

# Dermatology Specialists of Greater Cincinnati, Inc

7794 Five Mile Road Suite 240

Cincinnati, Ohio 45230-2368

Tiffany Pickup, M.D. Amanda M. Crone, M.D. Meghan Jez, PA-C Tara Lair PA-C Ariana Niver NP-C

## 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

\_\_\_\_\_  
Parent or Legal Guardian Signature Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_