



Dermatology Associates
OF THE LOWCOUNTRY

AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until _____, 200____. *(Please define the period as one day, one week, one month or a year – this form cannot exceed one year)*

I (We) the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to medical treatment rendered under the general or special supervision of any member of the medical staff. It is understood that this authorization is given only after a specific diagnosis has been made and is granted to provide authority and power to render care, which the aforementioned provider in the exercise of his best judgment may deem advisable. A minor, by law, **must** be accompanied by a parent/guardian on the first scheduled appointment.

Please remember that co-payments and any additional fees incurred must be paid at time of service.

List any Restrictions: _____
Address: _____ City: _____ State: _____ Zip: _____
Patient Date of Birth: _____
Allergies: _____
Medications: _____
Health Problems: _____

TELEPHONE NUMBERS WHERE PARENT(S)/GUARDIAN MAY BE REACHED

Mother: _____ Home: _____ Work: _____
Father: _____ Home: _____ Work: _____
Legal Guardian: _____ Home: _____ Work: _____
Primary Care Physician: _____
Address: _____ City: _____ State: _____ Phone: _____

INSURANCE PROVIDER (Please bring your insurance card(s) & photo id)

Primary

Insurance Company: _____ Policy # _____

Secondary (if applicable)

Insurance Company: _____ Policy # _____

Signature of Parent/Legal Guardian

Date