

Stepping Stone Pediatrics, LLC

Please note that this form is to be applied to a whole family unit to assist you in completing paperwork. Family members who share the same insurance and emergency contact information as well as HIPPA authorizations may be included together on this form. (SSP = Stepping Stone Pediatrics)

Family members (children) this form applies to:

Last name	First	Birthdate

Last name	First	Birthdate

Notice of Privacy Practices

I, _____, have received a copy of Stepping Stone Pediatrics' notice of privacy practices titled "Our Promise!"
Parent/guardian's name

 Signature of parent/ legal guardian

 Date

HIPAA Authorizations

By signing this authorization, I authorize Stepping Stone Pediatrics to use and/or disclose certain protected health information (PHI) about the children above for the purposes indicated below. I do not have to sign this authorization in order to have my child receive treatment from Stepping Stone Pediatrics. In fact, I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Stepping Stone Pediatrics' Privacy Officer.

This authorization expires two years after the date it was signed.

Alternative caregivers: We realize at certain times a parent/guardian might not be able to accompany a child to our office to see the pediatrician. We do request that for **well visits** a **parent** be present as we exchange important information regarding your child's health, growth and development. For sick visits do you authorize an alternative caregiver (for example grandparent, baby sitter) to have access to your child's PHI?

Yes I authorize No, I do not authorize Signature _____ Date _____

School / Camp physical forms: Do you authorize SSP to complete and forward to the appropriate place school and camp forms as provided to us by you?

Yes I authorize No, I do not authorize Signature _____ Date _____

Communications: So you authorize SSP to leave information on a home answering machine?

Yes I authorize No, I do not authorize Signature _____ Date _____

Emergency Contacts

If we need to reach you in an emergency, please provide information on someone **not** living in your home.

Emergency Contact _____ Relation to child _____
 Phones: Home _____ Work _____ Other _____

Insurance

Person Responsible for account _____ Relation to child _____
Last Name First Name Middle

Birth date _____ SS# _____

Street Address _____

City _____ State _____ Zip _____

Phones: Home _____ Work _____ Cell _____

Employers Name _____

Employer's Address _____

City _____ State _____ Zip _____

Primary Insurance Company _____ Phone _____

Member ID# or policy# _____ Group/Plan# _____

Address to submit claims to _____

City _____ State _____ Zip _____

Are patients covered by secondary insurance? yes no

Secondary Insurance Company _____ Phone _____

Member ID# or policy# _____ Group/Plan# _____

Address to submit claims to _____

City _____ State _____ Zip _____

Secondary Insurance: If secondary insurance member is different from person responsible for account, please provide the following:

Person Responsible for account _____ Relation to child _____
Last Name First Name Middle

Birth date _____ SS# _____

Street Address _____

City _____ State _____ Zip _____

Phones: Home _____ Work _____ Cell _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip _____

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release the minimum necessary information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date: _____