Affiliated Dermatologists, Inc.

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Treatment of Minors

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

My minor child will be coming to the office for evaluation and treatment of his/her dermatological condition unaccompanied. I authorize the physician to treat my child as needed. This authorization will be valid for one year.

I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, co-payments, and balances after my insurance has paid.

Name of Minor:______________________________________ Date of Birth:_____________

□ For the treatment of ____

Specific Condition(s)

□ Any condition needing medical attention.

Signature of Parent or Guardian:____________________________________ Date:___________

Patient Name DOB ACCT#

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