Integrated Dermatology of Sanford, PLLC

Minor Consent Form

## PATIENT INFORMATION

Minor patient: _____Date of birth: _____

Name of parent(s) or legal guardian: _____

## SECTION I

I agree that the practice 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.

I agree that: (1) I am the minor's 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 minor.

I agree to be responsible for payment of all charges that are not paid by insurance. I authorize Integrated Dermatology of Sanford, PLLC to bill my insurance on file.

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

Print Name: _____

Date: _____

## SECTION II

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 give permission to the person(s) named below to seek necessary medical care for the minor named above in my absence.

1. _____

Relationship to patient : _____

Mobile phone : _____

2. _____

Relationship to patient : _____

Mobile phone : _____

3. _____

Relationship to patient : _____

Mobile phone : _____

4. Minor child (self): _____

Mobile phone : _____

**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.**

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**Unaccompanied Adolescent Minor's Affirmation**

I am an unaccompanied adolescent minor which means I came alone to this medical practice. I am seeking routine medical treatment from Integrated Dermatology of Sanford, PLLC and I understand that if I need treatment that is not routine, the practice may choose to reschedule my appointment or will to contact my parent(s), legal guardian(s), or legal custodian(s) to get consent for this treatment.

Parent(s)/Legal Guardian(s):

Signature: _____

Print Name: _____

Date: _____

Adolescent Minor (if consenting to unaccompanied treatment):

Signature: _____

Print Name: _____

Date: _____

Witness Signature: _____ Print Name: _____

Date: _____