TREATMENT FOR MINORS

Many times, parents and/or guardians find themselves unable to accompany their teens 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 to Affiliated Dermatologists and Dermatologic Surgeons, P.A. and/or Affiliated Ambulatory Surgery, P.C. permission to treat my child when he/she arrives at the office unaccompanied.

_____ _____ _____

Signature of Parent/Legal Guardian Date Witness of Signature

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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. As such, I authorize the above entity to charge to my 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 expenses, medically-unnecessary services, co-payments and insurance balances, should my primary insurance be with a company with which the healthcare provider at Affiliated Dermatologists and Dermatologic Surgeons, P.A. and/or Affiliated Ambulatory Surgery, P.C. have contracts. If my insurance company is not one with which the healthcare provider has a contract, 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 credit card for that unpaid balance without further permission or notice.

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

_____ Visa _____ MasterCard _____ American Express _____ Discover

Credit Card # _____ Exp. Date _____

Name as it appears on the credit card: _____

_____ _____

Signature Date