Affiliated Dermatologists of Virginia

CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian of _____, date of birth_____ do hereby consent to any medical care determined by an Affiliated Dermatologists of Virginia (ADOV) physician to be medically necessary for my child while said child is under the care of _____, relationship to child_____.

I understand that this authorization is given in advance of any specific diagnosis or treatment, however authority is given to the above named adult to give consent to any and all diagnosis and treatments as recommended by the physician.

I understand that I remain financially responsible for any expense incurred by the minor patient.

Signature of Parent or Legal Guardian

_____ Date _____

If Applicable:

In the event that my child is of driving age and I will not be accompanying him/her to their doctor appointment I authorize treatment as deemed medically necessary by any ADOV physician and assume all financial obligations for said treatment.

Signature of Parent or Legal Guardian

_____ Date _____

Office policy requires a parent or legal guardian be present for New Patient appointments.

This consent is valid for established patients only.

Any minor without consent will need to reschedule their appointment.

April 2020