All About Kids Pediatrics

Jill Overcash, MD FAAP
Claire Wilkiemeyer, MD FAAP
Mary Abraham, MD FAAP

2000 Riverside Parkway, Suite 207
Lawrenceville, GA 30043
Phone 678-646-0404
Fax 678-646-0202

CONSENT TO TREAT MINOR CHILDREN

(Please print all information)

I, ____, parent or legal Guardian of ____, born _______________________, do hereby consent to any medical care determined by the physician to be necessary.

This authorization is effective beginning :_______________________

Signature of Parent or Legal Guardian: ____________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. For future reference, our privacy policy is available on our website: www.allaboutkidsgeorgia.com

Patient Name:____________________________________ (please print)

Signature of Parent: _________________________________Date:_________________

*If this Acknowledgement is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: ___________________________ Relationship to Patient:_________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

You May Refuse to Sign This Acknowledgement