EVANS
DERMATOLOGY
PARTNERS

CONSENT FOR TREATMENT OF MINORS

Patient's Name _____ ***Date of birth*** _____

Occasionally parents/guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Dr. Colby Evans, Dr. Amy McClung, Eryn McIntyre PA-C and their staff permission to treat my child when they arrive at the office unaccompanied.

This authorization shall remain in effect until revoked in writing by the undersigned parent/guardian.

_____ _____
Signature of Parent or Guardian Date

PAYMENT AUTHORIZATION

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 physician to charge to my major credit card (listed below) under the following circumstances:

I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, copayments, and insurance balances, should be primary insurance be with a company with which the physician is 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, should my account fall into a 45-day or later (after the date of service) category, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

A receipt for charges will be mailed to my address.

☐VISA ☐MasterCard ☐American Express

Credit Card #: _____ Expiration Date: _____

Name as it appears on the credit card: _____

_____ _____
Signature Date