Lakeside Dermatology

Consent for Medical and Surgical Treatments for Minor:

This form authorizes Lakeside Dermatology, LLC to evaluate and treat your minor Child/charge without you (the parent/legal guardian) being present. This permission includes treatment of lesions requiring minor surgical procedures, injections, cryotherapy with liquid nitrogen or other minor destructive techniques, and the writing of all prescriptions.

I hereby give consent to Lakeside Dermatology LLC for medical evaluation and treatment of my child/charge if a parent/legal guardian is not present.

Please note that all copays are due at the time of service. If you are unable to accompany the patient, please make sure your minor is able to pay the copay required by your insurance company on the date of service.

*If a NEW diagnosis is rendered during a return visit, the parent/legal guardian will need to be contacted and permission granted if the new problem is to be treated.

I certify that I have read and understood all information presented to me before signing this consent form. I have also been given the opportunity to ask questions.

_____	_____
Patient Name	DOB
_____	_____
Name of Parent/Guardian	Parent/ Agent/ Guardian Signature
_____	_____
Best call back number	Witness Signature/Date

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