DENVER SKIN DOCTORS

Consent to Treat a Minor

This authorization allows us to treat a minor patient in the absence of their parent or legal guardian. This authorization also allows us to bill for the services provided to the minor patient as detailed in our Patient Financial Policy form. To protect 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 form. Signing below indicates you understand and accept the above terms.

Name of Patient:_____

Date of Birth of Patient:_____

Signature of Parent/Guardian:_____

Name and Relationship to Patient (please print): _____

Phone Number(s) of Parent/Guardian:_____

Date of Signature: _____