DERMATOLOGY
— & Skin Cancer —
SURGERY CENTER
an affiliate of
PREFERRED DERMATOLOGY

(972) 390-9002
www.mdbarrows.com

MINOR CONSENT

By completing this form, you are giving us the consent to see and treat your child without a parent present. This includes, but is not limited to, consent for all reasonable and necessary medical treatment and/or surgical treatment and/or other medical procedures which are required during my/our absence for the below-named and described minor/child.

A minor/child(ren) under the age of 18 must have a parent or legal guardian present. In the event that this is not possible, we require you to complete this form and have your child bring it with him/her to the appointment. If you have a legal guardianship of a child(ren) that will be coming without you, we will need a copy of your guardianship papers. If a grandparent or older sibling accompanies your child, we still need this completed consent form from the parents/guardian. **Co-payments, co-insurance and any outstanding balance are due at the time of service. Please ensure the child will be prepared or call the office to make proper arrangements.**

Patient's Name: ______________________________________ Date of Birth: ______ /______ /______

This form is good for: ☐ anytime OR ☐ one time only

If this is a one-time consent, please indicate the date of the appointment: ______________________

Parent Name (Print): ____ Phone: ______________________

Parent Signature: ____ Date: __________________

Emergency Medical Treatment: In the event of an emergency, if you are unable to reach me at the above number, contact:

Name: ____ Phone: ________________________

Relationship: ____