OPTIONAL

Parental Consent for Treatment of Minors

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

Many times, parents/guardians find themselves unable to accompany their children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child. Parent or guardian must be present at the first appointment and no procedures may be performed without the physical presence of parent or guardian. Your child should be prepared to make co-payments at the time of service.

I hereby authorize my child to be evaluated by the providers at Johnson County Dermatology PA, should my child arrive at the office unaccompanied by a parent or guardian. I understand that procedures may not be performed without my physical presence.

_____ Date ___/___/___

Signature of Parent/Guardian

Payment on File Authorization

I acknowledge that I have reviewed and understand Johnson County Dermatology PA's office policy and understand that not signing this form does not negate your financial responsibilities outlined in the office policy. I hereby authorize Johnson County Dermatology PA, to charge/refund the credit card or checking account provided for payment of charges/refunds to my account. Charges to include but are not limited to: patient responsibility amounts left by your insurance carrier, late cancel or no show fees, and services not covered by your insurance plan. I understand that it is my responsibility to have enough credit availability to cover any charges that I may incur. Johnson County Dermatology PA, cannot be held liable for any "over limit" fees or any other fees you may incur from the processing of these payments/refunds. This authorization will be kept on file and I agree to update any information on this account. This form will remain in effect until revoked in writing by either the card holder or Johnson County Dermatology PA. A new form must be submitted if information such as the list of authorized users or name of person authorized on the card is amended.

Name:_____Email:_____

Signature:_____Date: _____

Check credit card using and fill out below O Visa O Discover O American Express O Master Card	
Card Number	SEC Code
Name on card	Exp date

Optional: Max amount to be charged at one time: $ _____