DERMATOLOGY PARTNERS

CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

In order for us to treat a minor without a parents/legal guardian present, please complete this form:

I, _____ (print name here) am the parent/legal guardian of

_____ (print name of minor), currently a minor, whose date of

birth is _____/_____/_____.

I authorize Dermatology Partners to provide medical care to my son/ daughter, including, but not limited to, diagnostic exams (including laboratory testing), treatment, procedures, and prescribing of medications deemed appropriate by his/her provider.

I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

This consent will remain in effect for (1) one calendar year from the date of signature, unless the patient reaches the age of eighteen or parent/legal guardian revokes in writing to Pennsylvania Dermatology Partners.

Payment is expected the day of the appointment and can be made by cash, check, or credit card when checking in, or in advanced over the phone.

By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing this were answered.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Phone Number MRN

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