

ATHENS AREA PEDIATRICS LLC

PATIENT (LEGAL) FIRST NAME	MI	PATIENT LAST NAME	DOB	AGE
STREET ADDRESS			PATIENT SEX	
CITY, STATE, ZIP CODE				
CELL PHONE- FATHER		CELL PHONE- MOTHER		
NAME AND ADDRESS OF PERSON RESPONSIBLE FOR CHILD'S ACCOUNT				
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER		
PARENT/GUARDIAN INFORMATION				
FATHERS NAME		MOTHER'S NAME		
FATHER'S EMPLOYER		MOTHER'S EMPLOYER		
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		
FATHER'S SOCIAL SECURITY NUMBER		MOTHER'S SOCIAL SECURITY NUMBER		
WHO HOLDS THE INSURANCE POLICY: _____ Mother _____ Father				

BACK →

CONSENT TO TREAT MINOR

We require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18.

PLEASE NOTE we do not see patients under the age of 18 years old for checkups without an adult accompanying them and strongly encourage a parent or legal guardian to attend all well-child visits.

Please sign the first authorization below to allow us to care for your child. If you would like us to care for your child if the child comes in alone or brought in by another person, please sign the second authorization below as well. **Please note it is Georgia state law that consents be on file for minor children and renewed every 365 days.**

Patient Name: _____ DOB: _____

1. Authorization to treat a minor **when accompanied** by a parent or legal guardian.

I am the parent or legal guardian of the patient named above. I authorize and consent to the patient receiving medical, immunizations, or other healthcare treatment as is considered necessary by the clinical staff at Athens Area Pediatrics LLC

Printed name of parent/guardian: _____

Signature: _____

Date: _____

2. Advance authorization to treat a minor patient **when not accompanied** by a parent or legal guardian

I am the parent or legal guardian of the patient named above. If the patient comes into the clinic alone or is brought in by another person, I give advance authorization and consent to the patient receiving routine or emergency medical, immunizations or other healthcare treatment as is considered necessary by the clinical staff at Athens Area Pediatrics LLC. If the Patient is being seen for a well check visit or followup vaccine visit, and is due for vaccines, I understand that the vaccines that are appropriate for the visit will be given per vaccine schedule.

Printed name of parent/guardian: _____

Signature: _____

Date: _____

ATHENS AREA PEDIATRICS LLC

Patient Name: _____ DOB: _____

Our Notice of Privacy Policy states we may disclose your personal protected health information (PHI) to others involved in your care such as a spouse, child, parents, caregivers or others.

Please complete section A or B:

A). List anyone you would authorize us to share or discuss your PHI with. This could include medical treatment, diagnosis and releasing of records.

Please list names of all who may have access to your child's health information below.

Name:	Relationship:	Phone Number:

B). If you do not wish for us to discuss your child's PHI to anyone, Please initial here: _____

Your right to limit uses of PHI for treatment, payment and operations (TPO):

Under these terms of the NPP you can ask Athens Area Pediatrics to limit how your PHI is used or disclosed to carry out treatment, payment or operations.

You may change or revoke this consent at any time by completing a new form or sending us a letter.

Parent/Guardian Signature: _____ Date: _____

Relationship if other than patient: _____

BACK 

Late/No Show Policy

Due to multiple no shows for office visits, we will be implementing a no show policy. Moving forward this policy will constitute a dismissal from the practice after 3 no shows. Please be considerate and remember to cancel an appointment in advance in order to allow other patients to be seen within a timely manner.

If you are unable to make your appointment, please notify us. If you are here more than 15 minutes late we may not be able to accommodate your visit on that day.

- A \$25 fee will apply for all No Show appointments.

Name of person signing: _____

Signature: _____

Date: _____