DAWSON PEDIATRICS

****We will need a copy of Driver's License and Insurance Card at each visit.****

Patient Information Form

Child's Name ____ DOB _____/______/_____ Male_____ Female_____
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American .... Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined

Child's Name ____ DOB _____/______/_____ Male_____ Female_____
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American .... Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined

Child's Name ____ DOB _____/______/_____ Male_____ Female_____
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American .... Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined

Child's Name ____ DOB _____/______/_____ Male_____ Female_____
Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American .... Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown ☐ Declined

Preferred Language *(circle one)*: ENGLISH SPANISH OTHER_________ Preferred Method of Contact___________

Child(ren) reside(s) with: ☐ Mother ☐ Father ☐ Guardian Other: ______________________________
*** If child is in custody of someone other than parent(s), we **HAVE** to have current copies of custody forms or guardianship paperwork on file. ***

Mother's name____________________________________ DOB _____/_____/_____ SS# ______ - _____ - ______
Street address ____ *City* _____________________ *State* _____ *Zip* ________
Home phone ________________________ *Cell* ________________________ *Work* _____________________
Employer ___________________________________ *E-mail:* ____

Father's name____________________________________ DOB _____/_____/_____ SS# ______ - ______ - ______
Street address ____ *City* _____________________ *State* _____ *Zip* ________
Home phone ________________________ *Cell* ________________________ *Work* _____________________
Employer ___________________________________ *E-mail:*____

Guardian's name_____________________________________ DOB ____/____/____ SS#______ - ______ - ______
Relationship to patient________________________________ *Start Date of Guardianship*___________________________
Street address ____ *City*_____________________ *State*_____ *Zip* ________
Home phone ________________________ *Cell* ________________________ *Work* _____________________
Employer ___________________________________ *E-mail:*____

Emergency Contact *(other than parent/guardian):*_________________________________ Ph #____________________
Relationship______________________________________

Preferred Pharmacy_____________________________ City____________________ Ph #_______________________

Insurance Co ____________________________ ID # ___________________________ Group # ___________________
Policyholder's Name ____________________________ DOB _______________ Relationship☐Patient ________________
Does this patient have Secondary Insurance? __Yes __No *(If yes, please notify the receptionist)* NO INSURANCE *(Self-pay)*

*** Who can we thank for referring you to our office? ___ Friend ___ Insurance ___ Website Other__________________

Parent/Guardian Signature: ____ **Date:** ____________ Revised: 12/2016

Dawson Pediatrics Vaccine Policy

At Dawson Pediatrics, our top priority is the health and safety of our patients and the community we serve. As part of our commitment to providing evidence-based medical care, we follow the immunization guidelines recommended by the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the Georgia Department of Public Health.

Vaccine Requirement for Patients
To remain a patient at Dawson Pediatrics, parents and guardians must understand and agree to the following:

- **All patients are required to receive all vaccines mandated by the state of Georgia.**
- While we do offer an **alternate vaccine schedule**, all required vaccines **must be completed before the next round of vaccines are due.**
- **Delays that result in incomplete immunizations by the next recommended due date** will be considered non-compliance with this policy.

This policy helps ensure that we provide a safe environment for all our patients, especially those who are medically vulnerable and cannot be vaccinated.

By signing below, I acknowledge that I have read and understand the Dawson Pediatrics Vaccine Policy. I agree that my child(ren) will receive all required vaccinations according to the recommended or approved alternate schedule, and that vaccinations will be administered when due.

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Parent's Signature Date

Revised 07/22/2025

Well-Visits and Additional Charges

The providers at Dawson Pediatrics agree strongly with the AAP Recommendations that your child should receive regularly scheduled checkups which may include routine labs and testing of hearing and vision.

Insurance companies have recently changed what they will cover during a checkup. Our billing office has many calls from patients with questions regarding their bills for charges incurred during a "Check-up" that are not covered under routine well care. We have created the list below to educate families and about what is routinely covered at preventive care visits; however, each insurance company and individual policies are different. The list below is examples of what is typically performed and considered a covered service during a preventive "Check-up" visit:

During Check-Ups, all children:

- **Measure height, weight and head circumference (depending on age) and plot them on our growth chart. A body mass index (BMI) is calculated for all children older than 3 years.**
- **Thoroughly check body parts and systems**
- **Discuss age related anticipatory guidance**
- **Discuss safety information**
- **Discuss nutrition appropriate for age**
- **Discuss development and growth**
- **Discuss schooling (if age appropriate)**
- **Educate and administer any age appropriate vaccinations**
- **Fill out forms for sports**
- **Refill Medications**

Other concerns that are more complicated and involve more time or expertise such as chronic headaches, stomach pains, ear pain, wheezing, psychological/school problems, or other medical issues usually require a separate code and charge in addition to the check-up. Your insurance company may consider these additional codes and/or charges as two separate visits and *they* may require co-pay.

We practice medicine based on guidelines from the American Academy of Pediatrics. Occasionally, some things such as **blood work, other labs, forms on the tablets and hearing and vision** are either not covered by your insurance or are put towards your deductible. These billing issues are between *you and your insurance company*, and we always suggest you check with your insurer/employer or HR department, BEFORE coming to the doctor to know what is covered by YOUR plan. Dawson Pediatrics is not responsible for knowing your individual plan details and files your insurance claim for you as a courtesy.

Your signature below verifies that you agree to and understand that having additional testing or concerns at a preventive visit may be an added expense for which you will be responsible.

_____ _____

Patient Name **DOB**

_____ _____

Patient Name **DOB**

_____ _____

Patient Name **DOB**

_____ _____

Patient Name **DOB**

_____ _____

Parent/Guardian Signature *(unless 18 yrs or older)* **Date**

Financial Policy

INSURANCE

- For your convenience, our office will file insurance claims on your behalf. However, your insurance policy is a contract between you and your insurance company. You will need to bring your insurance card each time you visit our office. It is your responsibility to ensure that our providers actively participate with your insurance carrier.
- If we are your children's primary care physician, your insurance company will need to be notified of this. If your insurance company does not have this information on file at the time of your visit, you will be financially responsible for the visit.
- We agree to reasonably assist you if there are questions with your claim. It is your responsibility to know and understand your insurance coverage. We will contact your insurance company to verify that you have coverage, but we cannot be responsible for contacting them to obtain your benefit coverage.
- Dawson Pediatrics will not become involved in disputes between you and your insurance company. We will provide accurate and truthful information in accordance with all applicable laws, contracts, and coding guidelines to facilitate accurate claim processing and payment.
- To properly file your insurance claim(s), we must obtain a current copy of your child's insurance card each time you visit our office. This will help your insurance pay your claims in a timely manner and save you from being billed. In the event you do not provide proof of insurance, payment will be expected at the time of service. Further, ***if you provide us with incorrect insurance information, you will be responsible for the bill.***
  - It is your responsibility to contact your insurance company and find out whether our providers are participating physicians within your insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our providers may participate in only one of these areas, and not in all.
  - It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your own insurance policy. You will be responsible for the charges of any services and procedures that are not covered by your insurance policy.
  - The following circumstances may result in you being billed directly (not intended to be an exhaustive list). ***Remember that your insurance company, not Dawson Pediatrics or your provider, makes decisions about what will be paid for and what will not.***
    - We are not participating in providers in your plan; insurance coverage is not in effect on the date service.
    - Non-covered lab work is ordered /performed
    - Non-covered services are performed or are denied for the reason, "not medically necessary"
- **Secondary Insurance:** We are pleased to bill secondary insurance as a courtesy to our patients. To ensure a smooth process, please provide the secondary insurance information at the time of your child's visit. If this information is submitted after primary insurance has processed the claim, we cannot guarantee that the secondary insurance will cover the balance. In such cases, you will be responsible for any remaining amount due.
- **Self-Pay Patients:** If you have no insurance coverage, payment is due in full at the time of service for both well- and sick visits, to receive a ***prompt discount***. If you are unable to pay in full at the time of service, please contact our office in advance to make payment arrangements with our billing manager.
- **Newborns:** As a courtesy, we will hold claims until the baby's 1 month visit to allow time for them to be added to your insurance policy. If the baby is not active on the 1-month visit, then that visit will be made a self-pay visit and will need to be paid at the time of service. The account will be left as self-pay until we show active coverage for baby.

PAYMENT DUE AT TIME OF SERVICE

- **Copays:** Dawson Pediatrics is contractually required by your insurance company to collect all copays for each child on each visit, regardless of who brings your child in to be seen. Please ensure arrangements are made for payment prior to your child arriving at our office.
- **Balances:** Payment is required for any outstanding balance on the account at the time of service or financial arrangements will have to be made before any future appointments can be scheduled. We will be happy to provide an itemized statement for your records.
- **Denied Claims:** Balances not paid by the insurance company through no fault of Dawson Pediatrics, will be billed directly to you for payment. These denials could include instances where the insurance company is waiting on you to contact them for coordination of benefits, to pick a primary care provider, correct child's date of birth or name, etc.
- **Divorce/Separation Decrees:** Dawson Pediatrics is not party to your divorce/separation decree. The adult accompanying the child is responsible for any copays or balances on the account. We will be happy to provide you with an itemized statement and receipt for reimbursement from the other party.

Financial Policy

PREVENTATIVE CARE VISITS

- Many insurance policies cover these visits in full, however, many insurance contracts are now applying copays and/or deductibles, regardless of our in-network status with the insurance company. It is ultimately your responsibility to understand your individual contract as we do not have access to the specifics of your contract with your insurance company.
- If during a well-visit your child is sick or time is spent on a concern not related to normal growth and development, an office visit may be charged in addition to the well-visit. You will be responsible for any financial responsibilities incurred, including co-pays, co-insurance, and/or deductibles. It may be more prudent to schedule a separate office visit to go over anything beyond normal growth and development or reschedule the well-visit to focus on the more immediate concern.

BILLING

- As the parent or guardian of a child registered with Dawson Pediatrics, you agree to be responsible for all balance incurred on behalf of your child's medical care. Your billing statements are posted to your child's portal, which may be found at https://dawson.pcc.com/portal, and statements are mailed monthly as well.
- We will send an email and text notifications to all patients who have incurred a balance as soon as a balance is showing on the account. If an account gets to be 60 days old you will receive a phone call from our billing department to make a payment or set up a payment plan.
- If you have any special financial needs, please let us know as soon as possible by speaking with a member of our billing department, in person or by phone. We are willing to work with our parents as best we can to meet their needs and to continue providing care for our patients.
- **Triage/After Hours Consult:** Dawson Pediatrics follows the recommendations of the American Academy of Pediatrics (AAP) and charges for After Hours Telephone Care to patients for the services of the on-call provider. We will send these after-hours consultants to your insurance plan in the form of a telemedicine encounter. If insurance covers the charge, the guarantor will be responsible for any out-of-pocket responsibility applied by the insurance carrier. If your insurance does not cover the charge, or denies the charge for any reason, the encounter will be billed to the guarantor. If you are a self-paid patient, the charges will be billed directly to the guarantor. Dawson Pediatrics has provided the services of the CHOA nursing advice line for after-hours calls at no cost to our patients. We encourage you to call a triage nurse during office hours with your questions, and reserve after-hours calls for emergencies only.
- **Labs:** At Dawson Pediatrics, certain lab tests are performed in-house by our staff, and the results will be available during your visit. However, some tests conducted in-office may be sent to an external lab for further analysis. Please note that if this occurs, you may receive a separate bill directly from the outside lab. *Dawson Pediatrics is not responsible for any charges or balances resulting from tests sent to outside facilities. You are responsible for any bills you receive from these external labs*.
- **Motor Vehicle Accident:** Due to third party billing rules, we are unable to file a claim with your medical insurance. If your child comes in to be checked out after an auto-accident. We are happy to see your child and assess them, however, we will treat the visit as self-pay. Once the visit is completed, you can request an itemized receipt of the visit, and you can submit it to your auto-insurance for reimbursement.
- **Payment Plans:** Any balance that is over $100 will be set up on a structured payment plan before being seen for a visit. All payment plans must be secured with a credit card, and a payment plan agreement must be signed. The payment plan agreement will offer details on how your account will be managed the duration of the agreement.
- **In-House Collections:** Any account that is 90 days old will be sent to our in-house collections. Payment in full or a payment plan will be required to be set up with a member of our billing team before we will be able to schedule any further appointments.
- **Collections:** Any balance that is 120 days old will be sent to our collection company, unless the account is on a payment plan. If an account is sent to our collection company, ***then a 40% collection fee will be added on top of the balance due.*** When a balance has gone to collections, we will have no other option but to discharge the patient from our practice.
- **Returned Checks:** As a courtesy, we do accept personal checks. We do not accept third party checks. Any check that is returned to us for any reason will be subject to a service charge. The first returned check will be charged a fee of $30 or 5% of the face value, whichever is greater, plus any costs we incur because of the dishonored check. The second returned check will be charged a fee of $30 or 5% of the face value, whichever is greater, plus any costs we incur because of the dishonored check. A letter will be mailed to the family and all returned checks plus applicable fees, must be paid by cash, cashier's check, money order, or credit card within 10 days of the receipt of the letter per Georgia la (Section 16-9-20 of the Official Code of Georgia). After a second offense, we will no longer accept checks of your family account.

Financial Policy

- **Refund Policy:** There are times when overpayments occur, and parents have the option to leave the balance on the account for future out-of-pocket expenses or to have a check issued to them for the amount of the overpayment. Any patient who was self-paid at the time of service and subsequently had insurance coverage retroactively applied to the date of service, resulting in payment from the insurance for that visit, may choose to receive a check for the credit amount or leave it on the account for future visits.

Administrative Fees: Listed below are the services for which we charge an administrative fee. Most of these services are time-consuming and cumbersome on staff's time. ***These services are not billed to your insurance company unless otherwise indicated and they are your responsibility***.

- No Show/Missed Appointments Fees
- Sports Forms
- Ear Piercing
- Medical records
- Third Party Medical Records Requests

By signing below, you acknowledge that you have read, understand and agree to abide by Dawson Pediatrics' Financial Policy and pay for any and all medical services your child(ren) receive(s) from Dawson Pediatrics. You acknowledge that if my insurance company refuses to pay, for whatever reason, these fees will become my responsibility.

_____	_____
Patient Name	Date of Birth
_____	_____
Patient Name	Date of Birth
_____	_____
Patient Name	Date of Birth
_____	_____
Patient Name	Date of Birth
_____	_____
Patient Name	Date of Birth
_____	_____
Parent/Guardian Signature	**Date**

PATIENT PORTAL USER AGREEMENT AND INFORMED CONSENT

The Dawson Pediatrics portal utilizes technology to deliver secure communications between patients and Dawson Pediatrics. The term "patient portal" refers to the part of Dawson Pediatrics information system that provides access to patients' health information and allows for secure communication, including prescription, referral and appointment requests.
"Electronic communication" means e-mail or text messaging with patients outside of a patient portal.
Patient portal policy
The following policies and limitations apply to the use of Dawson Pediatrics patient portal.

1. Patient portal communication is not for emergency purposes. If you are having an emergency, dial 911 or go to your local hospital.
2. Correspondence via patient portal is supplemental to physician/patient encounters. Dawson Pediatrics will not provide patient portal-based diagnosis and treatment.
3. Sensitive subject matter, such as HIV/AIDS, STDs, mental health, behavioral health, drug treatment, or genetic testing information cannot be discussed through the patient portal.
4. Other electronic communication with the health care professional, such as non-patient portal email or text messaging is prohibited.
5. Communications sent via patient portal must be courteous, respectful, appropriate, fact-based and truthful.
6. Communications should be responded to within two business days. You agree not to use this portal if you need a response sooner or on an urgent basis. If your need is urgent you must contact the practice directly.
7. You agree not to share your password with anyone and that you are solely responsible for protecting your password.
8. You agree that access to the site is provided on an "as is available" basis and that our practice cannot guarantee you will be able to access the portal at any time. Internet based communications are inherently insecure since no technology guarantees privacy or security of information sent over the internet. You agree to use caution when providing information via this portal, and acknowledge that keeping messages secure is your responsibility.

Conditions of participation
Access Dawson Pediatrics is restricted to the above-named patient. This service is optional, and we reserve the right to suspend or terminate the service and/or your access to it at any time. If the practice suspends this service, you will still have access to copies of your medical record and other health information, upon request.
The patient acknowledges that he/she agrees to comply with the Dawson Pediatrics, Patient Portal Policy outlined above.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Parents Signature: _____ Date: _____

Patient Consent for Treatment & Use and Disclosure of Protected Health Information

Consent to Treatment and Examination
With this consent, I voluntarily give authorization for my medical treatment or my child's medical treatment to the providers at Dawson Pediatrics, P.C. Permission is hereby given for patient(s) listed to receive any medical/surgical procedure, x-rays, drug, or laboratory test, medication or exam, as may be deemed necessary by the physicians.

I fully understand that payment is required at the time of service, and should my claims be filed to my insurance company, any unpaid balance is my responsibility. When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.

Consent for Use and Disclosure of Protected Health Information
I hereby give consent for **DAWSON PEDIATRICS, P.C.** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Dawson Pediatrics describes such uses and disclosures more completely.)

With this consent, DAWSON PEDIATRICS, P.C. may call my home or other alternative location and leave a message on voice mail, answering machine, or with a person in reference to any items that assist the practice in carrying out TPO. Such items include appointment reminders, insurance items, and any calls pertaining to my child's clinical care. DAWSON PEDIATRICS, P.C. may mail to my home or other alterative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements. With this consent, DAWSON PEDIATRICS, P.C. may also send email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements.

I have been offered a written copy of the **Notice of Privacy Practices** of DAWSON PEDIATRICS, P.C. prior to signing this consent. DAWSON PEDIATRICS, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices will be posted in the office or may be obtained by forwarding a written request to the Privacy Officer, Dawson Pediatrics 300 Dawson Commons Circle, Ste 320 Dawsonville GA 30534.

I have the right to request, in writing, that DAWSON PEDIATRICS, P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, DAWSON PEDIATRICS, P.C. may decline to provide treatment to me.

Use of Information for Counseling Services (Minor Privacy Rights in Georgia)

Under Georgia law, minors (children under the age of 18) have the right to seek and receive mental health counseling without parental consent in certain circumstances. These include:

- If the minor is 12 years or older and seeking mental health services related to substance abuse, mental health, or emotional well-being.
- When the minor is a victim of abuse.
- When the minor poses danger to themselves or others.

In such situations, the minor's privacy is protected, and their mental health records may not be disclosed to parents or guardians without the minor's consent, except in situations where there is a threat of harm to the minor or others.

Confidentiality of Counseling Records

In compliance with Georgia law, if your child receives counseling or mental health services, their information will be kept confidential. However, we may disclose information in the following situations:

- If there is a risk of harm to the minor or others.
- If mandated by law or a court order.
- For coordination of care with other healthcare providers, with the minor's consent.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Dawson Pediatrics, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Dawson Pediatrics, PC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Dawson Pediatrics, PC:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, contact Stephanie Pierce

If you believe that Dawson Pediatrics, PC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Stephanie Pierce, Administrator, 300 Dawson Commons Circle, Suite 320, Dawsonville, GA 30534, 706-216-2771, Fax 706-216-2944, spierce@dawsonpediatrics.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Stephanie Pierce, Administrator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Patient Name_____ **Date of Birth**_____

Patient Name_____ **Date of Birth**_____

Patient Name_____ **Date of Birth**_____

Patient Name_____ **Date of Birth**_____

~~ **Parent/Guardian Signature** *(unless 18 yrs or older)*_____ **Date**_____

~~ **Relationship to Patient:** _____

****

Internal Use Only:
If a patient or patient's representative refuses to sign the Patient consent for Use and Disclosure of Protected Health Information, please document the date and time the notice was presented to patient and sign below.

Presented on (date & time): _____ by (name & title): _____

Revised: 2025

DAWSON PEDIATRICS
300 Dawson Commons Circle, Suite 320 · Dawsonville, GA 30534
Tel: (706) 216-2771 · Fax: (706) 216-2944

CANCELLATION AND NO-SHOW POLICY

As of August 1, 2018, Dawson Pediatrics has implemented a new Cancellation and No-Show Policy.

To provide the highest quality of care in a timely manner, we have reviewed our current policies with respect to schedule management and felt that a change was in order. Wait times and availability of appointments are directly impacted by late arrivals and no-shows. Managing these issues more effectively will cut down on the delays of care and lack of available appointments, otherwise lost when patients do not call in to reschedule. The new policy is designed to provide a significant amount of flexibility to our patient population, while at the same time ensuring that those who regularly miss scheduled appointments are held accountable. We want this policy to be a deterrent, not a source of revenue.

Cancellation and No-Show Policy:

- If you cancel your child's appointment less than 24 hours there will be a $25.00 cancellation fee applied to the account after the second cancellation and then any other appointment cancelled less than 24 hours.
- After your child has **No Showed two times there is a $25.00 No Show Fee** that has to be paid prior to the next visit and they are placed on a 6 month probation for Same Day Only list, which means you have to call in the day you know you are able to bring them in for a Well-Check, Sick, any Mental Health, etc, appointments, to see if we have an appointment available for you to be seen.
- After your child has **No Showed three times there is another $50.00 No Show Fee** that must be paid prior to the next visit and they are permanently placed on a Same Day Only list.
- If your child has **four No Shows, there will be another $50.00 No Show Fee that must be paid and the provider is made aware of the excessive no shows and you child will be up for possible dismissal.**

Your appointment is reserved exclusively for you and your child. Please be considerate of others. If you miss your appointment or cancel at the last minute this takes away from other patients that need to be seen.

As a courtesy, we make appointment reminder calls and reminder text providing we have accurate information. Again, this is a courtesy so if you should not receive this courtesy call and the appointment is missed the charge will still apply. This requires that you arrive on time for your appointment. If you are late for your appointment, we may not be able to accommodate you, or we may need to reschedule your visit. If you think that you will be late for your appointment, please call us as soon as possible so that we may advise you if we can accommodate or if your appointment needs to be rescheduled.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Parent's Signature: _____ Date: _____

Revised 04/18/2019

Authorization to Bring and/or Communicate

A parent or guardian must accompany all children/teens under the age of 18. The parent or guardian can designate other people to seek medical care for their minor by completing the information below.

Please be advised that we will not be able to administer vaccines regardless of who is listed below if a parent/guardian is not present.

- **This form is required for EACH child**.

*****Please be advised that we DO NOT recommend you list person(s) that may not care for your child on a **routine** basis and may not know the medical history of your child.-*

I, _____, give the following person{s} permission to make medical decisions in my absence, speak to office staff for advice or triage related to my child's health, pick-up school forms, pick-up shot records and pick-up prescriptions for my child, based on the choices below for matters pertaining to my child, _____, date of birth _____.

Please note any exceptions to the above statement, if applicable, under each individual listed below. (For example: "John DoeGrandfather-is not allowed to pick-up prescriptions, etc.)

Name_____ Relationship_____ Phone_____

**Exceptions*_____

Name_____ Relationship_____ Phone_____

**Exceptions*_____

Name_____ Relationship_____ Phone_____

**Exceptions*_____

Name_____ Relationship_____ Phone_____

**Exceptions*_____

***For any child 16 and Older- _____I, give permission for them to get Vaccines and blood work when they are by themselves.**

_____, I do NOT give them permission to get Vaccines and Blood Work when they are by themselves.

Printed Name_____

Parent/Guardian Signature *(unless 18 yrs or older)*_____ **Date**_____

REVISED 04/02/25

DAWSON PEDIATRICS
300 Dawson Commons Circle, Suite 320 · Dawsonville, GA 30534
Tel: (706) 216-2771 · Fax: (706) 525-7422

Authorization for Release of Medical Information

Patient Name_____ **Date of Birth**_____

Patient Name_____ **Date of Birth**_____

Patient Name_____ **Date of Birth**_____

Patient Name_____ **Date of Birth**_____

PARENTS: Please be advised, that if this form is not filled out completely, we will not be able to receive/release your child's medical records. Please include Practice Name, Address as well as, telephone and fax numbers. For **Newborns**, Please put the hospital at which they were born.

☐ *I authorize Dawson Pediatrics to* **Release Information TO**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number *Fax Number*

OR

☐ *I authorize Dawson Pediatrics to* **Obtain Information FROM:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number *Fax Number*

***Please indicate an expiration date for this release, by checking the appropriate box below:

☐ Expires_____ ☐ Does Not Expire

Reason for Transfer_____

Please release all pertinent medical records on the above named child/children. Records should include all inpatient records, office notes, lab results and immunization records.
The signature below serves as authorization to transfer the records. I understand that these records may include psychiatric, chemical and substance abuse, HIV and AIDS information, and that I may withdraw this authorization in Writing at any time, except to the extent that action has been taken based on this authorization.

_____ _____
Parent/Guardian Signature *(unless 18 yrs or older)* **Date**