All About Kids Pediatrics

Jill Overcash, MD, FAAP
Amanda Bennett, CPNP
2000 Riverside Parkway, Suite 207
Lawrenceville, GA 30043
Phone 678-646-0404
Fax 678-646-0202
www.allaboutkidsgeorgia.com

Consent to Treat Minor Children

I, _____, parent or legal guardian of _____, born on ___/_____/_____, do hereby consent to any medical care determined by the provider 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 the office's Notice of Privacy Practices. For future reference, our privacy policy is available on our website. www.allaboutkidsgeorgia.com

Patient Name: _____

Signature or Parent/Legal Guardian: _____

Date: _____

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

Personal Representative's Name: _____

Relationship to the Patient: _____

For Office Use Only

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

- Individual refused to sign
- Communication barrier prohibited obtaining acknowledgement
- An emergency situation prevent us from obtaining acknowledgement
- Other (please specify)