DERMATOLOGY ASSOCIATES
1900 HARRISON AVE. • PANAMA CITY, FL 32405
(850) 769SKIN (7546)
Fax (850) 785-2123

MINOR PATIENT CONSENT FORM

Patient's Name: _____ **Patient's Date of Birth:** _____/_____/_____

It is always desirable and recommended that a parent or legal guardian attend a minor child's appointment. Unfortunately, due to informed consent laws, we cannot treat your child for a new condition until we have informed you of the specific diagnosis and suggested treatment they require and then receive your consent. **If a parent or legal guardian is not present at the time of a minor child's appointment, the child can only be evaluated, and only if a parent or legal guardian consents to the evaluation in advance by completing Section 1 below. Unfortunately, no treatment for a newly discovered condition can occur until authorized by a parent or legal guardian after receiving the appropriate information.**

Evaluation authorization by parent/legal guardian only: ***(Check one box only)***

☐ I will be attending all appointments with my minor child and do not want my minor child evaluated unless I am present.

☐ I will not be attending follow up appointment(s) with my minor child and give consent for any evaluation deemed appropriate by the provider. I understand that unless I am immediately available to consent to any additional treatments, my minor child will need to come back for additional treatment after I provide the necessary informed consent.

Treatment authorization by parent/legal guardian only: ***(Check one box only)***

☐ I will be attending all appointments with my minor child and will be present to give consent if a procedure is recommended. You may not treat my minor child without my consent at the time of treatment.

☐ I will not be attending follow up appointment(s) with my minor child and give consent for ongoing care of any previously diagnosed condition for which I have already provided informed consent.

Insurance information:
If you ***are*** attending the appointment with your minor child, please present the insurance card(s) and photo identification to the receptionist.
If you ***are not*** attending the appointment(s) with your minor child, please have your minor child bring the card(s) to the appointment or attach a copy of the card(s) to this form. Also send along any co-payments.

Name of parent/guardian: _____ **Parent/Guardian's date of birth:** _____/_____/_____

Parent/Guardian's relationship to patient: _____

Payment Policy:
The parent or legal guardian who signs this form will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. We will only respond to a court order that directs Dermatology Associates to act in a certain way.

Guardian Signature: _____ **Today's Date:** _____/_____/_____

Parent/Guardian Contact information:

Father/Guardian (please print): **First name** _____ **Last name** _____

Phone # _____ **Okay to leave a message? Y / N**

Secondary # _____ **Okay to leave a message? Y / N**

Mother/Guardian (please print): **First name** _____ **Last name:** _____

Phone # _____ **Okay to leave a message? Y / N**

Secondary # _____ **Okay to leave a message? Y / N**