Consent to Treat Minor

Patient with or without Parent Present

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

I authorize Houston Dermatology Associates to provide medical care to my son/daughter, including but not limited to: diagnostic examination (including laboratory testing), treatment procedures including biopsies, and prescribing of medication as deemed appropriate by his/her physician.

If parent or legal guardian will NOT be present at time of visit, we require a copy of parent/legal guardian's driver's license to be on file, otherwise the minor will not be seen.

Name of person authorized to accompany child: _____

I understand that, should my 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 eighteen, 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 Houston Dermatology Associates.

By signing this, I acknowledge I have read and agreed to this consent and that any questions I had prior to signing were answered by Houston Dermatology Associates.

Payment is expected the day of the appointment and can be made by cash, check, or credit card when checking out.

_____ _____

Signature of parent/legal guardian Date

Phone numbers:

Home: _____ Work: _____

Cell: _____