sheperd
INTEGRATIVE DERMATOLOGY

Consent for the Treatment of Minors

Patient's Name:_____Patient's Date of Birth: _____

This form has been prepared for your convenience should you be unable to accompany your child to their appointment.

Parent/Guardian Name: _____ Phone Number:_____

I, hereby grant Sheperd Integrative Dermatology permission to treat my child when they arrive at the office unaccompanied by a parent or guardian.

_____ I understand that I am responsible for any payments due on my child's account. Any deductibles, copays, co-insurances, non-covered services, cosmetic treatments, or past due balances are due at the time of service.

_____ I understand that it is my responsibility to provide the most up to date insurance information and failure to do so could result in a balance for services rendered.

Please select one of the following:

____ I would like to keep this form on file for this and all future appointments.

____ This form is valid for this visit only. Date of Visit: _____

Parent/Guardian Signature: _____ Date: _____