



# Welcome to our practice!

Thank you for choosing Stamford Pediatric Associates. We are honored to be your pediatrician and are committed to providing you with the best care possible. We look forward to building a partnership with your family, and appreciate the trust and confidence you have placed in our practice.

Our practice consists of eight board-certified pediatricians. Our doctors are the only ones who evaluate and diagnose your children when they come in for a well check-up or a sick visit. Our fully trained nursing staff will handle the routine administration of certain tests, procedures and immunizations.

We strongly believe in open and ongoing communication with each of our patients. As a result, a Stamford Pediatrics physician is available by phone 24 hours a day, 7 days a week. To ensure prompt answers to your routine questions, we also have a pediatric triage nurse available from 9:00 AM to 4:00 PM during the business week. In addition, as an adjunct to our after hours care, urgent medical questions can be answered by highly trained and experienced pediatric nurses from Rainbow Babies and Children's Hospital nightly from 9:00 PM to 7:00 AM. The nurses follow standard protocols for medical care, and will notify a Stamford Pediatrics pediatrician immediately if the circumstance requires it. The feedback from parents about this service has been extremely positive, and we are excited to be able to provide it to our patients.

To further ensure the highest level of communication with our patients, we have established a Stamford Pediatrics website. Our homepage [www.stamfordpediatrics.com](http://www.stamfordpediatrics.com) has information about our practice including office policies, schedule of visits, insurance information and important phone numbers and websites. In addition, a wealth of medical information, including medication dosing and vaccine schedules, is available. We strongly encourage you to take advantage of this valuable resource.

We encourage all patients to review our policies regarding insurance, payments and fees which are posted on our website. Please realize that your medical insurance is a contract between you, your employer and your insurance provider. We are not a party to that contract. You are responsible for knowing what is and is not covered under your insurance plan. You will be required to pay for any deductibles, co-insurance, co-pays, lapses in coverage and any other balance not paid by your insurance company. If you do not have access to the internet to review our policies and fees, or if you have any questions about our business practices our billing department is available to help you.

Last but not least, remember to have fun! Raising a child is very challenging, but it is also extremely rewarding. It goes by fast, so try to enjoy the journey while you can. We will make every effort to help you along the way.

**The Physicians and Staff of Stamford Pediatrics**

In a patient centered medical home the patient and their needs come first. As your medical home, we will work together as a team along with other health care professionals to assist you with all your health care needs. Team members consist of you (the parents), the patient (your child), your primary care physician, the nurses and the triage nurse and in some cases a member of our front office staff. All team members are not involved in every case but as your medical home we have the ability to provide you with the team approach at any time.



## HOW OUR TEAM CAN HELP YOU

We make it our mission to get to know our patients and their families. If your primary care physician is not available or out of the office, any of our other physicians would be happy to see you. They can answer any and all of your questions. If your child requires a follow up visit while your primary care physician is out of the office, another physician will be made aware and will be available for all follow up questions and visits.

Our team often consults with other medical specialists. If you need to see a specialist, your team can provide you with the information needed to contact the specialist's office to set up an appointment. In urgent situations, our team will contact the specialist for you and help set up an appointment when it is convenient for you. As a team, we will provide the specialist with all the information needed for your visit. We will follow up with the specialist after your appointment and come up with the best plan of action for the patient. Remember to tell your team about any other health care professionals you may have seen in the past.

Our team has convenient office hours for your appointments and can be reached during regular business hours. After the office has closed for the day, the on call physician can be reached by calling the office and having our after hours service page them. The physician will return your call promptly and instruct you on the best course of action. Our team utilizes a pediatric advice line, which assists parents with any questions or concerns they may have while the office is closed. Our team is able to access your child's medical records after hours to review any pertinent information. The physicians also have the ability to access records from Stamford Hospital if necessary.

Our team utilizes an electronic medical system to track all of your health care information. All office visits and correspondence with the office are saved in the patient's records. Each of our exam rooms have self-management handouts for patients, distributed by the physician, to take home with them. If a handout is given, it is noted in the patient's record. We also have a number of helpful website links listed on our website including [www.healthychildren.org](http://www.healthychildren.org) which is a very informative website. We want our patients to know that they are a full partner in their own care. We encourage them to learn about their condition and to follow a plan made in conjunction with their team. Goals should be set that are reasonable to reach. We want all of our patients to leave the office with a clear idea on how to care for themselves.

Any information we receive from other medical specialists concerning our patients' health is scanned into their medical record. This way, the entire medical record is easily accessible to our entire team and organized to ensure efficiency.

We follow the American Academy of Pediatrics (AAP) and Barton D. Schmitt evidence-based guidelines. The AAP guidelines are comprehensive, family-oriented, accessible, and culturally-effective to all children and youth. Both the AAP and Barton D. Schmitt guidelines are used during triage calls with our team and during office visits to ensure the best quality of care is provided.



STAMFORD  
PEDIATRIC  
ASSOCIATES



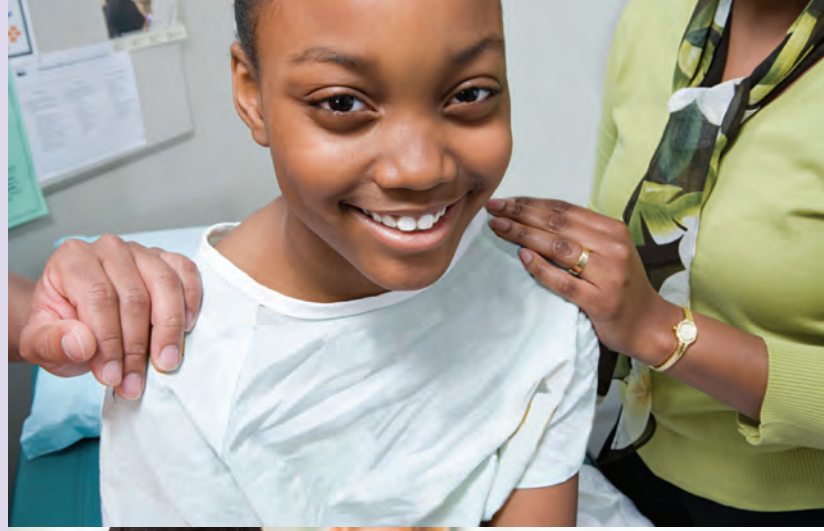
# WHAT YOU CAN CONTRIBUTE TO THE TEAM

## COMMUNICATION

Make a list of any questions you may have concerning your child's health and well being. Feel free to share how you feel about the quality of care you are receiving and what may or may not be working for you so changes can be made.

## STAY HEALTHY

Make sure you schedule all of your regular well appointments and stay up to date on vaccines. If parents are not in agreement with our standard immunization schedule, our team will work with you to come up with an alternative schedule that is better suited for you. Immunizations may be given separately, however all patients must be immunized. As a team, both parents and physician must agree upon and adhere to the alternative schedule. Occasionally, our physicians like to follow up with a patient before their next well appointment, so it is important to make those appointments as well. Our team is also available for sick and follow up appointments to ensure we keep your child healthy.



# WHAT YOU CAN CONTRIBUTE TO THE APPOINTMENT

- Bring your list of questions
- Update your team on any changes to the patient and family medical history
- Share what is and is not working for you. If you are having trouble sticking with your care plan, tell your team about it so changes can be made together if necessary.
- Make sure you understand what is expected from you before you leave the office. Use your own words to repeat back the things you have discussed. This way, both of you know the information is clear.
- Bring your insurance card and information with you to each visit
- Be familiar with the office policies and ask about any you do not understand





**NOTICE OF PRIVACY PRACTICES**  
**for**  
**Stamford Pediatric Associates, P.C.**

Effective Date of this Notice: Effective May 26, 2017

Privacy Officer Contact name: Antoinette Syrotiak

Privacy Contact Office – Telephone Number: 203-324-4109

**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.**

We understand that your medical/health information is personal and private. In order to provide you with quality care and to ensure compliance with certain legal requirements, we create a record of the care and services you receive in our office(s). We respect the privacy and confidentiality of medical/health information about you and that can be identified with you. This is called “protected health information”. Your protected health information is contained in the medical and billing records maintained by our practice. It includes demographic information and information that relates to your present, past or future physical or mental health and related health care services.

This Notice of Privacy Practices (“Notice”) describes the ways in which we may use and disclose your protected health information. It also describes your rights and our legal obligations with respect to your protected health information.

This Notice applies to uses and disclosures we may make of all your protected health information, whether created by us in our practice or received by us from another health care provider.

**A. OUR LEGAL DUTY TO PROTECT YOUR HEALTH INFORMATION**

Federal and State laws require us to:

- Ensure the privacy of your protected health information, which we have either created in our practice or received from another health care provider, whether it is about your past, present, or future health care condition;
- Maintain the privacy of your protected health information regarding payment for your health care;

- Explain the manner in which we may use and disclose your protected health information;
- Abide by the terms of this Notice, as currently in effect; and
- Obtain your written authorization to use or disclose your protected health information for reasons other than those listed below and permitted by law.

## **CHANGES TO THE NOTICE**

We reserve the right to amend this Notice at any time in the future, and make the new provisions effective for all protected health we maintain, regardless of when it was created or received. If the Notice is amended, we will:

- Post the revised Notice, with the new effective date, in our office(s);
- If we have a website, post the revised Notice on our website; and
- Make copies of the revised Notice available to you upon request.

## **INCIDENTAL DISCLOSURES**

In the process of using or disclosing your protected health information for an authorized use, we may make incidental disclosures. We will take reasonable steps to limit incidental disclosures.

<p><b>B. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PROVIDE YOU WITH TREATMENT, TO OBTAIN PAYMENT FOR SERVICES RENDERED TO YOU, AND FOR HEALTH CARE OPERATIONS.</b></p>
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### **1. For treatment:**

We may use and disclose your protected health information to provide you with medical treatment and services, and to coordinate or manage your health care and related services. We may disclose your protected health information to our doctors and nurses, as well as to any other party involved in your care, either within our practice or to an outside health care provider. We may also disclose your protected health information to providers or facilities who may be involved in your care after you leave our facility or our care.

**A practice-specific example:** Our health care providers may disclose information about your health condition to a physician to whom you have been referred, a pharmacist who

needs the information to dispense your prescription, or a laboratory that requires it to perform testing.

## **2. For Payment:**

We may use and disclose your protected health information to bill and receive payment for the treatment and services we provide. We may disclose your protected health information to an insurance company or managed care company, Medicare, Medicaid, or any other third party payor. We may also provide protected health information to collection departments, consumer reporting agencies or any other health care provider who requests information necessary for them to collect payment.

**A practice-specific example:** We may inform your insurance company about a treatment that we intend to provide so that we can obtain the appropriate approvals and/or to confirm coverage for your treatment.

## **3. For Health Care Operations:**

We may use and disclose your protected health information as necessary for us to operate our medical practice. We may use and disclose your protected health information for internal operations, such as general administrative activities and quality assurance programs.

For example, we may use and disclose your protected health information:

- To review and improve the quality of care you receive;
- To train and educate doctors, nurses, students, volunteers or other medical staff;
- To plan for services, such as when we assess certain services that we may want to offer in the future;
- To evaluate the performance of our employees;
- To our lawyers, consultants, accountants, and other business associates;
- To compare your information with that of several other patients to determine if we should offer new services or if new treatments were effective;
- To identify groups of patients who have similar health problems (“population management”) to give them information about treatment alternatives, programs, or new procedures;
- To organizations that assess the quality of care we provide to our patients (such as government agencies or accrediting bodies);

- To organizations that evaluate, certify or license health care providers, staff or facilities in a particular specialty;
- To assist others who may be reviewing our activities, such as accountants, lawyers, consultants, risk managers, to assist us in complying with state and federal laws;
- If we are in the process of selling our business or merging with other health care entities, or giving control to someone else;
- For procedures involving health care fraud and abuse detection and compliance; and
- To develop internal protocols.

**Practice-specific example:** We may disclose information as it relates to health care operations to accountants who are auditing our billing records.

**C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION IN LIMITED SITUATIONS.**

The following are situations in which we may use or disclose your protected health information without your written authorization or an opportunity for you to agree or object, as described below.

**1. As Required by Law:**

We may disclose your protected health information when required to do so by federal, state or local law or other judicial or administrative proceedings.

**2. Emergencies:**

We may use or disclose protected health information as necessary in emergency treatment situations.

**3. Public Health Risk:**

We may disclose your protected health information for public health activities. For example, we may disclose protected health information about you if you have been exposed to a communicable disease or may otherwise be at risk of spreading a disease. Other examples may include reports about injuries or disability, reports of births and deaths, reports of child abuse and/or neglect, and reports regarding the recall of products.

**4. At Our Office:**

*Unless you object*, we may use and disclose certain limited information about you on our sign-in sheet while you are in our office(s). This information may include your name, but will not include information about your condition. We will also call your name to notify you that the provider is ready to see you or that we need to discuss something with you.

**5. Individuals Involved in Your Care or Payment for Your Care:**

*Unless you object*, we may disclose protected health information about you to a family member, relative, close personal friend or any other person you identify, including clergy, who is involved in your care. These disclosures are limited to information relevant to the person's involvement in your care or in payment for your care.

**6. Disaster Relief:**

*Unless you object*, we may disclose protected health information about you to an organization assisting in disaster relief efforts. Even if you object, we may still share information about you if necessary to respond to emergency circumstances.

**7. Reporting Victims of Abuse or Neglect:**

When authorized by law, or if you agree to the report, and if we believe that you have been a victim of abuse or neglect, we may use and disclose your protected health information to notify a government authority.

**8. Health Oversight Activities:**

When authorized by law, we may disclose your protected health information to a health oversight agency for activities, such as audits, investigations, inspections, licensure actions or other legal proceedings. A health oversight agency is a state or federal agency that oversees the health care system.

**9. Judicial and Administrative Proceedings:**

We may disclose your protected health information in response to a court or an administrative order. In certain circumstances, we also may disclose protected health information in response to a subpoena, a discovery request, or any other lawful process by another party involved in the action. We will make a reasonable effort to inform you about the request.

**10. Law Enforcement:**

We may disclose your protected health information for certain law enforcement purposes, including, but not limited to:

- Reporting certain types of wounds and/or other physical injuries (i.e. gunshot wounds);



- Reports required by law;
- Reporting emergencies or suspicious deaths;
- Complying with a court order, warrant, subpoena (in certain circumstances), or other legal process;
- Identifying or locating a suspect or missing person, material witness or fugitive;
- Answering certain requests for information concerning crimes, about the victim of crimes;
- Reporting and/or answering requests about a death we believe may be the result of a crime;
- Reporting criminal conduct that took place on our premises; and
- In emergency situations to report a crime, the location of the crime or victim or the identity, description and/or location of a person involved in the crime.

**11. Coroners, Medical Examiners, Funeral Directors:**

We may disclose your protected health information to a coroner, medical examiner or funeral director. We may disclose information about deceased patients to funeral directors if necessary to allow them to carry out their duties. We may disclose protected health information about you to a coroner or medical examiner for the purposes of identifying you should you die.

**12. Organ/Tissue Donation Organizations:**

If you are an organ donor, we may disclose your protected health information to an organization involved in the donation of organs and tissue to enable them to carry out their lawful duties.

**13. Research:**

In some situations, your protected health information may be used for research purposes, provided that the privacy and safety aspects of the research have been reviewed and approved by an institutional review board or a privacy board. The board must have established procedures to ensure that your protected health information remains confidential.

**14. To Avert a Serious Threat to Health or Safety:**

We may use or disclose your protected health information if we believe it is necessary to prevent a serious threat to your health or safety or the health or safety of the public or

another person. We may only make the disclosure to a person or entity that would be able to help lessen or prevent the threatened harm.

**15. Military and Veterans:**

If you are a member of the armed forces, we may use and disclose your protected health information as required by military command authorities. We may also disclose your protected health information to the appropriate foreign military authority if you are a member of a foreign military.

**16. National Security and Intelligence Activities:**

We may disclose protected health information to authorized federal officials conducting national security, counterintelligence, and intelligence activities authorized by law.

**17. Protective Services for the President and Others:**

We may disclose your protected health information to authorized federal officials, as needed, to provide protection to the President of the United States, other authorized persons, foreign heads of states or to conduct certain special investigations.

**18. Inmates/Law Enforcement Custody:**

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official for the following purposes:

- To enable the correctional institution or law enforcement official to provide you with necessary health care services;
- To protect your own health and safety;
- To protect the health and safety of others; and/or
- For the safety and security of the correctional institution.

**19. Workers' Compensation:**

We may use or disclose your protected health information to comply with laws and regulations relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries and/or illnesses.

**20. Fundraising Activities:**

If we engage in any fundraising activities allowed by HIPAA, we may use limited protected health information such as your name, address and phone number, age, gender, date of birth, your treating physician, outcome information, your health insurance status, and the dates you received treatment or services, to contact you in an effort to raise money for a program developed by our practice. We may also disclose

contact information for fundraising purposes to a foundation related to our organization.

You have a right to instruct us not to contact you about fundraising. If you do not want to be contacted, you should notify us in writing by contacting the Privacy Contact Office at the telephone number listed on the first page of this Notice who will explain whether we do any fundraising, and if so, how you may Opt Out of fundraising communications.

#### **21. Appointment Reminders:**

We may use or disclose protected health information to remind you about:

- appointments in our organization; and
- appointments that we have scheduled for you with other health care organizations.

Please note that we will use the contact information that you have provided to us to contact you (e.g., to mail, email, text or call you) with appointment reminders.

#### **22. Business Associates:**

We may disclose your protected health information to our business associates under Business Associate Agreements. Business associates may include:

- Answering Services;
- Transcription Services;
- Accounting Services;
- Attorney/Legal Services.

<b>D. YOUR AUTHORIZATION IS REQUIRED FOR ALL OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION.</b>
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Except for those circumstances listed above, we will use and disclose your protected health information only with your written authorization. You may revoke your authorization, in writing, at any time. If you revoke an authorization, we will no longer use or disclose your protected health information for the purposes covered by that authorization, except where we have already relied on the authorization.

Please note that our use or disclosure of your protected health information relating to: psychotherapy notes (if we have such notes), for marketing purposes, and for any sale of protected health information generally require your authorization.

## **E. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.**

You have the following rights regarding your protected health information that we maintain:

### **1. The Right to Access Your Protected Health Information:**

Except under limited circumstances, and upon written request, you have the right to inspect and obtain a copy of your protected health information. Your protected health information is contained in our medical and billing records or any other record used by us to make decisions about your care.

Under current state law, we may charge you no more than 0.65 cents per page, plus first-class postage, if we make a copy of your medical record. (There are some circumstances under which we are not permitted to charge you for the record, but in most cases we may charge.) We may also charge you a reasonable fee for copying x-rays and furnishing tissue slides or blocks.

To inspect and request a copy of your protected health information, you should submit your written request to us.

We must respond to your request within 30 days, by either supplying the records or sending a written notification of denial. We may deny your request to inspect or receive copies of your protected health information in the following limited circumstances:

- The information was compiled exclusively in connection with a criminal, civil or administrative proceeding;
- The disclosure to the patient is prohibited by the Clinical Laboratory Improvement Act (42 U.S.C. §263a);
- You are a correctional institution inmate and the correctional administrators have provided reasons for denying access;
- The information is for a research study not yet complete;
- The Privacy Act (5 U.S.C. §552a) prohibits access;
- The information was obtained by a person other than a health care provider upon our promise to keep the information confidential, and access would reveal the informant's identity;
- We determine access is likely to endanger the life or safety of the patient or others;

- The information contains information about another person and we determine that access is likely to cause substantial harm to that person;
- The request for access is made by the patient's personal representative and we believe access is likely to cause substantial harm to the patient or others.

If you are denied access to your protected health information, in some cases you will have the right to request a review of this denial. The review will be performed by a licensed health care professional designated by us, who did not participate in the original decision to deny access.

## **2. The Right to Request Restrictions:**

You have the right to request a restriction on the way we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on the protected health information that we disclose about you to a family member, friend or other person involved in your care or the payment of your care.

If you wish to request such a restriction, you should submit your written request to us. You must tell us what information you want restricted, to whom you want the information restricted, and whether you want to limit our use, disclosure or both.

*Generally, we are not required to agree to such a restriction.* If we do agree to the restriction, we will honor that restriction except as needed to provide you with emergency treatment.

We are required to honor your requested restriction that we withhold protected health information from your insurance plan, subject to you paying for the services you do not wish disclosed, and other specific details. If you wish to request such a restriction, please let us know immediately. We will provide you with additional details on how to obtain this restriction. Be advised, Medicaid may not allow you to make this request.

## **3. The Right to Request Confidential Communications:**

You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address.

You should submit your written request for confidential communications to us. You must tell us how and where you want to be contacted.

We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.

#### **4. The Right to Request an Amendment:**

You have the right to request that we amend medical or billing records, or other protected health information maintained by us, for as long as the information is kept by us. Your request must be made in writing and must explain the reasons for the requested amendment.

We may deny your request for amendment if the information:

- was not created by us (unless you prove the creator of the information is no longer available to amend the record);
- is not part of the records maintained by us;
- in our opinion, is accurate and complete;
- is information to which you do not have a right of access.

We must respond to your request within 60 days of receiving the request. If we agree to the amendment, we will notify you and amend the relevant portions of your medical record. We will also make a reasonable effort to inform business associates and other individuals known to us, or identified by you, as having the protected health information being amended.

If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial and explain to you that you have the right to submit a written statement disagreeing with the denial. Your statement of disagreement will be attached to your medical record. If you should submit a statement of disagreement, we have the right to insert a rebuttal statement into the medical record. We will provide you with a copy of the rebuttal statement. If you do not wish to submit a statement of disagreement, you may request that a copy of the amendment request and a copy of our denial be included with all future disclosures.

Should we deny your request for an amendment, you have the right to pursue a complaint process by contacting our Privacy Contact Office, or you may contact the Secretary of Health and Human Services to lodge your complaint.

If you wish to request an amendment, you should submit the request to us in writing.

#### **5. The Right to An Accounting of Disclosures:**

You have the right to request an accounting of certain disclosures of your protected health information made after April 14, 2003. You may request an accounting of disclosures made up to six (6) years before the date of your request, beginning with



records created on or after April 14, 2003. An accounting is a listing of disclosures made by us or by others on our behalf, but does **not** include:

- disclosures made for treatment, payment and health care operations;
- disclosures made directly to you, that you authorized, or those which are made to individuals involved in your care;
- disclosure made to correctional institutions or law enforcement official about an inmate in custody;
- disclosure made for national security or intelligence purposes;
- disclosure of a limited data set; or
- an incidental disclosure.

You must submit your request for an accounting of disclosures to us in writing. You must state the time period for which you would like the accounting. We must respond to you 60 days after receipt of your request. The accounting will include the disclosure date, the name, address (if known) of the person or entity that received the information, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure. If you request a listing of disclosures more than once within a 12-month period, we will charge you a reasonable fee for the accounting. The first accounting, within a 12-month period, is provided to you at no charge.

#### **6. The Right to a Paper Copy of This Notice:**

You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone. In addition, you may obtain a copy of this Notice on our website, [www.stamfordpediatrics.com](http://www.stamfordpediatrics.com).

#### **7. Right to Be Notified of a Breach of Unsecured Protected Health Information**

You have the right to be notified in the event there is a breach of your unsecured protected health information. While we *never* expect this to happen, if it does, we will contact you (usually by mailing a letter, but we might also call you) to explain what happened, and provide you with additional details and we will let you know that who you can call at our office for more information.

## **F. SPECIAL RULES REGARDING THE DISCLOSURE OF MENTAL HEALTH CONDITIONS, SUBSTANCE ABUSE, AND HIV-RELATED INFORMATION.**

For uses and disclosures of your protected health information related to care for mental health conditions, substance abuse, or HIV-related information, special restrictions may apply. For example, we generally may not disclose this specially protected information in response to a subpoena, warrant or other legal process unless you sign a special authorization or if a court orders the disclosure.

### **1. Mental Health Information:**

If needed for your diagnosis or treatment in a mental health program, mental health information may be disclosed as needed between your treatment team members, and very limited information may be disclosed for payment purposes. Otherwise mental health information may **not** be disclosed without your authorization, except as specifically permitted by state or federal law.

### **2. HIV-related Information:**

HIV-related information will not be disclosed, except under limited circumstances set forth under state or federal law, without your specific written authorization.

### **3. Substance Abuse Treatment:**

If you are treated in a substance abuse program, information which could identify you as alcohol or drug-dependent will not be disclosed without your specific authorization except for purposes of treatment or payment or when specifically required or allowed under state or federal law.

### **4. Psychotherapy Notes:**

A special authorization is required for the disclosure of psychotherapy notes, and special rules may apply which limit the information which is disclosed.

## **G. COMPLAINTS**

If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the federal government.

1. To file a complaint with the federal government, you may contact:

If you are in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont:

Peter Chan, Regional Manager  
Office for Civil Rights  
U.S. Department of Health and Human Services

Government Center  
J.F.Kennedy Federal Building - Room 1875  
Boston, MA 02203  
Voice phone (800) 368-1019  
FAX (617) 565-3809  
TDD (800) 537-7697

-OR-

If you are in New Jersey, New York, Puerto Rico, or the Virgin Islands:

Linda Colon, Regional Manager  
Office for Civil Rights  
U.S. Department of Health and Human Services  
Jacob Javits Federal Building  
26 Federal Plaza - Suite 3312  
New York, NY 10278  
Voice Phone (800) 368-1019  
FAX (212) 264-3039  
TDD (800) 537-7697

-OR-

You may file a complaint through the OCR Complaint Portal at:

[https://ocrportal.hhs.gov/ocr/cp/complaint\\_frontpage.jsf](https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf)

2. To request additional information, to request that we respond to questions, or to file a complaint, you should contact the Privacy Contact Office listed on page one.
3. You will not be retaliated against for filing a complaint.



## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.**

CHILDREN'S NAMES (please list)

_____	_____
_____	_____
_____	_____

I, \_\_\_\_\_, hereby acknowledge that Stamford Pediatric Associates, P.C. has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

**Privacy Contact:** 203-324-4109

I also understand that I am entitled to receive updates upon request if Stamford Pediatric Associates, P.C. amends or changes its Notice of Privacy Practices in a material way.

_____ Signature	_____ Relationship to Patient, if signed by someone other than patient.
_____ Print Name	_____ Date

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### THIS SECTION IS TO BE COMPLETED BY STAMFORD PEDIATRIC ASSOCIATES IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgment.
- Other (specify): \_\_\_\_\_

_____ Name and title of employee	_____ Date
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## STAMFORD PEDIATRIC ASSOCIATES, P.C. - PATIENT INFORMATION

**Responsible Billing Party Name:** \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Dad or Mom (Please circle)

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Soc Sec: \_\_\_\_\_

**Email Address:** \_\_\_\_\_

Employer: \_\_\_\_\_ Bus. phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Spouse's Name:** \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Dad or Mom (Please circle)

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Soc Sec: \_\_\_\_\_

**Email Address:** \_\_\_\_\_

Employer: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

	Children's Names	Date of Birth		Children's Names	Date of Birth
1)	_____	_____	(2)	_____	_____
(3)	_____	_____	(4)	_____	_____
(5)	_____	_____	(6)	_____	_____

**Please be sure to list any additional biological parents AND any step parents for the children below**

**Name:** \_\_\_\_\_ Relationship to Child(ren) \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_ Soc Sec: \_\_\_\_\_

### In Case of Emergency Contact (Other than parents)

Name	Relationship	Phone
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- Please note the following:
1. All professional services rendered are charged to the Responsible Billing Party. The Responsible Billing Party is responsible for all fees, regardless of insurance coverage. It is also customary to pay for those services when rendered, unless other arrangements have been made in advance with our office bookkeeper.
  2. If your account should have to go to collection at any time, you will be charged the collection company's fee along with your outstanding bill amount.
  3. A copy of this signature for release of information to your insurance company or referring physician is as valid as the original.
  4. By signing this document I am giving express consent for Stamford Pediatric Associates to provide care and treatment to my child(ren).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Stamford Pediatric Associates, P.C. Insurance and Financial Information

The goal of Stamford Pediatric Associates is to provide high quality medical care to our patients. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Prompt payment allows us to control costs. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our Business Manager. We accept cash, checks, debit cards, MasterCard or Visa.

Returned checks will be charged a \$30 fee.

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. **You are responsible for knowing what is and is not covered under your insurance plan.**
3. It is your responsibility to pay for deductibles, co-insurance, copays and any other balance not paid by your insurance company.
4. We do not submit to secondary insurance.

We must emphasize that as child care providers, our relationship is with you not your insurance company. All charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, you **must** contact us promptly for assistance in the management of your account.

### **Financial Policies**

If we do not participate with your insurance carrier, payment in full is expected at the time of your visit. You will receive a detailed bill to submit to your insurance company. It is your responsibility to submit this to your insurance company for reimbursement.

Charge Fee - Effective April 2002, a charge fee is an administrative fee of \$10 when copay is not paid on the date of visit.

Miss Fee- Effective April 2002, if a physical exam appointment is missed and not canceled within 24 hours your account will be charged \$75 per child.

Form Fee- Effective April 1, 2003, you are entitled to one school/camp/daycare form per child per year. Additional forms will require a \$10 fee.

PAL Calls- Effective April 1, 2003, each time you use Pediatric Advice Line, a \$20 charge will be added to your account and will appear on your monthly statements.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. Our staff has been instructed to make every effort to clarify any concerns you may have about your account. If you have any questions concerning our policy or need assistance, please contact us. We are here to help you.

Please complete the registration information on the other side.  
Thank You.



**STAMFORD PEDIATRIC ASSOCIATES, PC**  
**MEDICAL HISTORY FORM**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PAST HISTORY:**

Does your child have any serious illnesses or medical conditions?  Yes  No

Explain \_\_\_\_\_

Has your child had any surgery?  Yes  No

Explain \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No

Explain \_\_\_\_\_

Is your child allergic to medicine or drugs?  Yes  No Explain \_\_\_\_\_

Is your child allergic to foods?  Yes  No Explain \_\_\_\_\_

**BIOLOGICAL FAMILY HISTORY:**

Please let us know if these conditions are present on either side of the family. If the history is unknown, please write a "U" next to the items. If you are unsure, please write a "?"

**Condition**

**Who might have it**

Alcohol and/or drug abuse \_\_\_\_\_

Allergies \_\_\_\_\_

Anemia (low red blood count) \_\_\_\_\_

Arthritis (under 55) or hip disease \_\_\_\_\_

Asthma \_\_\_\_\_

Bleeding disorder \_\_\_\_\_

Cancer (before 55 years old) \_\_\_\_\_

Childhood hearing loss \_\_\_\_\_

Diabetes (before 55 years old) \_\_\_\_\_

Digestive problems (colitis, gastritis, celiac) \_\_\_\_\_

Developmental or learning disability \_\_\_\_\_

Early heart disease, stroke or sudden death (before 55 years old) \_\_\_\_\_

\_\_\_\_\_

Eczema \_\_\_\_\_

Epilepsy or seizures \_\_\_\_\_

High cholesterol/takes cholesterol medication \_\_\_\_\_

Immune problems, HIV, or AIDS \_\_\_\_\_

Liver and/or kidney disease \_\_\_\_\_

Mental illness/depression/anxiety \_\_\_\_\_

Obesity \_\_\_\_\_

**SOCIAL HISTORY:**

Who lives at home? (Please include all) \_\_\_\_\_

What is the child's living situation if not with both biological parents?

\_\_\_\_\_

Completed by: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Date: \_\_\_\_\_

DOCTOR INITIALS \_\_\_\_\_



**STAMFORD PEDIATRIC ASSOCIATES, PC**  
**MEDICAL HISTORY FORM**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PAST HISTORY:**

Does your child have any serious illnesses or medical conditions? \_\_Yes \_\_No

Explain \_\_\_\_\_

Has your child had any surgery? \_\_Yes \_\_No

Explain \_\_\_\_\_

Has your child ever been hospitalized? \_\_Yes \_\_No

Explain \_\_\_\_\_

Is your child allergic to medicine or drugs? \_\_Yes \_\_No Explain \_\_\_\_\_

Is your child allergic to foods? \_\_Yes \_\_No Explain \_\_\_\_\_



## PATIENT INFORMATION

Parent / Guardian Name: \_\_\_\_\_

Children's Name(s): \_\_\_\_\_

Based on new government guidelines we are required to ask you race, ethnicity and preferred language. This information will be used to help monitor quality and improve patient care.

### Race (please check one or more if applies)

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian / Alaskan Native | <input type="checkbox"/> White, not of Hispanic origin |
| <input type="checkbox"/> Hispanic / Latino                | <input type="checkbox"/> Asian / Pacific Islander      |
| <input type="checkbox"/> Black, not of Hispanic origin    | <input type="checkbox"/> Two or more races             |
| <input type="checkbox"/> Refused to report                | <input type="checkbox"/> Other                         |

### Ethnicity (please check one or more if applies)

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian / Alaskan Native | <input type="checkbox"/> White, not of Hispanic origin |
| <input type="checkbox"/> Hispanic / Latino                | <input type="checkbox"/> Asian / Pacific Islander      |
| <input type="checkbox"/> Black, not of Hispanic origin    | <input type="checkbox"/> Two or more races             |
| <input type="checkbox"/> Refused to report                | <input type="checkbox"/> Other                         |

### Preferred Language (please check one or more if applies)

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> English           | <input type="checkbox"/> Hindi   |
| <input type="checkbox"/> Spanish           | <input type="checkbox"/> Kannada |
| <input type="checkbox"/> Chinese           | <input type="checkbox"/> Russian |
| <input type="checkbox"/> German            | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Refused to report |                                  |



1275 Summer Street, Suite 301  
Stamford, CT 06905  
Phone: (203) 324-4109  
Fax: (203) 969-1271

36 Old Kings Highway South  
Darien, CT 06820  
Phone: (203) 655-3307  
Fax: (203) 655-9607

Dear Parent:

It is our pleasure and honor to care for your family. We are proud of the practice and are pleased you have selected us.

We are grateful for the many referrals we receive. Please let us know how you were referred to us.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Doctor: \_\_\_\_\_

- Specifically wanted to see Doctor
- Willing to see anyone/first available

**HOW WERE YOU REFERRED TO OUR PRACTICE (Please Circle)**

Friend \_\_\_\_\_

1-800-DOCTORS through Stamford Hospital

Gynecologist \_\_\_\_\_

Stamford Pediatrics Website

Insurance Carrier Listing

Other \_\_\_\_\_

Seen other Advertisement (if so where) \_\_\_\_\_