

# PENINSULA CHILDREN'S CLINIC

## Receipt of Notice of Privacy Practices / Written Acknowledgement Form

I, \_\_\_\_\_, parent or guardian of, \_\_\_\_\_,  
have received a copy of the Peninsula Children's Clinic Notice of Privacy Practices.

**X** \_\_\_\_\_  
Signature of parent or guardian Date

## Permission to Seek Medical Attention

I hereby authorize the following persons:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

as my agent to give consent to surgical or medical treatment by any Peninsula Children's Clinic  
medical provider for my child, \_\_\_\_\_ .  
(Child's name)

Such consent may include, but is not limited to, administration of necessary anesthetics, medical treatment, tests, X-ray examinations, transfusions, injections or drugs, and the performing of whatever procedures may be deemed necessary or advisable.

**Specifically, I do / do not authorize vaccine administration for my child.**  
(circle one)

This authorization shall remain effective unless revoked in writing by the undersigned.

**X** \_\_\_\_\_  
Signature of parent or guardian Date

## No Show Policy

Dear Parent,

While we appreciate your family as patients here, we often have families waiting for appointments. When someone does not show up for their scheduled time it leaves someone else with a sick child waiting.

In order to have mutual respect, we ask that you honor your appointment time or contact us as soon as possible if you can't make it, so we may call another family to fill the appointment.

If a family has missed three appointments in a year's time, we may ask you to seek care elsewhere so we may attend to patients in need.