PARENTAL CONSENT FOR THE TREATMENT OF MINORS

At Southeastern Skin Cancer & Dermatology 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 Southestern Skin Cancer & Dermatology and its Physicians, and Medical Providers, permission to treat my child when he/she arrives for services Southeastern Skin Cancer & Dermatology. 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 Southeastern Skin Cancer & Dermatology.

_____ _____
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 services.

My minor child will be coming to your office for regular treatment of his/her dermatological condition. When unaccompanied, I authorize Southeastern Skin Cancer & Dermatology, its Physicians, 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: deductibles, non-covered services, medically unnecessary/cosmetic services, co-payments, and insurance balances, should my primary insurance be with a company with which Southeastern Skin Cancer & Dermatology is contracted. If my insurance company is not one with which Southeastern Skin Cancer & Dermatology is contracted, I am responsible for the entire amount of charges at the time of service.

_____ Should the Southeastern Skin Cancer & Dermatology account maintain an unpaid balance 45 or more days past the date of service, I authorize this office to generate charges to my major credit card account for that unpaid balance without further permission or notice.

_____ I request a Receipt for Charges to be mailed to my address.

_____VISA _____MASTERCARD

CREDIT CARD # _____ EXPIRATION DATE _____

NAME AS IT APPEARS ON THE CREDIT CARD _____

_____ _____
Signature of Parent (or Legal Guardian) Date

Southeastern SKIN CANCER & DERMATOLOGY