Alta Dermatology Group
130 S. 63rd Street ~ Suite 114 ~ Mesa, Arizona 85206
480~981~2888

CONSENT TO TREAT MINOR PATIENT

Because Arizona Law requires the consent of a Parent/Legal Guardian for medical care of minors, this form has been prepared for your convenience should you be unable to accompany your teen or young adult children to their appointment. If your child is unaccompanied by a Parent/Legal Guardian for their initial office visit they will be asked to reschedule their appointment.

After their initial appointment, a minor may be seen for treatment without the Parent/Legal Guardian being present as long as this Consent Form has been completed.

I,_____, am the parent/legal guardian of _____, currently a minor, whose date of birth is _____/_____/_____.

I authorize the health care professionals of Alta Dermatology Group to provide medical care to my son/daughter, including, but not limited to, diagnostic examinations, treatment of lesions requiring minor surgical procedures, injections, cryotherapy with liquid nitrogen or other minor destructive techniques.

I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated. I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required.

By signing this, I acknowledge that I have read and understand this consent.

Signature _____ Date _____

Emergency Phone:

Home (_____) _____

Work (_____) _____

Cell (_____) _____

*****All Copay amounts, deductibles and co-insurances will be due at the time of service. Please ensure that the patient and/or the patient's guardian is equipped to pay the charges designated by your insurance company. Thank you! *****