Consent for Treatment of Minor Child

Minor Patient Name and Date of Birth:_____

Name of Parent(s) or Legal Guardians: _____

SECTION I (MANDATORY)

I agree that Mountain Laurel Dermatology (MLD) can provide necessary medical care and treatment (including, but not limited to drugs, testing, and procedures). This consent does not apply to surgery or invasive procedures, general anesthesia, or psychotropic drugs.

I agree that: (1) I am the minor's only parent or legal guardian and I have the authority to sign this form without the approval of any other person or entity, or (2) I have the legal authority to consent to all forms of healthcare for the minor. *I agree to be responsible for payment of all charges that are not paid by insurance. I authorize MLD to bill my insurance on file.*

Parent(s)/Legal Guardian(s)Signature: _____

Print Name: _____

Date: _____

SECTION II (OPTIONAL)

This permission applies to times when I am not present. This includes times when the minor is alone or is with a person named below. I understand that if the minor is brought to MLD for non-routine medical treatment, the practice will try to notify me by phone. I give permission to the person(s) named below to seek necessary medical care for the minor named above in my absence.

Friends/family(including stepparents)_____

Minor child (self): _____

Other:_____

I understand that this consent is valid from the date signed until revoked in writing by the patient's parent(s) or when the patient is no longer a minor. *I understand that the patient's routine appointment may be rescheduled if the patient presents without proper authorization per this form.*

_____

Signature of Parent or Legal Guardian Date

_____

Printed name of Authorized Representative and Relationship