AFFILIATED TROY DERMATOLOGISTS

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PARENTAL CONSENT FOR THE TREATMENT OF MINORS

At **Affiliated Troy Dermatologists,** we understand that parents may be unable to accompany their teen or young adult children to appointments. For your convenience, we have prepared this form to expedite his/her Medical Care.
PATIENT_____PATIENT D.O.B. _____

I hereby grant to **Affiliated Troy Dermatologists** and its Doctors, and Medical Providers, permission to treat my child when he/she arrives for follow-up visits/services at **Affiliated Troy Dermatologists**. This permission extends to instances when I am unable to accompany him/her to the facility and when I am unable to remain present for the completion of services.

I attest that I understand the reasons for which treatment is being sought for my child and that the procedures and possible complications resulting from the care of my child have been explained to my satisfaction. I understand that this signed consent will remain in effect for one (1) calendar year from the date of signage and my only means to revoke this consent is in writing, attention to the Office Manager of Affiliated Troy Dermatologists.

_____ _____
Signature of Parent (or Legal Guardian) Date

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD ACCOUNT

This agreement is required if you wish that your unaccompanied minor be seen for visits/services.

My minor child will be coming to your office for regular treatment of his/her dermatological condition. I understand that when unaccompanied I must send cash or check with my minor child or I authorize **Affiliated Troy Dermatologists**, its Doctors, and/or staff to issue charges to my credit card account (listed below) under the following circumstances:
INITIALS
_____ I understand that I am responsible for payment of the following charges at the time of service: non-covered services, medically unnecessary/cosmetic services, and copayments should my primary insurance be with a company with which **Affiliated Troy Dermatologists** is contracted. If my insurance company is not one with which **Affiliated Troy Dermatologists** is contracted, I am responsible for the entire amount of charges at the time of service.

_____ If you do not wish to leave credit card on file, you must initial here in agreement that you will send cash, check, or credit card with your minor child to every visit.

_____VISA _____MASTERCARD _____AMERICAN EXPRESS _____DISCOVER

CREDIT CARD #_____ EXPIRATION DATE _____CVC#_____

NAME AS IT APPEARS ON THE CREDIT CARD _____

_____ _____
Signature of Parent (or Legal Guardian) Date