Minor/Child Consent

This authorization serves two purposes:

1) It allows us to treat a minor patient in the absence of their parent or legal guardian. For example, a teenage patient with acne could be authorized by their parent or guardian to be seen without the parent or guardian present. Initial here if you wish to authorize Clarus Dermatology, PA to provide all medically necessary treatment for the patient listed below even in your absence: _____

2) This authorization allows us to bill for the services provided to the minor patient. Our standard financial policy still applies. To protect you and us from fraud we cannot bill a responsible party with a different last name or address than the patient's, unless that person is present to sign this sheet.

Signature of Responsible Person:_____

Name of Responsible Person:_____

Date of signature: _____

Name of Patient:_____

Patient Date of Birth:_____

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