CLEAR SKIN DERMATOLOGY & Cosmetic Surgery

West Suburban Dermatology & Cosmetic Surgery

TREATMENT TO MINORS CONSENT FORM

Patient Name:	Date of Birth:/
	d themselves unable to accompany their teen or young adult been prepared for your convenience should you at some time rung adult children.
will be asked to reschedule their appoint follow up appointments without a Paren	a Parent/Legal guardian present for initial office visit or they tment. If the patient is 16 or 17 years old, they can be seen for tt/Legal guardian only if Parent/Legal guardian fills out and ar Skin Dermatology & Cosmetic Surgery to provide treatment
I hereby grant Clear Skin Dermatology teen when they arrive at the office unacc	& Cosmetic Surgery permission to treat my 16 or 17 year old companied on:
	until
Date of Permission	End Date of Permission
Signature of Parent/Legal Guardian	//
asked to reschedule their appointment. I seen for their appointment with an adult	T have an adult present for all office visits or they will be if the patient is 15 years old or younger, they will be able to be present other than a Parent/Legal guardian only if it is this consent form authorizing Clear Skin Dermatology &
I hereby grant Clear Skin Dermatology arrive at the office accompanied by the	& Cosmetic Surgery permission to treat my child when they authorized named adult listed below.
Name of Authorized Adult	Relationship to Patient
	until
Date of Permission	End Date of Permission
	/ /
Signature of Parent/Legal Guardian	Date

**Copay amounts will be due at the time of visit. Please ensure that the patient and/or patient's guardian is equipped to pay the copay amount designated by your insurance company.