patient _____

AUTHORIZATION, ASSIGNMENT & RELEASE

I, the undersigned, have insurance coverage and assign directly to Yasmeen Gangani, M.D., all the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Yasmeen Gangani, M.D., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I hereby authorize Yasmeen Gangani, M.D., to be an attending physician and to administer to the patient any examination, treatment and medications she deems therapeutic to the presenting complaint.

Signature of Parent/Guardian _____ Date _____

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HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office.In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contract you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine the compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____
Name of Patient

_____ _____
Parent/Guardian Signature Date