ONESKIN DERMATOLOGY

CONSENT TO TREAT A MINOR

I understand, as significant information is needed at the initial visit and treatment plans are created, it is essential for a parent/ legal guardian to be present at the initial visit and all subsequent visits. Children without a legal guardian at their visit will be rescheduled. Notes from legal guardians with permission to treat is not acceptable.

I acknowledge grandparents, older siblings, step-parents etc. are not considered legal guardians without a court document that must be presented at the time of service.

I understand that unless documents are provided showing otherwise, both parents are assumed to make appointment and treatment decisions for their child. Disagreements on approach to treatment is between the parents to discuss. Payment is due at the time of service regardless of which parent is responsible for medical coverage.

I understand there may be times when I may allow my adolescent child to be unaccompanied for a follow-up visit and all payments that are due at the time of service will be handled by me either prior to the visit or with the CCOF for my child.

I, the undersigned, hereby authorize OneSkin Dermatology, its providers and staff, to provide my minor child with examinations and basic treatments.

Patients Name : _____ Date of Birth ___/___/_____

Parent/Guardian Name : _____ Today's Date ___/___/_____

Parent/Guardian Signature : _____

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