Sandhills PEDIATRICS

Insurance/HIPAA Form-MOTHER INFORMATION ONLY

Mother's Name_____**Date of Birth**_____

Mothers Primary Insurance: _____Policy Number:_____

Policyholder's Name: _____Group Number_____

DOB:_____ SSN: _____

Secondary Insurance: _____ Policy Number:_____

Policyholder's Name: _____Group Number_____

DOB:_____ SSN: _____

Acknowledgement of Privacy Practices (HIPAA)

Preferred Method of Contact: (Please ***Choose One*** and Provide the Information for that Method)

Phone #: _____ Please *Select One*: ☐ Home ☐ Cell ☐ Other

The Health Information Portability & Accountability Act requires medical offices obtain written permission from the patient (18 years or older) or their legal representative, prior to speaking with a third party or giving information regarding our patient. This means that we cannot speak to counselors, grandparents, spouse's, etc. or mail documents unless you list the individuals or organizations that you give us permission to share information with below. Medical providers that we referred you to are excluded from this restriction to ensure continuity in their care.

Who may accompany the above listed patient (THE MOTHER) to appointments, receive medical information/advice, and/or schedule appointments?

Name_____Relationship_____

Name_____Relationship_____

I understand that any person whose name does not appear on the above list will not be given access to any medical information or to schedule appointments without further written permission.
I hereby acknowledge that I have been given an opportunity to review the privacy practices at SCLNWC. I understand that I may obtain a copy of the Notice of Privacy Practices at my request.

This notice has been issued and considered effective on the date signed.
We will keep this signed form on file for a minimum of six (6) years.

Patient Signature_____**Date**_____