Dermatology Specialists of Greater Cincinnati, Inc

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Consent to Treat Minor Patient-Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: _____**DOB**: _____

For occasions when you may not be with your child, **please list individuals who may give us consent to see your child:**

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

LIMITATIONS or Allergies: Identify any specific limitations or allergies (If none, state "none")

_____

Family Physician: _____ **Phone:** _____

☐ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult.

This consent shall be in effect for: ☐Date_____ (only)
☐Indefinitely until revoked by written communication

AUTHORIZATION:

I (parent/legal guardian name) _____ request and authorize Dermatology Specialists of Greater Cincinnati and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Dermatology Specialists of Greater Cincinnati and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, cosmetic or aesthetics, injections, wart treatments, local anesthetic, skin biopsies, minor suturing, non-narcotic medication prescriptions.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand. This consent will remain in effect until written communication to revoke / update or patient turns 18 years of age.

_____
Parent or Legal Guardian (please print) Relationship

_____ Cell Phone: _____ Business Phone: _____
Parent or Legal Guardian Signature