Skin Solutions DERMATOLOGY

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Minor / Child Consent to Treat

Patient Name: _____ Date of Birth: ___/___/___

I am the parent, guardian, or personal representative, which hereby grants Dr._____ permission to treat the above named person when they arrive at the office unaccompanied. I agree there are no court orders now in effect that prohibit me from signing this consent. I do request and authorize the doctor and practice staff to perform necessary services for the above named minor, including but not limited to xrays, light based treatments, injections, etc., which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

_____ ___/___/___
Signature of Parent Date

_____ _____
Printed Name Relationship

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied, I authorize the above physician to charge to my major credit card (listed below) under the following circumstances:

Initials

_____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, copayments and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

_____ For whatever reason, should my account fall into a 45 day or later (after the date of service) category, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

_____ I would like a receipt for charges to be mailed to my address on file.

q VISA q MasterCard q American Express q Discover q Other

Credit Card #: _____ Expiration Date: ___/___/___

Name as it appears on the credit card: _____

_____ ___/___/___
Signature Date