ADVANCED OBSTETRICS AND GYNECOLOGY, LLC
CONFIDENTIALITY INFORMATION FOR MINORS

Our goal is to provide you with the best medical care possible. In order to do that, it is important that you provide us with complete and accurate medical information. Withholding medical information may result in inappropriate or ineffective treatment. While we understand that there may be topics or information that you may want to keep from your parent(s) or guardian(s), it is important that you understand that we cannot guarantee complete confidentiality.

- If you are insured under your parent(s)/guardian(s) insurance plan, they will receive EOB (explanation of benefit) information from their insurance carrier which may include diagnosis, procedures codes and/or dates of service.
- If you are insured under your parent(s)/guardian(s) prescription plan, they will have access to information from their insurance carrier regarding any medications that may be prescribed for you.
- If any procedures, medications or testing are not covered by your insurance plan, your parent(s)/guardian(s) might receive a bill for this care.
- As a minor, your guardian(s)/parent(s) have access to your medical records and can request a copy.
- By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian (except for a limited set of circumstances.)

Federally funded Title X family planning clinics are available and must provide confidential services to minors and may not require parental consent for minors to receive their services.
For a complete listing of Title X family planning clinics in your area, please visit the 'New Jersey Division of Family Health Services' website at:
www.state.nj.us/health/fhs/adult/familyplan.shtml
Or call 1-(800) 230-PLAN or (908) 782-7727

Communication is critical.
We encourage you to involve your guardian(s)/parent(s) when making healthcare decisions.

Upon reaching the age of 18, patients will need to personally complete a new set of patient forms including demographic information and authorized contact information.

Patient Name: _____ **DOB:** ____ / ____ / _____
(Please Print)

Patient Signature: _____