

COBB PEDIATRIC ASSOCIATES, P.C.

SIGNATURE SHEET

Patient Name _____ Account # _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

I have received, read and understand your **Notice of Privacy Practices (HIPAA)** containing a description of the uses and disclosures of my child's protected health information.

Signature _____ Relationship to Patient _____

THE USE OF NURSE PRACTITIONERS IN THIS OFFICE

As you are aware, we use **Nurse Practitioners** in our office for those levels of our practice that has been approved by the Georgia State Board of Medical Examiners.

Your signature on this approval form conveys to Cobb Pediatric Associates, that you are in agreement with being treated by our **Nurse Practitioners**, who are acting under our supervision, for routine checkups, minor illnesses and injuries.

Signature _____ Relationship to Patient _____

FINANCIAL POLICY

I have been given a copy of Cobb Pediatric Associates **Financial Policy** statement to read. My signature below signifies that I fully understand and accept the terms of this practice's **Financial Policy**.

Signature _____ Relationship to Patient _____

APPOINTMENT CANCELLATION POLICY

I have been given a copy of Cobb Pediatric Associates **Appointment Cancellation Policy** to read. I understand that I must cancel my appointments twenty four (24) hours prior to the scheduled appointment time.

Signature _____ Relationship to Patient _____