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TREATMENT OF MINORS

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child. **This Agreement is required if you wish your unaccompanied child to be seen.**

I hereby grant Advanced Dermatology/North Baltimore Dermatology permission to treat my child _____ ("minor child"), whose date of birth is _____, when he/she arrives at the office unaccompanied.

I understand that I am responsible for payment of my minor child's account at the time of service for deductibles, non-covered services, medically unnecessary or cosmetic services, co-payments and insurance balances, should my primary insurance be with a company with which the physician is contracted.

Name of Responsible Party

Date

Signature of Responsible Party

AUTHORIZATION TO CHARGE SERVICES TO A MAJOR CREDIT CARD

I authorize Advanced Dermatology/North Baltimore Dermatology to charge my major credit card (listed below) for any deductibles, non-covered services, medically unnecessary or cosmetic services, co-payments and insurance balance at the time of my minor child's dermatologic visit.

- Visa MasterCard American Express Discover

Credit Card # _____ Expiration Date: _____

Name as it appears on the credit card: _____

Signature

Date

This will remain confidential and valid for one year.