

Consent To Treat Minor Patient Without Parent Present

In order for us to treat a minor without a parent/legal guardian present, please complete this form:

I, _____ (print name here) am the parent/legal guardian of
_____ (print name of minor), currently a minor, whose date of birth is
____/____/____.

I authorize Lake Washington Dermatology to provide medical care to my son/daughter, including, but not limited to, diagnostic exams (including laboratory testing), treatment procedures, and prescribing of medications deemed appropriate by his/her provider.

I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to Lake Washington Dermatology.

Insurance co-payment is expected the day of the appointment and can be made by cash, check, or credit card when checking in, or in advance over the phone.

By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing this were answered.

Signature of Parent/Legal Guardian

Date

Phone Numbers:

Home: _____ Cell: _____ Work: _____

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