PERMISSION FOR TREATMENT OF MINORS

SUTTON
DERMATOLOGY + AESTHETICS

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

This form has been prepared for your convenience should you, at some time, be unable to accompany your child.

I hereby grant the providers of Sutton Dermatology + Aesthetics permission to treat my child when they arrive at office, unaccompanied, for any dermatology related condition.

Parent Name:_____

Parent Daytime Phone: _____

Signature of Parent: _____ Date: _____/ _____ / _____

This consent is valid for 12 months from the date signed.

PAYMENT AGREEMENT

This agreement is required if you wish your unaccompanied child to be seen by the providers of Sutton Dermatology + Aesthetics

Please initial all that apply:

_____ I understand that I am responsible for payment at the time of service for non-covered services, medically unnecessary services, and co-payments.

_____ I agree to send such payment along with my child at the time of the appointment.

_____ 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 and will send full payment with my child.