Associates in Dermatology, Inc.

Consent to Treat a Minor

Patient name: _____ Date of birth: _____

I, the undersigned, parent(s) or legal guardians of the above named patient, a minor, do hereby authorize the physicians and physician extenders, at Associates in Dermatology, Inc. (AIDerm) to provide healthcare services, including assessment, planning, diagnosis and treatment approved by a supervising physician who is licensed to practice in the state where the minors' healthcare service is being rendered.

In an emergency, it is understood that authorization is granted to the physicians and physician assistant at AIDerm to provide emergency care, treatment, and/or hospital referral which is deemed necessary in the exercise of his or her best judgment.

Consent to Treat a Minor child accompanied by an adult other than the child's parent or legal guardian.

I, the parent or legal guardian of the patient named above, do hereby authorize the providers at AIDerm to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's name: _____ Relationship to the child: _____
(Print Name)

Adult's name: _____ Relationship to the child: _____
(Print Name)

Consent to Treat a Minor child unaccompanied by an authorized adult.

I, the parent or legal guardian of the patient named above, do hereby authorize the providers at AIDerm to perform medical treatment as per the statements above when the minor established patient, 16 years or age or older is without the presence of a parent/legal guardian.

- I authorize my adolescent child to be treated at the office visit(s) if I am unable to attend.

This authorization is valid:

- For any and all medical treatment.
- For today only.
- For this specific problem(s) or a special date range. Please specify: _____

This consent will be valid until revoked in writing by me from the date signed unless otherwise specified in writing.

Parent or legal guardian: (Print name) _____ Date: _____/_____/_____

Parent or legal guardian signature: _____

17 Manhattan Sq. Hampton, VA 23666
Phone: 757-838-8030 Fax: 757-838-8413