CLEAR SKIN DERMATOLOGY & Cosmetic Surgery

West Suburban Dermatology & Cosmetic Surgery

TREATMENT TO MINORS CONSENT FORM

Patient Name:_____ Date of Birth:____/____/____

Many times Parents/Legal guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your teen or young adult children.

Children 16 or 17 Years Old:

Minors 16 or 17 years old, MUST have a Parent/Legal guardian present for initial office visit or they will be asked to reschedule their appointment. If the patient is 16 or 17 years old, they can be seen for follow up appointments without a Parent/Legal guardian **only** if Parent/Legal guardian fills out and signs this consent form authorizing Clear Skin Dermatology & Cosmetic Surgery to provide treatment to their teen.

I hereby grant Clear Skin Dermatology & Cosmetic Surgery permission to treat my 16 or 17 year old teen when they arrive at the office unaccompanied on:

_____ **until** _____

Date of Permission End Date of Permission

_____ ____/____/____

Signature of Parent/Legal Guardian Date

Children 15 Years Old or Younger:

Minors 15 years old and younger, MUST have an adult present for all office visits or they will be asked to reschedule their appointment. If the patient is 15 years old or younger, they will be able to be seen for their appointment with an adult present other than a Parent/Legal guardian **only** if Parent/Legal guardian fills out and signs this consent form authorizing Clear Skin Dermatology & Cosmetic Surgery to provide treatment to their child.

I hereby grant Clear Skin Dermatology & Cosmetic Surgery permission to treat my child when they arrive at the office accompanied by the authorized named adult listed below.

_____ _____

Name of Authorized Adult Relationship to Patient

_____ **until** _____

Date of Permission End Date of Permission

_____ ____/____/____

Signature of Parent/Legal Guardian Date

****Copay amounts will be due at the time of visit. Please ensure that the patient and/or patient's guardian is equipped to pay the copay amount designated by your insurance company.**