GENDLER DERMATOLOGY

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TREATMENT TO MINORS

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

Sometimes parents/guardians find themselves unable to accompany their children to appointments. This form has been prepared for your convenience if your child comes alone for his/her appointment.

I hereby grant Dr. _____ permission to treat my child when he/she arrives at the office unaccompanied.

Signature of Parent:_____ Date: _____

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

This agreement is required if you wish your unaccompanied child to be seen.

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied. I authorize the above-named physician to charge to my credit card (listed below) under the following circumstances:

Initials:

____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

____ For whatever reason, if my account is in arrears for 45 days or more after the date of service I authorize this office to generate charges to my credit card for the unpaid balance without further permission or notice.

____ A receipt for charges will be mailed to my address.

CREDIT CARD INFORMATION

	❑ Visa ❑ MasterCard ❑ American Express	
Credit card number:		Exp. Date: ___ / _____
Name: (as it appears on card)		
Signature:		Date: __ / __ / ____