

TREATMENT TO MINORS

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

Many times parents/guardians 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.

I hereby grant Dermatology Associates of West Michigan permission to treat my child when he/she arrives at the office unaccompanied.

_____/_____/_____
Signature of Parent or Legal Guardian Date
(signature is valid for one year from the dated signed)

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

This agreement is required if you wish your child to be seen without a parent or legal guardian present.

My minor child will be coming unaccompanied to the office for regular treatment of his/her dermatological condition. **I authorize Dermatology Associates of West Michigan to charge to my major credit/debit card (listed below) under the following circumstances:**

1. If my primary insurance is with a company with which the physician(s) ARE contracted, I understand that I am responsible for payment of my account for co-payments, deductibles, non-covered services, medically unnecessary services and co-insurance balances and that these charges will be automatically applied to the credit card below.
2. If my insurance is with a company with which the physician(s) ARE NOT contracted, I understand that I am responsible for the entire amount at the time of service and that these charges will be automatically applied to the credit card below.

**We can scan your credit/debit card directly into our computer if you prefer,
or you can complete this form and we will keep it on file.
This information will be kept strictly confidential.**

_____ I have read, understand and agree to all of the terms and conditions above.

Initials

___ VISA ___ Master Card ___ American Express ___ Discover

Credit/Debit Card #: _____

3 digit # from back of card: _____ Expiration Date: ___/___/___

Name as it appears on the credit card: _____

_____/_____/_____
Cardholder Signature Date

-----Office Use Only-----

Patient Name _____ Acct # _____