



# All About Kids Pediatrics

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## 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](http://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:

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

\*You May Refuse to Sign This Acknowledgement\*