AFFILIATED DERMATOLOGISTS & DERMATOLOGIC SURGEONS, P.A.

TREATMENT FOR MINORS 5/30/19

Patient Name: ____ Account # _________DOB _______

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 & Dermatologic Surgeons, P.A. permission to treat my child, _____________________________________, when he/she arrives at the office unaccompanied. I agree to be available by phone.

___________________________ ______ ________________________

Signature of Parent/Legal Guardian Date Witness of Signature

****

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).

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. 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.

___ Visa ______ MasterCard ______ American Express ______ Discover

Credit Card # __________________________________ Exp. Date _________

Name as it appears on the credit card: _______________________________________

_______________________________________ __________________

Signature Date