

# Town Square Dermatology

## Treatment of Minors

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

Child's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby grant to \_\_\_\_\_ permission to treat my child when they arrive at the office unaccompanied.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

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### 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 card (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 or cosmetic services, co-payments and insurance balances, should my primary insurance be with a company with which the physician is contracted. If my insurance company is not one with which the physician is contracted, I am responsible for payment of 25% of the account balance at the time of service.

\_\_\_\_\_ For whatever reason, should my account fall into arrears greater than 60 days, I authorize the unpaid balance to be charged to my major credit card (listed below) without further permission or notice.

\_\_\_\_\_ A receipt for charges will be mailed to my address.

Visa       Mastercard

Credit Card # \_\_\_\_\_ Expiration date: \_\_\_\_\_

Name as it appears on the credit card: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date