U.S. DERMATOLOGY partners

CONSENT TO TREAT MINORS

We cannot legally treat a minor child without a signed consent form. You must be present at your child's **initial visit** to sign the parental consent below.

Minor Information

Patient Name:	Patient DOB:

Parent/Legal Guardian Information

Name:	SSN#:
DOB:	Work Phone:
Relationship to Patient:	Cell Phone:

If you are not the parent, you will need to provide legal documentation that you are the legal guardian. This information will be kept in the patient's file.

Special Permissions: This agreement is required in order for the minor child to be seen and treated without the parent/legal guardian present.

_____(Initials) **Unaccompanied:** I grant permission to treat and provide any healthcare services to my child that the provider deems necessary for treatment, if my child arrives at the office unaccompanied.

_____(Initials) **Accompanied by Others:** If I am unable to accompany my child to the appointment, the below listed individuals have my permission to accompany my child and make medical decisions regarding my child.

Other Individuals Allowed to Accompany Minor:

Name:	DOB:	Relationship to Patient:
Name:	DOB:	Relationship to Patient:

Consent to Treat Minor: I authorize *U.S. Dermatology Partners* to treat and provide any healthcare services to my child deemed necessary for treatment and/or diagnosis. I also understand that, in the course of that treatment, photographs may be taken for clinical or educational purposes. I acknowledge that this consent will remain in effect until I revoke it in writing and present this document to the office or the minor reaches the age of 18 years.

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

Parent/Legal Guardian Signature:	
Date:	