COLUMBIA SKIN CLINIC, LLC

AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until _____, 201___. (*Please define the period as one day, one week, one month, or a year. This form cannot exceed one year.)*

I (We) the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to medical treatment rendered under the general or special supervision of any member of the medical staff. It is understood that this authorization is given only after a specific diagnosis has been made and is granted to provide authority and power to render care, which the aforementioned provider in the exercise of his best judgment may deem advisable. A minor, by law, must be accompanied by a parent/guardian on the first scheduled appointment.

Please remember that co-payments and any additional fees incurred must be paid at time of service.

List any Restrictions:_____

Address:_____ City:_____ State:____ Zip:_____

Patient Date of Birth:_____Allergies:_____Medications:_____

Health Problems:_____

Telephone Number s where parents/guardian may be reached

Mother:_____Home:_____ Work:_____

Father:_____Home:_____ Work:_____

Legal Guardian:_____ Home:_____ Work:_____

Primary Care Physician:_____

Address:_____City:_____State:_____ Phone: _____

Insurance Provider ***(Please bring your insurance card(s) & photo id)***

Primary Insurance Company:_____Policy #_____

Secondary Insurance company:_____ Policy#_____

_____ _____

Signature of Parent/Legal Guardian Date