DERMATOLOGY
ASSOCIATES
of SAN ANTONIO

Consent To Treat Minor Patient Without Parent Present

In order for us to treat a minor without a parent/legal guardian present, please complete this form and return it with a copy of the parent's/guardian's driver's license to Dermatology Associates of San Antonio.

I,_____________________________________(print name here) am the parent/legal guardian of ____________________________(print name of minor), currently a minor, whose date of birth is_____________________.

I authorize Dermatology Associates of San Antonio to provide medical care to my son/daughter, including, but not limited to, diagnostic examinations (including laboratory testing), treatment procedures, and prescribing of medications as deemed appropriate by his/her physician.

I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required.

This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to Dermatology Associates of San Antonio.

By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing were answered by Dermatology Associates of San Antonio.

Payment is expected the day of the appointment and can be made by cash, check, or credit card when checking out or in advance over the phone.

_________________________________ Signature of Parent/Legal Guardian

_________________________ Date

Phone Numbers:

Home:____________________________

Work:_____________________

Cell:______________________________