ABILENE DERMATOLOGY
AND SKIN SURGERY CENTER, PC
3190 Antilley Rd., Abilene, TX 79606-5015
Phone: (325) 672-5603 Fax: (325) 672-6570

TREATMENT TO MINORS

Patient Name: _____ Date of Birth ____/____/____

Abilene Dermatology requires that a minor patient, under the age of 18 years, must be seen and accompanied by a parent or adult guardian at the first visit. After the initial visit, if the parent or guardian would like the minor to be seen unaccompanied, we must have an authorization signature from a parent/guardian on file. I understand payment will be due at the time services are rendered.

I, _____ (parent/guardian) authorize Abilene Dermatology and/or its staff to medically treat my child _____ without my presence in the office. This treatment may include minor procedures such as feezing/cryotherapy, cautery (burning), biopsies, injections, and prescriptions for oral and/or topical medications. This consent will continue to be valid until revoked in writing.

I also hereby give my permission to (Name) _____ (Relationship) _____ to act on my behalf regarding the medical care of my minor child.

I understand that these consents will continue to be valid until revoked in writing.

_____ _____
Signature of Parent or Guardian Date

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

This agreement is required if you wish your unaccompanied child to be seen.

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied, I authorize the above physician to charge to my major credit cad (listed below) under the following circumstances:

Initials

_____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, copayments and insurance balances, should my primary insurance be with a company with which the physician(s) are contracted. If my insurance company is not one with which the physician is contracted, I am responsible for the entire amount at the time of service.

_____ For what ever reason, should my account fall into a 45 day or later (after the date of service) category, I authorize this office to generate charges to my major credit card for that unpaid balance without further permission or notice.

_____ A receipt for charges will be mailed to my address.

□ VISA □ MasterCard □ American Express □ Discover □ Other

Credit Card Number: _____ Expiration Date: ___/___/___ CVC Code: _____

Name as it appears on the credit card: _____

_____ _____
Patient Signature Date