TREATMENT TO MINORS

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

My minor child will be coming to the office for regular treatment of his dermatological condition unaccompanied, I authorize the above physician to charge my major credit card (listed below) under the following circumstances:

Services rendered to my minor child ______________________________
Name of Minor

for the treatment of ______________________________
Specific condition

to an amount not to exceed $ ______________________________
without further permission from or notice to me.

______________________________ ______________
Signature of Parent *Date*

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

Initials

_________ My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied, I authorize the above physician to charge my major credit card (listed below) under the following circumstances:

_________ I understand that I am responsible for payment of my account at the time of service for deductibles, noncovered services, medically unnecessary services, copayments and balances after primary insurance has paid, should my primary insurance be with a company with which the physician(s) are contracted.

_________ For what ever reason, should my account fall into a 45 day or later (after the date of service) category, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

_________ A receipt for charges will be mailed to my address.

❑ VISA ❑ MasterCard

Card # ______________________________

Expiration Date _____/_____/_____

____
Name as it appears on the card

______________________________ ______________
Signature *Date*