CLEAR LAKE dermatology

CONSENT TO TREATMENT OF A MINOR WHEN LEGAL GUARDIAN and/or PARENT (S) IS UNABLE TO BRING PATIENT

Patient Name: _____Patient's Date of Birth: _____

I, _____, parent or legal guardian of _____, give my consent for Clear Lake Dermatology to evaluate and treat my child. I understand that any charges accrued during the evaluation are expected to be paid at the time of service. I understand that a Physician and/or Physician Assistant will make every effort to explain any medical options to my child but ultimately my child will be responsible for their treatment plan. This consent is in effect until it is revoked in writing or on the 18th birthday of the minor.

X_____

Signature: Parent/Guarantor Date

Please email (clearlakederm@gmail.com) or fax (281-332-5957) a signed consent form and a copy of your driver license to our office.

Office Use Only: Chart Number: _____