****

**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, noncovered 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**

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| --- |
| \_\_VISA \_\_MASTERCARD \_\_AMERICAN EXPRESS \_\_DISCOVER |
| CREADIT NUMBER: | EXP DATE: CVV: ZIPCODE:  |
| NAME: (AS AT APPEARS ON CARD) |
| SIGNATURE: DATE: |