PERMISSION FOR TREATMENT OF MINORS



Patient Name:	Date of Birth:	//
This form has been prepared for your conveniend accompany your child.	ce should you, at some t	time, be unable to
I hereby grant the providers of Sutton Dermatolog they arrive at office, unaccompanied, for any de		
Parent Name:		
Parent Daytime Phone:		
Signature of Parent:	Date:	_//
This consent is valid for 12 months from th	e date signed.	
PAYMENT AGREEMENT		
This agreement is required if you wish your unac Sutton Dermatology + Aesthetics	companied child to be s	seen by the providers of
Please initial all that apply:		
I understand that I am responsible for pay services, medically unnecessary services,		vice for non-covered
I agree to send such payment along with	n my child at the time of	the appointment.
If my insurance company is not one with responsible for the entire amount at the third.	. ,	