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TREATMENT TO MINORS

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

Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Dr. _____ permission to treat my child when they arrive at the office unaccompanied.

_____ ___/___/___
Signature of Parent Date

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

This agreement is required if you wish your unaccompanied child to be seen.

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 what ever 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.

_____ A receipt for charges will be mailed to my address.

❑ VISA ❑ MasterCard ❑ Discover ❑ Other

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

Name as it appears on the credit card: _____

_____ ___/___/___ Signature
Date