393 East 2nd North
Rexburg, ID 83440
208-359-4841
www.alpinedermclinic.com

AUTHORIZATION FOR TREATMENT OF A MINOR

Parents often find it difficult to accompany their minor children to routine follow up appointments. This form has been created to give you the opportunity to authorize both treatment and payment for your minor child in your absence.

I, ______________________________, authorize Alpine Dermatology Clinic, P.C. to render treatment to my minor child, ______________________________, without my presence in the office.

____ ____________________
Signature Date

AUTHORIZATION FOR PAYMENT BY CREDIT CARD

Our financial policy requires payment at the time of service. All copayment, coinsurance, deductible, and non-covered amounts will be collected after your child sees the physician. If you have any concerns regarding costs, please contact our office prior to your child's visit.

I, ______________________________, authorize the office of Alpine Dermatology Clinic, P.C. to make charges to the credit card account listed below in payment for treatment rendered to my minor child.

☐ Discover ☐ Visa ☐ MasterCard

____ ____________________
Credit Card Number Expiration Date

______________________________ ______________________________
Security Code (3 Digits on back of card) Signature of card holder