Minor Patient Consent Form

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

All minors must be accompanied by a parent or a legal guardian for their first visit with our practice. Unfortunately, due to informed consent and contracting laws, we cannot treat your child for a new condition until we have informed you of the specific diagnosis and suggested treatment they require and then receive your consent and approval. **If a parent or legal guardian is not present at the time of a minor child's appointment, the child can only be evaluated, and only if a parent or legal guardian consents to the evaluation in advance by completing Section 1 below. Unfortunately, no treatment for a newly discovered condition can occur until authorized by a parent or legal guardian after receiving the appropriate information.**

1. **Evaluation authorization** by parent/legal guardian only: *Check one box only*

◯ I will be attending all appointments with my minor child and do not want my minor child evaluated unless I am present.

◯ I will not be attending follow up appointment(s) with my minor child and give consent and approval for any evaluation deemed appropriate by the provider. I understand that unless I am immediately available to authorize any additional treatments, my minor child will need to come back for additional treatment after I provide the necessary authorization and consent.

2. **Treatment authorization** by parent/legal guardian only: *Check one box only*

◯ I will be attending all appointments with my minor child and will be present to give consent if a procedure is recommended. You may not treat my minor child without my authorization and approval at the time of treatment.

◯ I will not be attending follow up appointment(s) with my minor child and give consent and approval for ongoing care of any previously diagnosed condition for which I have already provided informed consent.

3. **Insurance information:**

If you ***are*** attending the appointment with your minor child, please present the insurance card(s) and photo identification tothe receptionist.

If you ***are not*** attending the appointment(s) with your minor child, please have your minor child bring the card(s) to the appointment or attach a copy of the card(s) to this form. Also send along any co-payments.

Parent/Guardian Name: _____ Parent/Guardian's Date of Birth: _____/_____/_____
Parent/Guardian's Relationship to Patient: _____

4. **Payment Policy:**

The parent or legal guardian who signs this form will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court ruling or divorce decrees. We will only respond to a court order that directs Forefront Dermatology to act in a certain way.

Guardian Signature: _____ **Today's Date:** _____/_____/_____

5. **Parent/Guardian Contact Information:**

Father/Guardian: First Name _____ Last Name_____

Phone (8am-5pm) _____ ☐ Home ☐ Work ☐ Cell (choose one)
2nd Phone (8am-5pm) _____ ☐ Home ☐ Work ☐ Cell (choose one)

Mother/Guardian: First Name _____ Last Name_____

Phone (8am-5pm) _____ ☐ Home ☐ Work ☐ Cell (choose one)
2nd Phone (8am-5pm) _____ ☐ Home ☐ Work ☐ Cell (choose one)