

Stone Spring Pediatrics, LLC

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Receipt of Notice of Privacy Practices and Patient Information Policies Written Acknowledgement Form

I, _____, parent/guardian of _____,
(Print Parent/Guardian Name) (Print Child's Name)
_____,
(Print Child's Name)
_____,
(Print Child's Name)

have receive a copy of Stone Spring Pediatric's Notice of Privacy Practices and Patient Information Policies.

List Person/persons who may call and receive information about this patient:

Name _____ Relationship to patient _____
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____

List person/persons who may bring patient to office, sign for care, including vaccines:

Name _____ Relationship to patient _____
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____

**Payment is expected at time of service. Whoever brings patient is responsible for bringing insurance card/cards & paying co-pay/co-insurance/deductible at the visit.

Signature of Parent

Date

Refused Date: _____

Witness: _____