PARENTAL CONSENT FOR THE TREATMENT OF MINORS

At Integrated Dermatology Group, LLC dba Dermatology and Advanced Skin Care ("Dermatology and Advanced Skin Care"), 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 or her medical care.

PATIENT_____ PATIENT D.O.B. _____

I hereby grant to Dermatology and Advanced Skin Care, its physicians and other medical providers, permission to treat my child when he or she arrives for services at Dermatology and Advanced Skin Care. This permission extends to instances when I am unable to accompany him or her to the facility and when I am unable to remain present for the completion of services.

I attest that I fully 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 adequately explained to my satisfaction as evidenced by the separate signed consent addressing such procedure, which shall not be replaced by this document. Accordingly, I hereby consent to those certain procedures for my child, including without limitation, [wart destruction, intralesional kenalog injections, acne extractions, biopsies], and related procedures. I understand there will be charges for these procedures, as allowed by my insurance company, in addition to any office visit charges. I understand that I will need to be available by telephone during any medical visits with the physician or the physician assistant. I understand that if my child needs any minor surgical procedures including, but not limited to, biopsies, excisions or incision and drainage, I may be required to be present and that these procedures may require a second office visit that will incur associated copays/deductibles/coinsurance as required by my insurance company. I also understand that if I am not present for my child's medical visit and I have questions and concerns regarding his or her treatment that need to be addressed by the physician or other medical practitioner, I may be required to schedule another visit to discuss those questions and concerns.

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, sent to the attention to the Medical Director of Dermatology and Advanced Skin Care.

Telephone Number (preferred contact): _____

_____
Printed Name of Parent (or Legal Guardian)

_____ _____
Signature of Parent (or Legal Guardian) Date

RESPONSIBILITY TO PAY FOR SERVICES

My minor child will be coming to your office unaccompanied for regular treatment of his/her dermatological condition. On such occasions, I authorize Integrated Dermatology Group, LLC dba Dermatology and Advanced Skin Care ("Dermatology and Advanced Skin Care"), to prepare a due and payable invoice. I further agree as follows:

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 Dermatology and Advanced Skin Care is contracted. If my insurance company is not one with which Dermatology and Advanced Skin Care is contracted, I am responsible for the entire amount of charges at the time of service.

_____ _____
Signature of Parent (or Legal Guardian) Date