DERMATOLOGY GROUP OF ARKANSAS. P.A.

TREATMENT OF MINOR PATIENTS

POLICY

A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY ANY MINOR PATIENT (UNDER AGE 18) FOR THEIR FIRST VISIT TO THE DERMATOLOGY GROUP OF ARKANSAS.

After the first visit, the parent / legal guardian may provide a signed release that will permit the minor patient to be seen for that **SAME DIAGNOSIS** without a parent / legal guardian present. (See below.) However, if the patient presents with a new diagnosis, we must be able to contact the parent / legal guardian by phone to consult about any new treatment plan and to obtain authorization for new medication or treatments.

PLEASE COMPLETE ONE OF THE FOLLOWING OPTIONS (Second signature is optional):

CONSENT TO TREATMENT
(RELEASE TO TREAT UNACOMPANIED MINOR CHILD FOR PREVIOUSLY DIAGNOSED CONDITION)

I, _____ , authorize Dermatology Group of Arkansas, P.A. and its staff to treat my minor child. I expect to be contacted if a new condition arises.

Child's name: _____ Child's date of birth: _____

Parent / Legal guardian phone: _____

Parent / Legal guardian phone: _____

NON-CONSENT TO TREATMENT (MINOR CHILD MUST BE ACCOMPANIED FOR TREATMENT)

I, _____ , do not want Dermatology Group of Arkansas, P.A. and its staff to treat or evaluate my child without a parent / legal guardian present.

Child's name: _____ Child's date of birth: _____

This authorization is good for one calendar year. It must be renewed each year until the patient turns eighteen.

Signed: _____ Date: _____

Print Name: _____ Relationship: _____

Signed: _____ Date: _____

Print Name: _____ Relationship: _____